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, 17 July 2025 at 1.00 pm – 4.00 pm

Council Chamber, Chelmsford Civic Centre, Duke Street, Chelmsford, CM1 1JE.

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	1.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	1.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
		Community Beds				
3.	1.02 pm	Community Hospital Services Decision Making Business Case	Approve	To follow	T Abell	7
		Opening Business (continued)				
4.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
5.	2.12 pm	5.1 Approval of Minutes of previous Part I meeting held 15 May 2025. 5.2 Matters arising (not on agenda)	Approve Note	Attached Verbal	Prof. M Thorne Prof. M Thorne	12 -
6.	2.14 pm	Review of Action Log	Note	Attached	Prof. M Thorne	27
		Items for Decision / Non-Standing Items				
7.	2.15 pm	Neurological Services Update	Note	Attached	Dr M Sweeting	28
8.	2.30 pm	MSE ICB Annual Report and Accounts 2024/25	Ratify	Attached	Prof. M Thorne	33
		Standing Items				
9.	2.40 pm	Chief Executive's Report	Note	Attached	T Abell	34
10.	2.55 pm	Quality Report	Note	Attached	Dr G Thorpe	43
11.	3.10 pm	Finance & Performance Report	Note	Attached	J Kearton	47
12.	3.25 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty R Jarvis A Mecan	59

No	Time	Title	Action	Papers	Lead / Presenter	Page No
13.	3.45 pm	General Governance:				
		13.1 Board Assurance Framework	Note	Attached	T Abell	66
		13.2 Revised Committee Terms of Reference	Approve	Attached	Prof. M Thorne	84
		13.3 Committee effectiveness reviews 2024/25	Note	Attached	Prof. M Thorne	90
		13.4 New and Revised Policies	Note	Attached	Prof. M Thorne	97
		13.5 Approved Committee minutes	Note	Attached	Prof. M Thorne	99
		13.6 Updated Constitution	Note	Attached	Prof. M Thorne	183
		13.7 Corporate Objectives and Risk Appetite Statement	Approve	Attached	Prof. M Thorne	185
14.	3.55 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
15.	4.00 pm	Date and time of next Part I Board meeting: Thursday, 18 September 2025 at 2.00 pm, in Committee Room 4a, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, Essex SS2 6ER	Note	Verbal	Prof. M Thorne	-

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - July 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	Nil								
Anna	Davey	ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemead Medical Services Ltd
Anna	Davey	ICB Partner Member Primary Care)	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not participate in any discussion, decision making, procurement or financial authorisation involving the Colne Valley PCN.
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 Board Members' Interests - July 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 of Regular Attendees at Board meetings - July 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.
Emily	Hough	Executive Director of Strategy & Corporate Services	Breaking Barriers Innovation	x	x		Indirect	Close family member works for BBI.	Oct 2024	Ongoing	Will declare an interest in meeting if a relevant conflict arises and withdraw if appropriate.
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 discussed with my
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
Siobhan	Morrison	Human Resources Lead	Provide Community	x			Direct	Employed as Group Chief People Officer at Provide Community.		Ongoing	Interest to be declared as necessary so that appropriate arrangements can be made if and when required.
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.

AGENDA ITEM 2

Mid and South Essex Integrated Care Board - Register of Interests of Regular Attendees at Board meetings - July 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
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.
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.

Part 1 ICB Board Meeting, 17 March 2025

Agenda Number: 3

Decision- Making Business Case on services in mid and south Essex: The future configuration of community inpatient beds, midwife-led birthing and ambulatory services at St Peter's Hospital, Maldon.

Summary Report

1. Purpose of Report

The purpose of the Decision-Making Business Case (DMBC) is to enable the Mid and South Essex Integrated Care Board (MSEICB) to take an informed and evidence-based decision on the following proposals:

1. The future configuration and location of intermediate care and stroke rehabilitation community hospital beds within Mid and South Essex.
2. The proposal to permanently relocate the freestanding midwife-led birthing unit at the William Julien Courtauld Unit at St Michael's Health Centre, Braintree.
3. The proposal to relocate ambulatory services currently provided at St Peter's Hospital, Maldon.

The DMBC is based on the evidence compiled in the Pre-Consultation Business Case (PCBC) (published in January 2024), feedback from the public consultation that was undertaken between 25 January 2024 and 11 April 2024, recommendations made by the Community Consultation Working Group which met monthly between October 2024 and March 2025, and other relevant information gathered since the publication of the PCBC.

The DMBC considers the information and feedback which came forward during the public consultation, and which is covered in detail in the consultation feedback report as well as the recommendations put forward by the Community Consultation Working Group which are set out in detail in the 'Report from the Commission into St Peter's Hospital and associated options with care beds and birthing unit pathways across Mid and South Essex'.

The DMBC will enable decision makers to ensure that decision making, and subsequent implementation, is informed by detailed consideration of all relevant information, including the consultation and working group feedback and suggestions for successful implementation of these changes.

The DMBC includes:

- An overview of the feedback MSE ICB received from the public, patients, carers, NHS staff directly or potentially impacted by the proposals and other staff, public

representative organisations, Health and Overview Scrutiny Committees, local authorities, and many other key stakeholders during our public consultation.
- Information about all the proposed options and service changes, including additional information gathered via the Community Consultation Working Groups on the benefits and potential impacts on service users of the options presented, along with mitigations for the impacts.
- Recommendations for each proposal for consideration by the decision makers, and associated recommendations for implementation based on all the information gathered during this process.

2. Executive Lead

Tom Abell, Chief Executive

3. Report Author

Kate Butcher, Deputy Alliance Director for Mid Essex Alliance

4. Responsible Committees

The MSEICS Community Capacity Programme Board has been responsible for the oversight of the work programme and the development of the DMBC.

The MSEICB Board is responsible for the decision making on the recommendations made within the DMBC.

The following organisations have been involved in the decision-making process:

- The Board of the Mid and South Essex NHS Foundation Trust (MSEFT) which will consider the recommendations prior to the DMBC going to the ICB Board so they have full sight of the evidence and rationale on which the MSEICB Board decision is based. MSEFT own the St Peter's Hospital site, are the provider of the freestanding midwife-led birthing unit and provide a range of ambulatory care services from St Peter's Hospital. The Board of MSEFT have supported the proposed changes throughout the PCBC and consultation process and are committed to supporting delivery of high-quality services across the catchment area.
- The Board of the Mid and South Essex Community Collaborative (MSECC) comprised of the organisations providing NHS community services in Mid and South Essex (Essex Partnership University NHS Foundation Trust, North East London NHS Foundation Trust and Provide Community Interest Company), which will consider the recommendations prior to the DMBC going to the ICB Board so they have full sight of the evidence and rationale on which the MSEICB Board decision will be based on. MSECC provide both intermediate care (IMC) beds and stroke rehabilitation beds, and they also provide a range of ambulatory care services from St Peter's Hospital. The Board of MSECC have been in support of the proposed changes throughout the PCBC and consultation process and are committed to supporting delivery of high-quality services across the catchment area.
- NHS England (NHSE) which will consider the recommendations prior to the DMBC going to the ICB Board so they have full sight of the evidence and rationale on which the MSEICB Board decision is based. NHSE oversee

Integrated Care Boards and their service changes, ensuring they operate within national standards and fulfil their commissioning responsibilities. Any proposal for service change must satisfy the Government's five tests, best practice checks, and must be affordable in capital and revenue terms. NHSE (regional team) followed an assurance process to confirm they were satisfied with the proposals prior to the Integrated Care Board (ICB) formally consulting on them.

5. Link to the ICB's Strategic Objectives

- To ensure that the MSEICB and Integrated Care System (ICS) 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 ICS, 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

An Integrated Impact Assessment (IIA), which includes an equality impact assessment, health inequalities impact assessment and health impact assessment has been undertaken. The IIA also includes an assessment of the environmental impact of the proposed services changes and an assessment of travel analysis that has been undertaken as part of the decision-making process.

A Sustainability Impact Assessment, aligned to the ICS's Green Plan, was also completed.

7. Financial Implications

The key financial test, set out in NHS guidance 'Planning, assuring and delivering service change for patients (2018 and addendum 2022)' is that any proposal is affordable in capital and revenue terms ahead of public consultation. This test was met at the pre-consultation stage of the work programme.

At the outset of the project, a Community Capacity Finance Subgroup was established with representatives from the ICB, MSEFT and MSECC. This is a subgroup of the Community Capacity Programme Board overseeing the work programme.

All movements in cost relating to operational service delivery were modelled and signed-off by both clinical and workforce subject matter experts prior to financial modelling being undertaken.

Finance system partners have worked together throughout the project, to assess costs, and ensure a consistent approach to the financial modelling across the system.

The proposals within the DMBC and associated options (for intermediate care and stroke rehabilitation beds) were costed, reviewed and agreed by the Community Capacity Finance subgroup.

8. Details of patient or public engagement or consultation

There was significant patient, public and stakeholder engagement throughout the work programme:

- Pre- consultation engagement: engagement took place to develop the options and proposals presented within the PCBC. The programme was constructive in engaging with internal and external stakeholders. MSEICB worked closely with the public, patients, carers, community groups, staff, professionals, and other experts. MSEICB commissioned an external organisation, Kaleidoscope Health and Care, to support with pre-consultation engagement.

- Public consultation: consultation on the future number, location and function of NHS run community inpatient beds in mid and south Essex, the proposal to permanently relocate the freestanding midwife-led birthday unit to the William Julien Courtauld Unit at St Michael's Health Centre and the proposal to relocate ambulatory care services currently provided at St Peter's Hospital, Maldon, ran from 25 January 2024 to 11 April 2024. Feedback from the consultation was given conscientious consideration in the develop of the final recommendations within the DMBC.

- Community Consultation Working Group: In response to strong feedback during the consultation period, MSE ICB committed to a further phase of engagement to ensure proposals for community health services were fully co-developed with local communities and stakeholders. As part of this commitment, the ICB established an independent Community Consultation Working Group in autumn 2024. The working group met between October 2024 and March 2025 and developed a set of recommendations which were presented to the MSEICB Board in May 2025 and have been given conscientious consideration in the develop of the final recommendations within the DMBC.

9. Conflicts of Interest

Conflicts of interest known at the time of writing this report are:

MSEICB Board members:

- Paul Scott, Partner Member, Chief Executive of Essex Partnership University NHS Foundation Trust (EPUT): EPUT is part of the Mid and South Essex Community Collaborative, the provider of both IMC beds and stroke rehabilitation beds, and provider of a range of ambulatory care services from St Peter's Hospital, and therefore has a direct conflict of interest. EPUT also own Thurrock Community Hospital and Mountnessing Court, which are two of the sites IMC operate from in mid and south Essex.
- Matthew Hopkins, Partner Member, Chief Executive of Mid and South Essex NHS Foundation Trust (MSEFT): MSEFT own the St Peter's Hospital site, are the provider of the freestanding midwife-led birthing unit and provide a range of ambulatory care services from St Peter's Hospital, and therefore has a direct conflict of interest.

MSEICB Executive Team Members:

- Daniel Doherty, Alliance Director for Mid Essex Alliance, whose spouse works in one of the services involved in, but not impacted by the proposed service changes, and consequently has an indirect personal conflict of interest. Mr Doherty also resides in Maldon, the area most impacted by the proposed service changes, and so had an additional personal interest.

Conflicts have been managed throughout the consultation process and consequently the members cited above may remain in the meeting, but not partake in the decision-making process.

Further to this, it is noted that Dr Giles Thorpe and Joe Fielder both have indirect conflicts with family members working in the organisations involved, although it is noted that they would not be affected by the decision and therefore will be able to partake in decision making.

10. Recommendation/s

The Board is asked to take an informed and evidence-based decision on the recommendations set out within the Decision-Making Business Case.

The Decision-Making Business Case will be made publicly available on 17 July 2025 prior to the MSEICB Board meeting.

Minutes of the Part I ICB Board Meeting

Held on Thursday, 15 May 2025 at 2.00pm – 4.00pm

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

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Tom Abell (TA), Chief Executive, 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.
- 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).
- Sarah Muckle (SMu), Partner Member, Essex County Council.
- Dr Anna Davey (AD), Partner Member, Primary Care Services.

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.
- Samantha Goldberg (SG), Executive Director of Performance and Planning, MSE ICB.
- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB.
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), 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.
- Ceri Armstrong (CA), Head of Transformation and Commissioning, (representing Robert Persey, Partner Member, Thurrock Council).
- Emma Richardson (ER), Director of Commissioning, (representing Mark Harvey, Partner Member, Southend City Council).
- Barry Frostick (BF), Executive Chief Digital and Information Officer, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- James Halden (JH), Independent Chair of Community Consultation Group.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.

- Sophia Morris (SMo), System Clinical Lead, Health Inequalities, MSE ICB.
- Emma Timpson (ET), Associate Director of Prevention and Health Inequalities, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT)
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Robert Persey (RP), Partner Member, Thurrock Council.

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.

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.

Dr M Sweeting declared an interest during discussions relating to agenda item 8, Palliative and End of Life Care Delivery Plan.

No other 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 noted questions had been submitted by members of the public, as set out below.

Peter Blackman asked, according to the Health Services Journal (HSJ), there were reports of cuts to NHS England (NHSE) ring fenced budgets, with maternity, prevention, mental health and children's services suffering the biggest cuts, with the rest of the money being given to ICBs. What would Mid and South Essex Integrated Care Board (MSE ICB) do with this funding.

TA advised that in previous years, the ICB received System Development Funding which was ring fenced for a range of nationally identified priority areas. For 2025/26, many of these ring-fenced areas were included within the ICBs core allocation. In most cases, this enabled the organisation greater flexibility as to how the funding was utilised to meet prioritised needs of

its population. The exception being mental health funding which remained ring fenced as part of the Mental Health Investment Standard.

MSE ICB took the approach to retain investment in those areas where existing commitments had been made and, as such, continued to invest in the priority areas raised in the question. The ICB had not decommissioned any services as a result of the new flexibilities this funding approach had enabled.

Jackie Birch asked whether a full business case would be developed, agreed and financed within three years for the rapid investment and support into St Peters Hospital to keep the outpatients service, particularly given recent announcements and the indicative timescale that would be beyond the next general election.

TA advised that the five-year time horizon proposed by the community consultation group for a new facility in Maldon was intended to be a realistic estimate of the time it would take to agree the financing of any new facility, to proceed through the relevant NHS business case approvals process for such a facility and then go through the design, planning and construction period for the building. This was being worked on and would commit to a timetable, when able to do so. Ideally, this would be faster than 5-years.

In the meantime, as set out by the working group, MSEFT, the owners of St Peter's Hospital were reviewing the estate at the site for development of further business cases to improve the quality of the estate so it could continue to deliver good quality care for local communities whilst the longer-term solution was developed and agreed.

David Birch asked a question which related to accessibility for patients travelling to health appointments, treatments, diagnostics and operations.

TA advised that DD had taken part in qualitative research and awaited the outcome of the findings in relation to the accessibility of services. Once received, the findings would be shared with appropriate stakeholders and would be built into future commissioning intentions.

Paul Osman asked in the context of changes to the Quality Outcomes Framework (QOF), what was the ICB doing to ensure that GP surgeries kept track of cancer patients and carried out cancer care reviews, and to rectify the poor performance against cancer targets.

PG explained that whilst the cancer QOF had been removed, the cancer stewards and MSE Macmillan GPs continued to engage with GPs and Primary Care Networks (PCNs) to ensure cancer patients were supported throughout their pathway. Work being undertaken included:

- PCN visits to review individual practice cancer data.
- Monthly communications on cancer screening and referrals at PCN and practice level.
- Delivering a monthly cancer column to update practices on new pathways, cancer awareness months and support services for patients.
- Workshops with PCNs to educate and develop their wider workforce on cancer care and included care coordinators and social prescribers.
- Non-clinical staff would be included in these workshops to ensure consistency of coding of a cancer diagnosis including staging and treatments.

In addition, the cancer stewards were working in partnership with University College London Partners and Macmillan on an "Improving Cancer Journey" programme for patients in MSE.

SG noted the ICB had developed three interventions to support the oversight and performance improvement:

- ICB leadership at weekly access meetings at MSEFT, which focused on key operational metrics, enabling proactive monitoring and facilitated timely interventions.
- Targeted Tumour Sites Task Force Groups for breast, skin and urology were set up and jointly led by the ICB and the Cancer Alliance. The groups were conducting operational deep dives and utilised the cancer analyser tool to identify opportunities to streamline pathways, reduce delays and improve treatment timelines for patients.
- Elective outsourcing activity to support cancer to create additional capacity for cancer services, with the aim to reduce cancer waiting times and improve access for patients.

Stuart Scrivener asked what steps were being taken by the ICB to ensure mental health services were adequately funded and supported in the long-term and given the significant financial and wellbeing impact of the Lampard Inquiry on EPUT, was there any additional support the ICB could provide to help mitigate these challenges.

AM advised that MSE ICB was working to ensure long-term sustainability and enhancement of mental health services, particularly in light of the challenges highlighted by the Inquiry.

The ICB's Joint Forward Plan (2023-2028) and most recently the Medium-Term Plan outlined a commitment to integrated, patient-centred care that addressed health inequalities and prioritised mental health. The plan aligned with the NHS Long-Term Plan and emphasised collaboration with local authorities and community organisations to deliver comprehensive mental health services.

Additionally, the Integrated Care Strategy (2023-2033) emphasised principles such as prevention, partnership, and empowering frontline staff, to create a resilient mental health care system that could adapt to changing needs and consistent support for patients.

Many mental health patients had long-term relationships with the provider trust, so the ICB was focused on strengthening community-based services and support systems. This included initiatives to improve emotional wellbeing among children and young people, as well as targeted support for older adults. By fostering collaboration between healthcare providers, families, and community organisations such as the Voluntary, Community and Social Enterprise (VCSE) sector, the ICB aimed to create a more supportive environment for mental health patients. By prioritising long-term funding, embracing systemic reforms, and enhancing community support through system sustainability, the ICB sought to ensure that mental health services were adequately funded and supported for the future.

Rosie Novis and **Norman Huxter** asked questions that were unrelated to the agenda items, so written responses would be provided after the Board meeting.

Tom Kelly raised concerns regarding staffing at a provider organisation and his concerns would be referred to the relevant provider.

Peter Hollebon raised a personal issue which would be responded to by the appropriate ICB team.

4. Minutes of the ICB Board Meeting held 13 March 2025 and matters arising (presented by Prof. M Thorne)

MT referred to the draft minutes of the ICB Board meeting held on 13 March 2025 and asked members if they had any comments or questions.

There were no comments or amendments.

Matters Arising

An extraordinary Board meeting was held on the 30 April 2025 to review and approve the Operational plan. The Board was requested to ratify this decision.

There were no further comments.

Resolved: The Board approved the minutes of the Part I ICB Board meeting held on 13 March 2025 as an accurate record and ratified approval the Operational Plan.

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. Community Beds Working Group Final Report (presented by T Abell, C Hankey and Dan Doherty)

TA introduced the purpose of the Community Consultation Working Group (CCWG), established to review feedback from the Integrated Care Board (ICB's) consultation on community services in Mid and South Essex (MSE). The CCWG, chaired independently by JH, included representation from local councils, NHS partners, and community organisations including Healthwatch. The CCWG operated under a six-month mandate beginning October 2024, following significant feedback on the original consultation proposals. The remit of the group was to develop pathways of care; review the options proposed for the provision of maternity services and community beds; and make proposals for the future healthcare estate model and the future shape of services included within the original consultation. JH noted appreciation for the pause in the consultation to allow the CCWG to consider the consultation feedback and thanked those who had participated, including Andrew Sheldon who peer reviewed the report.

JH noted that the consultation had good intent but did not fully meet the needs of the Maldon district or satisfy the requirements for long-term financial sustainability. Splitting outpatient services across public service buildings in Maldon was found to be potentially unmanageable and more costly over time. Learning for future consultations included providing more fully developed proposals to allow meaningful stakeholder feedback.

Current and Future Use of the Estate in Maldon

The CCWG recommended that in the short-term outpatient services were to remain at St Peter's Hospital (SPH) while a new site was identified. MSEFT had begun survey and refurbishment work to improve the existing SPH facilities within the year; to ensure services were in better quality accommodation.

In the longer-term the CCWG recommended a proposal to create a new ambulatory care hub,

potentially co-located with GP and pharmacy services to address local primary care space deficits. The site redevelopment was preferred on the existing SPH site due to strong transport links. Partnership opportunities and capital funding options were being explored. The capital allocations included capital funding for a Community Diagnostic Centre (CDC), prudent borrowing from Maldon District Council, existing resources and partial capital receipts from disposing parts of the site.

Intermediate Care and Stroke Rehabilitation Beds

Demand analysis showed a need for only two stroke beds and four intermediate care beds in Maldon. Operating a dedicated unit at SPH was therefore considered unjustifiable. However, the CCWG recommended transitioning to a long-term block contract for care home bed capacity (replacing spot purchasing), accelerating rollout of the 'home first' model, and adopting Option B from the consultation to ensure equitable access and minimise travel time. It was noted that steps to respond to the recommendations had commenced with the acceleration of the home first model and recent approval by the Board supporting a procurement model for care home bed capacity as part of implementing the Medium-Term Plan (MTP).

Midwife Led Birthing Unit

Due to a variety of factors, notably the falling birth rates and an increasing rate of deliveries by caesarean section, the CCWG concluded that maintaining the birthing unit at SPH was not viable. The CCWG therefore recommended permanently relocating the midwife-led unit to William Julien Courtauld Unit in Braintree, maintaining all pre- and post-natal appointments in Maldon. Expansion and promotion of the home birth service, with improved monitoring and support was also recommended. It was noted that the model for staffing was peer reviewed independently by an NHS Trust who confirmed that it was a sound principle.

The CCWG also made it clear that the ambulatory appointments associated with maternity services currently delivered at SPH should be maintained in Maldon.

Oversight and Next Steps

The CCWG recommended the establishment of a standing community and stakeholder group to oversee future developments and estate changes. This would ensure transition of leadership into community hands and maintain public accountability. All recommendations would be integrated into the Decision-Making Business Case (DMBC) to be submitted to the Board for approval in July 2025 (the formal governance route to enable a final decision).

It was noted that the ICB would review the consultation process to identify way to strengthen future processes. TA advised that progress had been made in several areas, such as approval of the revised approach to Discharge to Assess (D2A) and reviewing issues with estates.

MH emphasised safety of births and the need for adequate capacity at Broomfield hospital considering the proposed changes. The Trust would continue to work closely with ICB colleagues on the DMBC and long-term sustainability of high-quality maternity services that the MSE population deserved.

GW queried the estimate of costs for construction of the new hub. TA commented that, based on the accommodation and assumption that a GP practice would be included, the costs were estimated at approximately £14 million. Further detailed work was to be completed in terms of

validation, areas to be developed, partnership opportunities to be explored and whether any other public services could be included.

SP asked for the timeframe that the proposal would be realised. TA confirmed that some services changes would occur quicker than others. The estates element was a five-year ambition.

JF suggested benchmarking against recent hub projects such as that in Waveney.

MT thanked JH and everybody involved for the work and the report which was accepted by the ICB.

Resolved: The Board:

- **Noted the report and recommendations of the independently chaired Community Consultation Group.**
- **Acknowledged that the findings would inform the development of the final Decision-Making Business Case (DMBC), which would be brought to the Board for formal consideration and approval by July 2025.**
- **Noted that no decisions were being sought at this stage, and that the Board would be asked to make its determinations once it had received and reviewed the full DMBC in due course.**

7. Lampard Inquiry Update (presented by Dr M Sweeting)

MS offered condolences on behalf of the ICB to those who had lost loved ones and acknowledged the impact the Lampard Inquiry would have on others, and confirmed the ICB was committed to being open and transparent. The Inquiry was reviewing the death of mental health patients within Essex between January 2000 and December 2023 and would continue until late 2026.

The ICB was working collaboratively with Suffolk and North East Essex and Hertfordshire and West Essex ICBs as designated ‘core participants’ who have a formal role and special rights in the Inquiry process. The ICBs had established a safeguarding memorandum of understanding, setting out the safeguarding process, led by MSE ICB. MS thanked the ICB Executive Nursing Officer and the Quality team for their support and the internal core team for their hard work.

The scope of the Inquiry was updated to define ‘inpatient deaths’ and include Drug and Alcohol Units and Learning Disability Units.

MS noted the challenge in retrieving historical data over the 23-year period, given the changing NHS landscape. Support was being provided to current and former ICB staff. The hearings were underway in London.

MT commented that reports in the media suggested responses to requests for information were taking a long time. MS confirmed this had not been raised as a concern for the ICB. There had been public criticism at the Inquiry of some providers for the time taken to respond to Rule 9 requests. However, this was due to several complex commissioning arrangements, historical filing arrangements, storage of records and the scale of information required.

NIB asked if any immediate lessons could be learnt from the Inquiry so far. GT advised that

the ICB had a close working relationship with EPUT and MSEFT, and a strong governance framework which focused on learning. The Patient Safety Incident Response Framework (PSIRF) enabled a holistic approach to learning from incidents. Assurance was sought from the *Evidence Assurance Group* and *Quality Together* meetings which were attended by wider system partners and focused on the quality of services and sustainable learning.

AD asked whether the ICB changes and efficiencies would affect the support the ICB provided to the inquiry. MS advised that as this was a statutory function of the ICB, the workforce would be funded for the longevity of the Inquiry.

Resolved: The Board noted the Lampard Inquiry Update Report.

8. Palliative and End of Life Care Delivery Plan (presented by Dr M Sweeting)

MS presented the Palliative and End of Life Care (PEoLC) Plan for Board approval, highlighting both strengths and areas for improvement through a case study. The Frailty and End of Life Care template enabled real-time updates and clinical decision-making, but gaps such as missing Advance Care Plans (ACPs), lack of anticipatory medicines, and fragmented access points were noted.

MS advised a palliative care conference (being delivered by the stewardship team and end of life group) was scheduled for June 2025 to review patient journeys and enhance experience. Outcome measures developed by BF's team now tracked ACPs, medication, and risk status in real time via the FrEDa (Frailty Marker) tool.

Key priorities for the coming year included improved access to and provision of end-of-life medicines; clear case management; 24-hour access to care; and advanced care planning (supported by a skilled workforce).

AD responded to NIB and advised that responsibility for ACP completion was shared across healthcare teams, with Integrated Neighbourhood Teams (INTs) playing a central role, working with oncology and palliative care teams, hospice nurses, GPs and PCN frailty teams. MS advised a shared care record (SCR) was vital for teams to access patient data and responding to MB and SP, noted that population health tools, underpinned by a competent workforce would help to identify high-risk patients for timely intervention of either specialist or generalist care.

Challenges included fragmented data systems and late recognition of end-of-life status. Efforts were underway to improve data integrated and workforce capability, including for Babies, Children and Young People (BCYP). Responding to EH, it was noted that a mapping exercise was undertaken, and a register developed for BCYP with the same principle as adults, so individuals could be recognised for implementation of appropriate plans.

A discussion commenced by DD noted that public education on end-of-life care was needed, with a societal shift toward end of life in the community and wrap around care, support, advice and guidance provided out-of-hours.

Hospices, though vital, face financial strain. MS and TA, responding to GW, acknowledged funding pressures and the need for strategic support to the voluntary sector, noting that this was under review.

GO sought confirmation that the whole clinical workforce was involved. TA advised that involvement was not fully comprehensive; a presentation had been provided to the People Board on future opportunities and careers within the voluntary sector and health service.

Resolved: The Board approved the Mid and South Essex All Age Palliative and End of Life Strategic Delivery Plan.

9. Mid and South Essex Hospitals NHS Trust compliance with 10 maternity standards (presented by Dr G Thorpe)

GT advised that provider organisations must show evidence of their compliance against the Maternity Incentive Scheme ('the 10 safety standards') annually. The ICB provided constructive 'check and challenge'.

The Board were asked to note that the review had concluded, and the Trust had, for year 6, achieved all 10 safety standards in line with NHS Resolution requirements.

Responding to JF, GT advised there were specific standards related to the number of neonatal nurses that were qualified in specialty. At the time of the report, the Trust had not met the required target, however, there was evidence of training underway, and the training plan had been provided, showing the Trust would meet that standard this financial year.

In response to GO, GT explained that the ICB hosted the Local Maternity and Neonatal System (LMNS) which focused on the views and experiences of those who utilised MSE maternity services. It focussed on a culture programme for health inequalities and equity of service provision and was closely monitored by the ICB. MH advised that a strong culture led to positive outcomes for patients. Evidence underpinned the scoring for the incentive scheme and was a good example of targeted resource demonstrating improvement in service.

Resolved: The Board noted the NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentives Scheme Year 6 - Mid and South Essex LMNS Evidence Assurance process report.

10. Mental Health Update – Manchester and Nottingham Reports (presented by Dr G Thorpe)

GT summarised the Great Manchester report related to incidences of abuse to some of the most vulnerable patients in society, and the Nottingham report related to the tragic deaths of innocent members of the public by an individual suffering from acute psychosis. Following the two investigations ICBs were required to seek assurance from provider organisations that they were responding to the recommendations of the reports.

There were several recommendations, particularly in relation to Greater Manchester, and EPUT and NELFT had responded fully.

GT thanked NIB, who as Chair of Quality Committee, had scrutinised both reports.

Resolved: The Board noted the Greater Manchester Review and Nottingham Review reports and that a Statutory Inquiry into the Nottingham attacks was being established.

Action: HC to share EPUT's full report in response to the Nottingham report with Board members, Executive Team and regular attendees.

11. Health Inequalities Annual Report 2024/25 (presented by R Jarvis)

RJ introduced the Health Inequalities Annual Report for 2024/25, outlining the ICB's continued commitment to addressing preventable and unjust differences in health outcomes across the population. ET explained that the report followed NHS England guidance and should be read alongside the 2025/26 Annual Report, which detailed how the ICB discharged its legal duty in reducing health inequalities and embeded this within its decision-making processes.

The report highlighted a persistent 10-year life expectancy gap between the most and least deprived areas in MSE, with additional disparities affecting vulnerable groups, including those with learning disabilities, mental illness, and individuals from Black and Asian communities. Tangible progress was noted, including increased uptake of health checks for vulnerable groups, a reduction in childhood tooth extractions in deprived areas, and a decline in smoking rates among expectant mothers. Outcomes from Talking Therapies for people of Global Majority backgrounds also exceeded those for White British individuals, attributed to targeted recruitment, outreach, and accessible support.

Despite these improvements, challenges remain. The report identified the need for continued focus on mental health inpatient care, cancer screening uptake in deprived areas, and cardiovascular hypertension management, particularly among younger and ethnically diverse populations. SMo emphasised the importance of integrated working and the use of population health tools to close the health gap. SMu and CA acknowledged the report's clarity and achievements, while also highlighting the need for further action, particularly in addressing wider determinants of health and supporting unpaid carers.

Board members discussed the critical role of the voluntary sector in delivering interventions and reaching underserved communities. Concerns were raised about data completeness, particularly regarding ethnicity and child and adolescent mental health services. ET confirmed ongoing efforts to improve data quality. JF noted the significantly reduced life expectancy for individuals with severe mental illness, and ET outlined the preventative work underway, including health checks and early death reviews.

GO queried how resource-limited services prioritise support for marginalised groups. ET and SMo confirmed that health equalities are embedded within several Medium-Term Plan programmes, and further data analysis is being undertaken to identify and address gaps. RJ concluded that, regardless of future ICB structures, health inequalities remain a key challenge and must be embedded in strategic commissioning. AM and LW added that local engagement and high-quality data are essential to targeting need and delivering equitable care and that residence were being educated about responsibility for their health through local engagement with Alliance Teams.

Resolved: The Board approved the Annual Health Inequalities statement for 2024/25 that would be published alongside the ICB's Annual Report and Accounts 2024/25.

12. Communications Strategy Update (presented by C Hankey)

CH presented the Quarter 4 Communications and Engagement Impact Report, which aligned with the ICB's communications strategy. The team had contributed significantly across strategic priorities, including winter resilience, primary care access, and public engagement in

the development of both the local Medium-Term Plan (MTP) and the national ten-year plan. Improvements were noted in staff engagement and media sentiment, with the report focusing on delivery, lessons learned, and continuous improvement, particularly in the context of reduced ICB running costs.

Internal communications remained central to organisational change, with the latest staff survey showing increased engagement in motivation, involvement, and advocacy; 41% of staff understood organisational priorities, but noted that access to information required improvement. This was being addressed through intranet enhancements and user-driven content design.

Externally, the *Next Door* platform had proven successful and was shared with MSEFT to ensure consistent messaging across the system. LinkedIn continued to be a key professional and internal communications channel. The email marketing strategy had been consolidated, resulting in increased subscriptions to email bulletins, particularly in women's and men's health.

The ICB website received over 100,000 visits during the period, with search engines driving traffic and e-bulletin links generating the highest engagement. Twenty-six press releases led to 92 pieces of coverage, 60% of which were positively toned. A new partnership with The Echo and Newsquest Essex helped reach digitally excluded audiences, ensuring access to trusted local information.

Stakeholder bulletin engagement increased, with the January edition showing a 10% rise. Parliamentary hub activity also grew, likely due to the presence of new MPs. Public engagement remained strong, with the virtual views platform reaching 1,000 members. The Research Engagement Network secured £63,000 in funding, supporting 24 community champions and enabling over a dozen individuals to access research opportunities.

More than 500 people participated in engagement activities related to the 10-year plan and local MTP, facilitated through community-led sessions and focus groups. In response to a query from MT, CH confirmed that the Readers Panel, composed of non-NHS members, regularly reviewed website content and communications for clarity and accessibility.

PG thanked the communications team for their support in primary care messaging, noting the positive impact of a unified cascade approach. BF asked about expanding Next Door across system partners, and CH confirmed ongoing work to share the virtual views platform with MSEFT and EPUT, including a pilot with a PCN to host a virtual Patient Participation Group. SP expressed appreciation for the team's progress.

Resolved: The Board:

- **Noted the Communications and Engagement Strategy update report.**
- **Endorsed the proposed improvement actions and acknowledged the capacity risks posed by running cost reductions, including the need to re-prioritise planned activity in 2025/26.**

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

TA presented his report and advised that a response was being drafted on the running cost reduction for ICBs with the aim to submit a plan to NHSE at the end of May, which would in

turn be shared with partners, stakeholders and communities.

Resolved: The Board noted the Chief Executives Report.

14. Quality Report (presented by Dr G Thorpe)

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

The well led inspection at MSEFT had concluded and colleagues in the organisation were awaiting the initial results.

A consultation had been launched by NHS England on the National Performance Assurance Framework of both provider organisations and ICBs, which would impact upon segmentation and any offer of support from the national team. Model ICB and future model regional workforce determinations work was ongoing.

Resolved: The Board noted the Quality Report.

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

JK presented the finance and performance report and the finance plan for 2025/26.

The annual accounts were being audited and would be submitted by 20 June 2025. The ICB's financial position at year end was break-even. Provider partners delivered a collective deficit of £112 million, a significant improvement on previous trajectories. There were lessons learned going forward into 2025/26 and movement in the ability to deliver efficiencies of a recurrent nature.

Board reporting on the 2025/26 financial plan would be further developed to focus on the 'run rate'. There was a risk to delivering the plan and the Board's support was welcomed in managing risks as they emerged. SG would also develop the performance report.

JF advised that the call for a 7% efficiency challenge was significant. The efficiency figure was 5.8% nationally last year and the national average was 7.1%.

GW, echoed by AM, commended the finance and governance teams in delivering the annual report and accounts. There had been a clean audit, internal controls were good.

MT commented that national confidence had been earned in the system as a whole.

SG provided an update on performance and advised that strengthened oversight governance across Urgent and Emergency Care (UEC), cancer and elective care to support our provider organisations continued.

UEC performance at year end was 71% against a national target of 78%. Ambulances delivered 81% against a national target of 90%. There was a focus on system-wide coordination to improve the maximisation of out of hospital opportunities in urgent care pathways which was supported and underpinned by the MTP for this year.

MSEFT remained in national oversight Tier 1 for underperformance in cancer standards. The February position saw non-delivery of the national standards for the 28-day faster diagnostics and the 62-day standards. The Cancer Alliance and ICB were supporting MSEFT on governance and oversight. Specific tumour site focus groups had been developed, including urology, breast and skin, to improve patient pathways and reduce timelines thus increasing compliance with national standards.

The year-end elective care target was not achieved. However, initiatives were being worked through to support demand management. Referrals were being reduced, with community pathways and capacity increased to support delivery of zero 65-week waits at the end of quarter 1 of this financial year and 60% of patients waiting no longer than 18 weeks by the end of 2025/26 in line with the Operating Plan.

MH confirmed that MSEFT's Board and leadership team were working hard to improve waiting times for people in MSE.

Resolved: The Board noted the Finance and Performance Report and the Finance Plan 2025/26 report.

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

PG presented the Primary Care and Alliance report, expressing thanks to Prof. Sanjiv Ahluwalia for his leadership during the transition of ICB responsibilities for primary care, pharmacy, optometry, and dentistry. Despite workforce challenges, access to primary care continued to improve. PG also acknowledged HealthWatch Southend's report on Pharmacy First, which highlighted positive public reception and improved access, with a new Community Pharmacy Commissioning and Transformation Group established to explore further opportunities.

Digital access initiatives (Connected Pathways Teams) remained successful, supported by dedicated resources. Eleven Integrated Neighbourhood Teams (INTs) were focused on frailty and end-of-life care, with additional teams contributing. Discussions were being held regarding dentistry in central government, with MSE recognised for its strong access performance. The ICB had been invited to contribute to the development of the national dental contract. Dentistry services had also begun opportunistic blood pressure checks and expanded access for children and young people.

In response to a query from JF, PG confirmed that reshaping of the Home to Assess pilot was underway with local authority partners. RJ reported that Better Care Fund plans for 2025/26 had been submitted, with enhanced discharge services remaining a priority. Joint commissioning with MSEFT was progressing, and a new service specification was in development. Work on the primary care estate strategy in Rochford had advanced, with Section 106 funding being explored for rapid mobilisation of projects. INT development continued in alignment with the Medium-Term Plan.

AM provided an update from Thurrock, where eye screening services for young people were under review. Engagement with Healthwatch on the NHS consultation had supported feedback on the Long-Term Plan. The 2025/26 INT work programme would prioritise frailty and end-of-life care, with early identification efforts underway. A business case was being developed to utilise space at Purfleet Care Centre to support care closer to home.

DD informed the Board that Sarah Green had stepped down as Mid Alliance Chair for personal reasons, with Adrian Coggins appointed as interim Chair.

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

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

17.1 Board Assurance Framework

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

Resolved: The Board noted the Board Assurance Framework update report.

17.2 New/Revised Policies

The Board noted the following new/revised policies, approved by the relevant Committees:

- 009 Financial Allocations and System Reporting Policy
- 010 Information Governance Framework and Policy
- 011 Information Sharing :Policy
- 012 Records Management and Information Lifecycle Policy
- 013 Access to Inforamation Policy
- 018 Management of Conflicts of Interest Policy (incuding 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
- 087 Pay Protection Policy

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

17.3 Approved Committee Minutes

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

- Audit Committee, 21 January 2025.
- Finance and Performance Committee, 4 March 2025.
- Primary Care Commissioning Committee, 12 February 2025 and 12 March 2025.
- Quality Committee, 28 February 2025.
- Digital and Data Technology Board, 13 February 2025.
- People Board, 6 March 2025.

Resolved: The Board noted the latest approved committee minutes.

17.4 Delegation to Audit Committee for approval of the Annual Report and Accounts 2024/25

MT advised that the Board was required to delegate to Audit Committee the approval of the annual report and accounts 2024/25 because of the timetable to meet national requirements.

Resolved: The Board formally delegated 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.

18. Any Other Business

There were no items of any other business.

MT thanked the members of the public for attending.

19. Date and Time of Next Board meeting:

Thursday, 17 July 2025 at 2.00 pm in the Council Chamber, Chelmsford Civic Centre, Duke Street, Chelmsford, CM1 1JE.

Part I Board Action Log July 2025

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 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	30/08/2025	Reporting built into 2025/26 Board workplan. Deferred to Board September 2025.	In progress
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	30/08/2025	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 September Board meeting.	In progress

Part I Board Meeting, 17 July 2025

Agenda Number: 7

Neurological Services Update

Summary Report

1. Purpose of Report

To provide the Board with a response to the questions raised by the Essex Neurology Network on 11 May 2025 regarding neurological services.

2. Executive Lead

Dr Matthew Sweeting, Executive Medical Director, MSE ICB.

3. Report Author

Scott Baker, Clinical Director of Allied Health Professionals and Leadership

4. Responsible Committees

Not applicable.

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

6. Impact Assessments

Not applicable to this report.

7. Financial Implications

Not applicable to this report.

8. Details of patient or public engagement or consultation

Not applicable to this report.

9. Conflicts of Interest

Helen Garvey Essex, Neurological Rehab Lead, MSE ICB, who will be presenting the patient journey part of this agenda item, is also a committee member of the Essex Neurology Network.

10. Recommendation/s

To Board is asked to receive the report as a formal response to the questions raised by the Essex Neurology Network.

Response to Essex Neurology Network (ENN)

1. Introduction

The Lancet Neurology stated in 2021 that more than 3 billion people worldwide were living with a neurological condition (Ref 1 below). Neurological disorders are the leading cause of disability and the second leading cause of death worldwide (Ref 2 below). Neurological conditions are now the leading cause of ill health and disability worldwide.

The overall amount of disability, illness and premature death (known as disability-adjusted life years or DALYs) caused by neurological conditions has increased by 18% since 1990 (Ref 1 below). In Western Europe, the ten conditions that accounted for the greatest nervous system DALYs in 2021 were migraine, stroke, dementia, diabetic neuropathy, autism, nervous system cancer, epilepsy, neurological complications due to preterm birth, neonatal encephalopathy and spinal cord injury (Ref 1below).

1 in 6 people in England live with a neurological condition and based on the population of Mid & South Essex (MSE) being 1.3 million people, it is estimated 216,000 people are affected from these conditions (Essex Neurology Network). Taking action to improve services can save money for the system and support economic prosperity, as well as benefitting patients (Essex Neurology Network).

2. Main content of Report

The Essex Neurology Network (ENN or the Network) is an umbrella organisation that brings together local neurology service providers, national and local support organisations, people, families and carers affected by neurological conditions and researchers. The Network currently works in close partnership with the University of Essex.

The Mission of the Network is to work together to ensure the best services and support for Essex people, their families and carers, who are affected by neurological conditions, so that they have access to high quality resources and the support they need to enable them to live an active and fulfilled life.

The aims of the Network are:

- To raise awareness and promote understanding of neurological conditions
- To secure the highest standards of service and care for people with, or affected by, a neurological condition, and for their families and carers
- To build strong relationships between patients and professionals
- To facilitate & encourage research into the provision of services and neurological conditions.

With the full delegation for the commissioning of neurological services having been transferred from NHS England to local East of England ICBs in April this year, the Essex Neurology Network (ENN) has asked Mid and South Integrated Care Board to *consider the following points, outlined below:*

1. Confirm that the Board is aware of the existence of ENN and by working through them, will identify unmet needs of people living with neurological conditions?

I can confirm that the ICB is aware of the Essex Neurology Network. Our Neuro Navigation Team has actively contributed to both the East of England regional neurosciences strategy and the regional gap analysis work undertaken in collaboration with the Trauma and Rehabilitation Network.

The Neuronavigation team continues to address unmet needs of people living with neurological conditions by exploring the opportunities that devolution of specialised commissioning to Integrated Care Boards may enable the improvement local delivery of services for the neurological population. One proposed project area is the early identification of rehabilitation pathways to reduce length of stay in acute and specialised rehabilitation settings by enhancing the service provision for people with cognitive and communication deficits resulting from any neurological condition. Strategically this would support the Gap Analysis Report undertaken by the East of England Rehabilitation and Trauma Network which identified the reduced provision of Level 1 Rehabilitation facilities.

2. Contribute to the East of England regional neurosciences strategy and East of England gap analysis work with the Trauma and Rehabilitation Network.

The Essex Neuro Navigation team are actively involved in the East of England Neuro rehabilitation steering group and have been involved in the gap analysis work. Helen Garvey, Essex Neurological Rehabilitation Leads is facilitating a session: **Rehabilitation pathways – Overcoming commissioning & service delivery challenges** at the rehab workshop being run by the East of England Trauma Network around commissioning challenges in rehabilitation – including for neurological conditions.

3. Reporting on improvements in data provision of neurological resources made available to people with neurological conditions.

When appropriate, individuals are directed to neurological resources as delivered by local providers including community and voluntary sector organisations and the Health Care and Wellbeing Hub at the University of Essex to support their ongoing needs. However, as it is not a contractual requirement with our service providers, data reporting of those residents who are signposted to these neurological resources is not available within the Integrated Care Board.

4. Confirm who in this ICB is in a senior leadership role, advocating for people with neurological conditions in the East of England Specialised Services Provider Collaborative meetings.

As the focus is at a provider level, clinical colleagues from Mid and South Essex Foundation Trust attend the East of England Specialised Services Provider Collaborative meetings. Their specialisms include neurology, geriatric medicine and epilepsy. The ICB Neuronavigation team within the ICB attend rehabilitation meetings and we also have System Clinical Leads for Diabetes and End of Life Care who advocate for improved patient care and pathway improvement in patients with dementia and frailty.

5. Confirm who is the senior accountable officer for people in this ICB's region who are living with neurological conditions.

We have developed a Medium-Term Plan (MTP) which covers a 5-year period and defines a set of opportunities to deliver improved outcomes for our population. All system partners have been engaged in the development of the MTP, which has taken an organisationally agnostic view, focused on meeting the needs of our population. The MTP aligns with national strategic shifts: treatment to prevention, acute to community care, and analogue to digital. Seven improvement programmes, led by a identified senior accountable officer, will support the delivery of the MTP and will cover neurological conditions such as stroke, diabetes and autism. In addition, we also have our Diabetes and Aging Well Stewardship Groups, each with a lead steward, who are responsible for driving changes in reducing health inequalities and improving population outcomes.

6. Identify opportunities to ensure people with lived experience of neurological conditions have their voices heard and documented, acknowledging and identifying ways that this can contribute to meaningful improvements.

Wherever service change and improvement are being considered or developed, then people with lived experience have played a central role.

Recent examples include the Community Beds consultation process https://virtualviews.midandsouthessex.ics.nhs.uk/changes-to-services, where a wide range of input from people with different lived experience was sought as part of the consultation.

Other examples include the Social Technical Allocation of Resources (StAR) process where stroke survivors and carers, and the Stroke Association, joined a series of sessions reviewing resource use across the pathway for acute stroke.

3. Recommendation

To Board is asked to receive the report as a formal response to the questions raised by the Essex Neurology Network.

4. References

1. Steinmetz, Jaimie D et al., 2021. Global, regional, and national burden of disorders affecting the nervous system, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. The Lancet Neurology, 23(4): 344-381.
2. Feigin VL, Vos T, Nichols E, Owolabi MO, Carroll WM, Dichgans M, Deuschl G, Parmar P, Brainin M, Murray C. (2020). The global burden of neurological disorders: translating evidence into policy. Lancet Neurology, 19(3):255-265.
3. Essex Neurology Network (2025). University of Essex. Available at Essex Neurology Network | University of Essex.

Part I ICB Board Meeting, 17 July 2025

Agenda Number: 8

Mid and South Essex Integrated Care Board Annual Report and Accounts 2024/25

Summary Report

1. Purpose of Report

To provide the Board with a copy of the final version of the ICB's Annual Report and Accounts 2024/25, which received a clean audit opinion and were approved by the Audit Committee prior to submission to NHS England (as previously delegated by the Board).

2. Executive Lead

Tom Abell, Chief Executive Officer

3. Report Author

Nicola Adams, Associate Director Corporate Services

4. Responsible Committees

Audit Committee approved the Annual Report and Accounts prior to submission to NHS England in accordance with authority delegated to the committee.

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

As set out in the Annual Report and Accounts 2024/25.

7. Details of patient or public engagement or consultation

The Annual Report includes information regarding public engagement or consultation undertaken during 2024/25.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to note the final version of the ICB's Annual Report and Accounts 2024/25, which is provided as a separate document and is available on the ICB's website.

Part I ICB Board meeting, 17 July 2025

Agenda Number: 9

Chief Executive's Report

Summary Report

1. Purpose of Report

To provide the Board with an update from the Chief Executive of key issues, progress and priorities.

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.

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

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation

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 10 year plan publication

On 3 July 2025, the Government published *Fit for the Future: The 10-Year Health Plan for England*, setting out a major programme of NHS reform following the Darzi-led review. The plan sets out a radical agenda for recovery and long-term transformation of the NHS, organised around three core shifts in service delivery, underpinned by changes to the workforce, financial flows, digital infrastructure, governance, and prevention strategy.

2.0.1 Three core shifts

a) Hospital to Community: The Neighbourhood Health Service

- Establishment of Neighbourhood Health Centres in every community (12hrs/day, 6 days/week).
- Rebalancing of NHS spend from hospital-based to out-of-hospital services within 3–4 years.
- New contractual models for primary and community care providers (single and multi-neighbourhood).
- Universal adoption of care plans for complex needs by 2027 and expansion of Personal Health Budgets.
- Major expansion in pharmacy scope, community-based urgent care, and dentistry reform.

b) Analogue to Digital: Power in Your Hands

- NHS App to become the front door to care by 2028, offering booking, self-referral, care planning, and feedback.
- Introduction of a Single Patient Record and "My NHS GP" for Artificial Intelligence (AI) powered triage.
- Adoption of ambient AI, remote monitoring, and virtual consultations at scale.
- Creation of a "HealthStore" for access to approved digital therapeutics.

c) Sickness to Prevention: Making the Healthy Choice Easy

- Comprehensive prevention programme including obesity, smoking, air quality, alcohol, and childhood health.

- Genomic population health service with risk stratification and personalised prevention.
- Expanded screening (e.g., lung cancer), vaccination, and digital delivery of prevention.
- Stronger cross-sector partnership working with local authorities and the private sector.

2.0.2 System Reform and Enablers

a) Workforce

- The plan sets out a lower projection for NHS staffing than was set out in the 2023 plan, but with a commitment to increase skill mix through development of advance practice and the use of technology to support staff in their work.
- Introduction of personalised development plans for all staff, local recruitment targets, and modernised employment contracts.
- The plan sets out an expectation that there is a reduction in international recruitment to under 10% by 2035, alongside the elimination of agency usage.

b) Finance and Productivity

- Shift to value-based funding: resources aligned to health outcomes not activity.
- Replacement of block contracts and movement towards ‘year-of-care’ tariffs.
- 2% annual productivity gain expectation for 3 years.
- New funding mechanisms to support integrated neighbourhood delivery.

c) Governance and Structure

- Merger of the Department of Health and Social Care (DHSC) and NHS England (NHSE); 50% reduction in central staffing.
- Reinstatement of NHS Foundation Trust freedoms and creation of ‘Integrated Health Organisations’ to hold whole-population budgets.
- Establishment of earned autonomy and failure regimes for providers.
- Stronger role for patient voice, including payment mechanisms linked to patient-reported experience.

2.0.3 Implications for ICBs

The Plan builds on the changes set out in the ICB Blueprint in the significant redefinition of ICB roles, expectations, and accountability. Key implications include:

a) Strategic Commissioning Role

- ICBs are confirmed as the lead strategic commissioners, expected to shift funding towards prevention and community care.

- Commissioning support units to be closed with commissioning capability to be strengthened locally.
- Introduction of new frameworks to assess ICB maturity and effectiveness.

b) ICB Structural and Governance Changes

- Recommits to the rationalisation of ICBs, with an expectation that ICB footprints will become coterminous with strategic authorities by the end of the Plan wherever feasible.
- Changes to ICB boards, with provider members being removed and local authority members being replaced with elected mayors over time.

c) Local Accountability and Delivery

- Requirement for ICBs to implement the Neighbourhood Health Service model, including capital and digital infrastructure planning for Neighbourhood Health Centres.
- Need to support the development of new provider models (e.g. multi-neighbourhood providers).
- ICBs to be accountable for new outcome measures, including healthy life expectancy, health-related economic inactivity, and uptake of prevention interventions.

d) Financial Flows

- Movement of funding from hospital to community and digital services.
- Responsibility for designing and deploying new incentive models (e.g. pay-for-performance, outcome-based contracts, personal budgets).
- Alignment with national tariff reforms and preparation for year-of-care payments.

2.1 ICB running cost reductions and changes

Building on the 10-year plan, work is progressing to reshape ICBs. Since the last Board meeting agreement has been reached on the establishment of three ICBs which will cover the East of England Region, and will result in a single ICB across Greater Essex.

To support this, initial plans have been submitted to NHS England on how a Greater Essex ICB will be able to achieve the ambition to reduce the running costs of ICBs as set out in March. The first stages of consultative activities have commenced with processes to appoint designate Chairs and Chief Executives running at the time of writing.

The current intention is for the new ICBs to be formed on 1st April 2026.

We will continue to keep our people and stakeholders as involved as possible as we work through this process.

2.2 National Oversight Framework

NHS England has published the new National Oversight Framework for NHS organisations for the current financial year, which sets out roles and responsibilities in the NHS around performance and how it will be assessed this year.

Through the framework, NHS organisations (with the exception of ICBs this year) will be placed in one of the following segments:

Segment	Description
1	The organisation is consistently high-performing across all domains, delivering against plans.
2	The organisation has good performance across most domains. Specific issues exist.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.
4	The organisation is significantly off-track in a range of domains.
5	The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve. or The organisation is a challenged provider where NHS England has identified significant concerns.

The Framework sets out the support, improvement and intervention arrangements that NHSE will deploy against each of the above segments, ranging from little or no action through to enforcement action.

The Framework also sets out the differing responsibilities for NHS organisations in respect of performance. Responsibilities for ICBs are as follows:

- Provide system leadership for population health, setting evidence-based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources.

  This includes holding their partners in the integrated care system (ICS) to account using the system levers that bind them together, such as joint system plans, partnership agreements, joint committees and collaboratives.

- Through effective strategic commissioning, invest in, purchase and evaluate the range of services and pathways required to ensure access to high quality care, to improve outcomes and to reduce inequalities within their footprint.

This includes monitoring provider performance against their contractual obligations for the services purchased as part of the ICB's population health strategy.

- Strategically align funding and resources with long-term population health outcomes and manage clinical and financial risks.

Although ICBs will not be segmented through the National Oversight Framework this year, given the significant changes they are undertaking this year, it does set out that their leadership capability will be assessed through the annual assessment process and also sets out the following set of metrics specific to ICBs:

- **Elective Care**
  - Annual change in the size of the waiting list.

- **Cancer**
  - Percentage of all cancers diagnosed at stage 1 or 2.

- **Primary Care**
  - Growth in the number of urgent dental appointments vs. target.
  - Percentage of patients describing booking a general practice appointment as easy.

- **Effectiveness and experience of care**
  - Acute bed days per 100,000 people
  - Change in the number of inpatients who are autistic or have a learning disability.
  - Average number of days from discharge ready date and actual discharge.
  - Percentage of continuing healthcare referrals completed in 28 days.
  - Percentage of mental health bed days that are out of area.
  - Percentage of people who receive all 8 diabetes care processes
  - Percentage of patients with GP recorded CVD who have their cholesterol rates managed to NICE guidance.
  - Percentage of hypertension patients treated to target.
  - Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional.

- **Patient safety**
  - NHS staff survey – raising concerns sub-score
  - Number of neonatal deaths and stillbirths per 1,000 total births
  - Percentage of children (aged 0-9) prescribed antibiotics in the last 12 months
- **People and workforce**
  - Sickness absence rate
  - NHS staff survey engagement theme score
  - NHS staff survey education and training theme score
  - GP leaver rate
- **Finance and productivity**
  - Planned surplus / deficit
  - Variance year to date to financial plan
  - Implied productivity level

- **Improving health and reducing inequality**
  - Average number of years people live in healthy life.
  - Cervical, breast and bowel screening rates
  - Percentage of pregnant women who quit smoking.
  - Percentage of inpatients referred to in-house tobacco treatment services who make a supported attempt to quit.
  - Percentage of patients supported by obesity programmes.
  - MMR vaccine uptake rate.
  - Deprivation and ethnicity gap in pre-term births.
  - Deprivation gap in early cancer diagnosis.
  - Deprivation gap in myocardial infarction and stroke admissions.
  - Percentage of annual health checks completed for patients with a learning disability or who are autistic.
- **System performance**
  - Urgent and emergency care – has the system been in the lowest quartile for 4 hour UEC performance for each of the last three months?
  - Elective care – has the system been in the lowest quartile for 18-week performance for each month of the last quarter?
  - Cancer care – has the system been in the lowest quartile for 62-day performance for each month of the last quarter?
  - Primary care – Is the system in the lowest quartile for overall primary care patient satisfaction?
  - Mental health – is the system in the lowest quartile for proportion of healthchecks for severe mental illness completed in the last year?
  - Finance – is the system projecting an annual deficit of over 2.5% or a deficit below 2.5% that is over 1% off plan?

Board members will note that there are several new measures included in this list which are not routinely reported to Board and Committees. Consequently, we will update our performance reporting to reflect this, alongside the actions which are being taken to improve performance where this is off track.

2.3 Areas of progress since the last Board meeting

Since the Board last met, we have been able to celebrate a number of achievements and areas of progress within our system which I wanted to draw Board members' attention to:

- We celebrated the progress made to improve Primary Care access over the last two years:
  - GP teams have expanded by the equivalent of 263 full-time staff over the last two years.
  - We have supported the roll out of cloud-based telephony and the implementation of total triage.
  - There has been a 65% increase in the number of NHS App logins, with a 35% increase in online repeat subscriptions and over 8.5 million online consultations having been submitted in 2024, up 42% year on year.

- Our community pharmacies have now delivered over 125,000 consultations through the Pharmacy First initiative, providing quicker and easy access to patients and an alternative to general practice for common conditions.

- We have seen the launch of the provision of whooping cough vaccinations in more than 30 community pharmacies across Essex and Suffolk to make it easier for pregnant women to access this important vaccination.

- We celebrated the progress that has been made to improve access to health checks during 2024/25 with 78% of people with a learning disability receiving a check, which is above the national standard of 75%, and 68% of people with a severe mental illness receiving a check, against the national standard of 60%.

- We saw continued focus on the progress within dentistry with the roll out of the dental care home service covering all 285 care homes in mid and south Essex (MSE). This saw a 90% reduction in the waiting list for home dental visits and most patients now being seen by Specialist Community Dental services within 4 weeks, down from waits of up to a year.

- Progress made in improving Children's dental health has also been noted, with a reduction in the proportion of young children from more-at-risk areas needing teeth removed due to poor oral health.

- We also saw the real life impact that the Shared Care Record deployment has had, with an advanced paramedic at East of England Ambulance Service being able to use it to access essential details that led to life saving treatment for a patient.

3. Executive Committee

Since the last report, there have been nine (9) weekly meetings (from 6 May 2025 to 1 July 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:

- Monthly review and approval of the ICB's risk position and Board Assurance Framework.
- Business Case for cardio vascular disease (CVD) Future Health Prevention Programme.
- Approval of draft system Digital & Data Strategy.
- Review of internal IT services and arrangements with commissioning support unit (CSU).
- Approval of Primary Care Estate plan for 2025-2027
- Approval of proposed governance for the system's Medium-Term Plan (MTP).
- Approval of investment for children and young people (CYP) services across 2025/26.
- Section106 Funding approval for Riverside Practice Branch premises, Southeast Essex.
- Approval of specification for a new Integrated Care Transfer Hub (ICTH) across MSE.
- Agreement for Re-procurement of Specialist Healthcare Tasks Service.

- Review of Service Restriction Policies (SRP) across Vasectomy, Female Sterilisation, Bladder Outflow Obstruction and Kidney Stones.
- Review of Learning Disability and Autism (LDA) service, with agreement for longer-term review of service.
- Approved development of Elective Care Demand Management business case to review existing programmes across the ICB.
- Approval of business case for Care Home Education Teams.
- Approval of contract for Enteral Feed Services across MSE.
- Review of ICB Corporate Estate, following lease agreement break-clause being enacted by the ICB.
- Approval of business case for sickle cell provision across MSE.
- Approval of business case for a 2-year dental pilot to be undertaken across Head and Neck cancer pathway to support significant waits.

The Committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability, development & review of the ICB annual report and worked together in preparation for the NHS England quarterly review that took place on 2 July 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

The Board is asked to note the current position regarding the update from the Chief Executive and the work undertaken and decisions made by the Executive Committee.

Part I ICB Board meeting, 17 July 2025

Agenda Number: 10

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.

To note, the members of the Quality Committee did not request anything to be escalated to the Board following the most recent meeting on 27 June 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 (MSEFT).
- Note the key risks to delivery of high-quality services as outlined in the month of June.

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. Regulatory Update

Mid and South Essex NHS Foundation Trust (MSEFT)

2.1. The Care Quality Commission (QCQ) have concluded their Well Led Review of MSEFT during 7-9 June 2025. The Trust is now awaiting the draft report following inspection, in addition to those relating to paediatric services across all three sites. Currently no indicative timescale has been provided.

2.2. To best support the Trust due to the number of inspection reports either requiring response or currently in process, NHS England and the ICB quality teams continue to offer supportive visits, critical analysis and supportive meetings in order to expedite actions that will be sustainable across all three sites in order to drive improvements in quality outcomes.

Essex Partnership University NHS Foundation Trust (EPUT)

2.3. There are currently no outstanding reports or expected visits for EPUT. The Trust continue to work through their action plan, with the ICB quality team.

3. Key Quality Risks

3.1. The key risks to quality of service provision across Mid and South Essex (MSE) during the month of June are identified as below:

3.1.1. **National Maternity and Neonatal Investigation** – MSEFT has been mentioned as one of the first four Trusts to be identified as part of the planned national investigation. No further detail of the investigation has been provided as yet; however, Trust representatives met with the Chief Executive and Chief Nursing Officer of NHS England for an initial meeting. Further information will be shared with the Board upon receipt of detail.

3.1.2. **Infection Prevention and Control** (IPC) – the IPC team have been involved in two recent cases related to Tuberculosis and Rabies. These cases are unique in nature and the team has been liaising with the UK Health Security Agency (UKSHA) to ensure that wider public health is protected, and that appropriate screening and monitoring regimes are in place. In addition, an IPC review of equipment services in Southend is currently ongoing to ensure that appropriate standards of cleanliness and practice are in place to safeguard residents across the Southend catchment area.

3.1.3. **Safeguarding (Babies Children and Young People – Mental Health)** – an ongoing challenge in supporting Children and Young People presenting with emotional dysregulation to the Emergency Departments of the acute

hospitals remains across MSE. A Safeguarding Risk Summit was commissioned by the Essex Children's Safeguarding Board during May 2025, with agreed task and finish groups being identified to focus on those children transitioning to adult services and neurodivergence. A further date for feedback on proposed actions is now planned for late July and October.

4. 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 key risks to delivery of high-quality services as outlined in the month of June.

Part I Board Meeting,17 July 2025

Agenda Number: 11

Month 2 Finance and Performance Report

Summary Report

1. Purpose of Report

To present an overview of the financial performance of the ICB and broader partners in the Mid & South Essex (MSE) system (period ending 31 May 2025).

The paper also presents our current position against our NHS constitutional standards.

2. Executive Leads

Jennifer Kearton, Chief Finance Officer.
Sam Goldberg, Executive Director of Performance and Planning.

Report Authors

Jennifer Kearton – Executive Chief Finance Officer.
Sam Goldberg, Executive Director of Performance and Planning.
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 1 July 2025.

4. Conflicts of Interest

None identified.

5. Recommendation

The Board is asked to note the Month 2 Finance & Performance Report and seek any further assurances required.

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 for 2025/26 of breakeven following receipt of additional £106m (million) deficit support funding. The system plan is considered very stretching for 2025/26 given the planned efficiency requirement of £219.2m, however it is imperative we deliver so we can continue to build a strong foundation for financial recovery over the medium term.

NHS England (NHSE) provided deficit support funding of £106m as part of the planning process bringing the MSE System plan to breakeven. Deficit support funding, in cash terms, is being supplied on a quarterly basis during the year, delivery to plan is a prerequisite to receiving the deficit support funding. Deviation from plan could put at risk future quarters supply of deficit support funding.

2. Key Points

2.1 Month 2 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB saw an increase of £11.2m between submitted plan and M2. £11m of the increase related to additional allocations to cover the cost of planned depreciation in 2025/26.

Table 1 – Allocation movements between submitted plan and month 2

Allocations	Current Month £m	Previous Month £m	Monthly Change £m
⊟ Recurrent			
Programme	2,352.16	2,352.16	0.00
Delegated - Specialised	297.26	297.03	0.24
Co-Comm	255.96	255.96	0.00
Delegated - DOP	111.04	111.04	0.00
Running Costs	19.20	19.20	0.00
Total	**3,035.62**	**3,035.39**	**0.24**
⊟ Non-Recurrent			
Programme	143.66	132.70	10.97
Delegated - Specialised	12.56	12.56	0.00
Delegated - DOP	0.07	0.07	0.00
Total	**156.29**	**145.33**	**10.97**
Total	**3,191.92**	**3,180.71**	**11.20**

The ICB position at M2 is in line with the planned position of a £1.97m year-to-date (YTD) deficit, driven by the profiling of planned efficiencies in year.

Table 2 – summary of the position against the revenue resource limit for month 12.

Income/Expenditure	YTD Plan £m	YTD Actual £m	YTD Variance £m	YTD Variance Mth on Mth Change £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m	Full Year Variance Mth on Mth Change £m
⊟ Income								
Allocation	(550.26)	(550.26)	(0.00)		(3,228.94)	(3,228.94)	(0.00)	
Total	**(550.26)**	**(550.26)**	**(0.00)**		**(3,228.94)**	**(3,228.94)**	**(0.00)**	
⊟ Expenditure								
Acute	264.19	264.19	(0.00)		1,515.10	1,515.10	0.00	
Community Health Services	41.21	41.26	(0.04)		244.73	244.74	(0.01)	
Continuing Care	32.26	32.26	(0.00)		190.20	190.20	(0.00)	
Mental Health	48.73	49.14	(0.41)		308.09	308.85	(0.77)	
Other Commissioned Services	4.10	3.84	0.26		(2.24)	(2.72)	0.48	
Other Programme Services	3.07	3.01	0.06		18.43	18.40	0.03	
Primary Care	103.96	103.96	0.00		621.66	621.66	(0.00)	
Specialised Commissioning	50.84	50.84	(0.00)		309.80	309.80	(0.00)	
Corporate	2.94	2.81	0.13		17.66	17.39	0.27	
Hosted Services Admin	0.26	0.26	0.00		1.55	1.55	0.00	
Hosted Services Programme	0.66	0.66	0.00		3.97	3.97	0.00	
Total	**552.23**	**552.23**	**(0.00)**		**3,228.94**	**3,228.94**	**(0.00)**	
Total	**1.97**	**1.97**	**(0.00)**		**0.00**	**0.00**	**(0.00)**	

2.2 M2 Efficiency Delivery

The M2 financial position includes delivery of £9.8m of YTD efficiencies, which is zero variance against plan. The ICB is forecasting to deliver the full £70.4m efficiencies in 2025/26. The ICB efficiencies plan includes £66m of recurrent efficiencies

Tables 3 & 4 – summary of ICB efficiencies delivery for month 2.

Efficiencies

ICB Efficiencies Category	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	FY Plan £,000	Forecast £,000	FY Variance £,000	Prior Month Variance £,000
Acute	5,084	5,084	0	31,809	31,809	0	
All-age Continuing Care	220	220	0	4,676	4,676	0	
Ambulance	274	274	0	1,643	1,643	0	
Community Healthcare	1,126	1,126	0	8,030	8,030	0	
Mental Health	1,014	1,014	0	7,318	7,318	0	
Other Programme Services	248	682	434	2,290	2,724	434	
Primary Care (inc. Primary Co-Commissioning)	1,278	1,278	0	9,769	9,769	0	
Running Costs	84	84	0	500	500	0	
Unidentified	434		(434)	4,349	3,915	(434)	
Total	**9,762**	**9,762**	**0**	**70,384**	**70,384**	**0**	

Efficiencies - Recurrent/Non-Recurrent

Recurrent/Non-recurrent	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	FY Plan £,000	Forecast £,000	FY Variance £,000
Non-recurrent	434	434	0	4,349	4,349	0
Recurrent	9,328	9,328	0	66,035	66,035	0
Total	**9,762**	**9,762**	**0**	**70,384**	**70,384**	**0**

2.3 ICB Risk

The ICB financial risk is reviewed as part of the month end closure. The ICB assessment at M2 is in line with plan.

2.4 ICB Finance Report Conclusion

The ICB is delivering to plan year to date and forecast to deliver breakeven at year end. Continued delivery of efficiencies and management of any in year pressures will be key to delivery of the overall planned outturn position.

2.5 Month 2 System Financial Performance

At month 2 the overall health system position was a surplus of £0.3m against plan.

Table 5 – summary of the System position against the revenue resource limit for month 2.

System I&E Analysis	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Full Year Plan £,000	Forecast Outturn £,000	Full Year Variance £,000
System Revenue Resource Limit	(550,264)	(550,264)	0	(3,228,936)	(3,228,936)	0
Total ICB Net Expenditure	552,232	552,232	0	3,228,936	3,228,936	0
TOTAL ICB Surplus/(Deficit)	(1,968)	(1,968)	0	0	0	0
Income	(381,762)	(384,741)	(2,979)	(2,255,404)	(2,255,405)	(1)
Pay	237,272	242,882	5,610	1,367,968	1,367,968	0
Non-Pay	137,554	135,168	(2,386)	835,372	834,478	(894)
Non Operating Items	8,466	7,971	(495)	52,064	52,959	895
TOTAL Provider Surplus/(Deficit)	(1,530)	(1,280)	250	0	0	0
TOTAL ICS Revenue Resource Limit	(550,264)	(550,264)	0	(3,228,936)	(3,228,936)	0
TOTAL ICS Net Expenditure	553,762	553,512	(250)	3,228,936	3,228,936	0
TOTAL ICS Surplus/(Deficit)	(3,498)	(3,248)	250	0	0	0
Less Non-Recurrent Deficit Support Funding	(27,223)	(27,223)	0	(106,000)	(106,000)	0
ICS Surplus/(Deficit) excluding Non-Recurrent Deficit Support Funding	(30,721)	(30,471)	250	(106,000)	(106,000)	0

The forecast outturn position against plan is breakeven net of £106m deficit support funding.

Both system providers continue to operate grip and control actions implemented during 2024/25 and continue to work collectively with the ICB to reduce the run rate during. The whole system continues to operate in Triple Lock with regional oversight of expenditure items greater than £25k.

2.6 System Efficiency Position

At month 2 the system has delivered £21.6m of efficiencies against a plan of £24.8m a shortfall of £3.2m. Current forecasts are to deliver the full year efficiency target of £219.2m.

Our overall financial position is dependent on the delivery of efficiencies and recovery of the current YTD position.

Table 6 – System Efficiency summary

System Efficiencies

Organisation	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Full Year Plan £,000	Forecast £,000	Full Year Variance £,000
ICB	9,762	9,762	0	70,384	70,384	0
EPUT	3,820	3,665	(155)	31,335	31,335	0
MSEFT	11,207	8,216	(2,991)	117,487	117,500	13
SYSTEM	**24,789**	**21,643**	**(3,147)**	**219,206**	**219,219**	**13**

2.7 System Capital Position

Total planned system capital expenditure for 2025/26 across the two provider Trusts and the ICB is £164.4m. The M2 position shows the system is £0.3m ahead of the £8.8m plan submitted to NHSE.

Table 7 – 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	2.71	1.76	0.96	79.33	79.33	0.00
EPUT	1.03	0.33	0.70	18.94	18.94	0.00
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Total	**3.75**	**2.09**	**1.66**	**98.27**	**98.27**	**0.00**
⊟ Internally Financed/System CDEL						
MSEFT	4.48	6.19	(1.72)	46.53	46.53	0.00
EPUT	0.57	0.82	(0.24)	17.19	17.19	0.00
ICB	0.00	0.00	0.00	2.41	2.41	0.00
Total	**5.05**	**7.01**	**(1.96)**	**66.14**	**66.14**	**0.00**
Total	**8.79**	**9.10**	**(0.30)**	**164.41**	**164.41**	**0.00**

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 Schemes						
ICB	0.00	0.00	0.00	2.69	2.69	0.00
Total	**0.00**	**0.00**	**0.00**	**2.69**	**2.69**	**0.00**

2.8 System Finance Report Conclusion

At month 2 the System is on plan to deliver the breakeven outturn position. The System forecast outturn position for 2025/26, excluding deficit support funding, totals £106m deficit.

Financial efficiencies are off plan YTD but are forecast to deliver to plan at year end. The System remains under regular review with both regional and national NHSE colleagues and continues to operate under strengthened internal governance and financial control.

2.9 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.

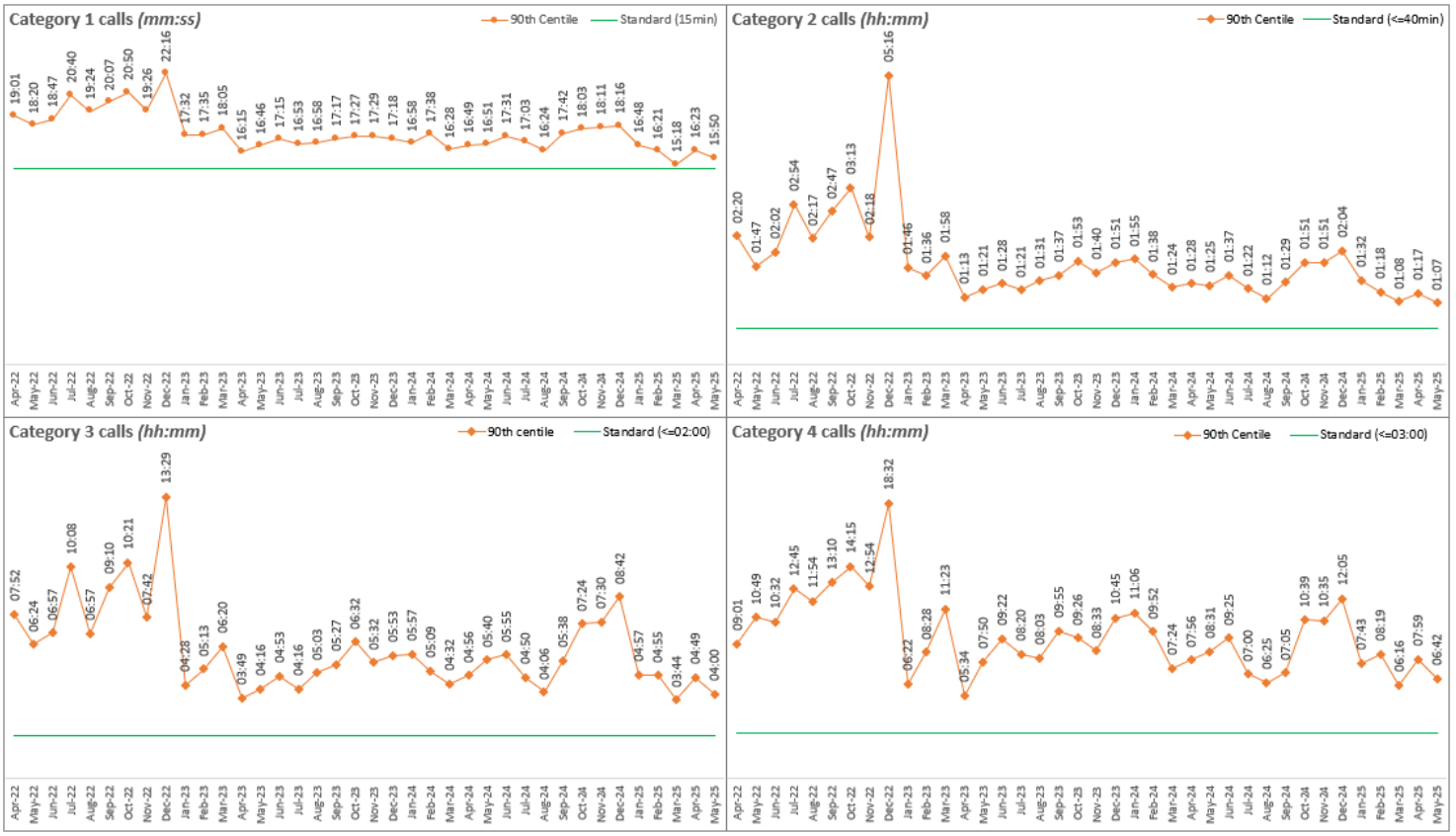
Our current performance is below the standard required as outlined below:

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 EEAST for all four categories of calls do not meet their respective standards as shown in the following graphs.

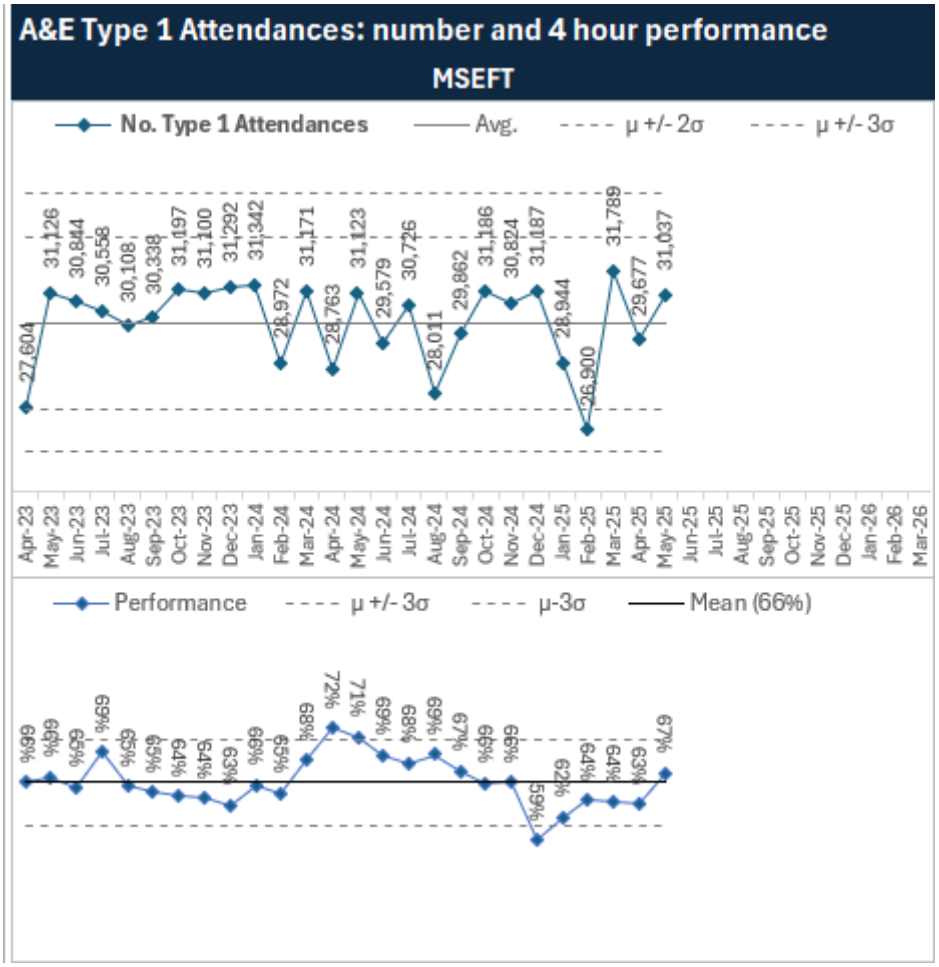


Emergency Department – waiting times

2025/26 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 2026.

May 2025 achievement of 67% remains just below the Operational Plan of >=69%.
The MSE system performance is identical to the MSEFT reported position.



2.10 Elective Care

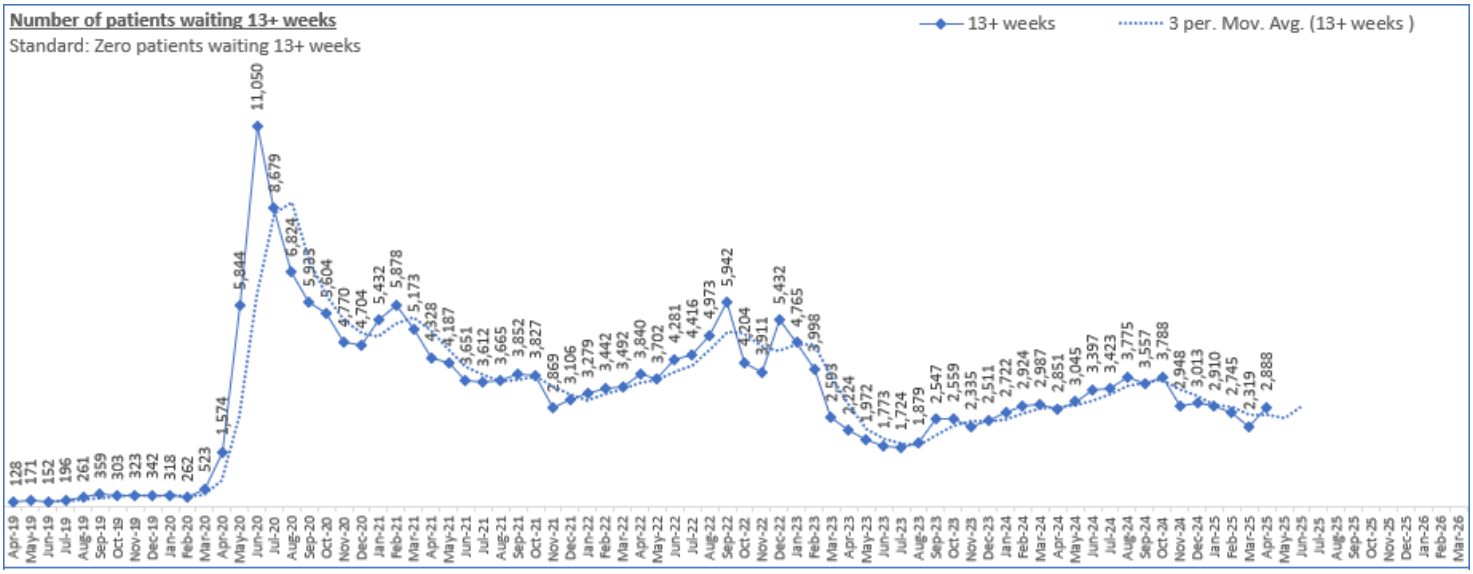
Performance against the Operational Plan for Elective, Diagnostic and Cancer is overseen via the respective system committees.

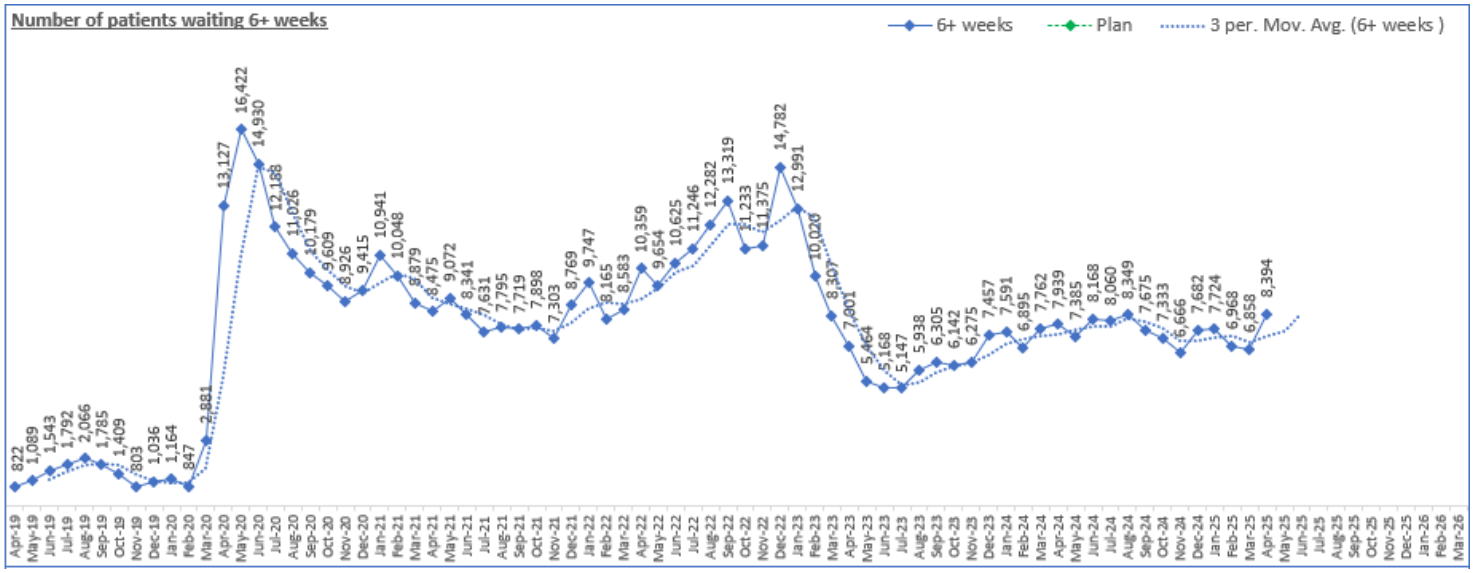
Diagnostics Waiting Times

Standard:

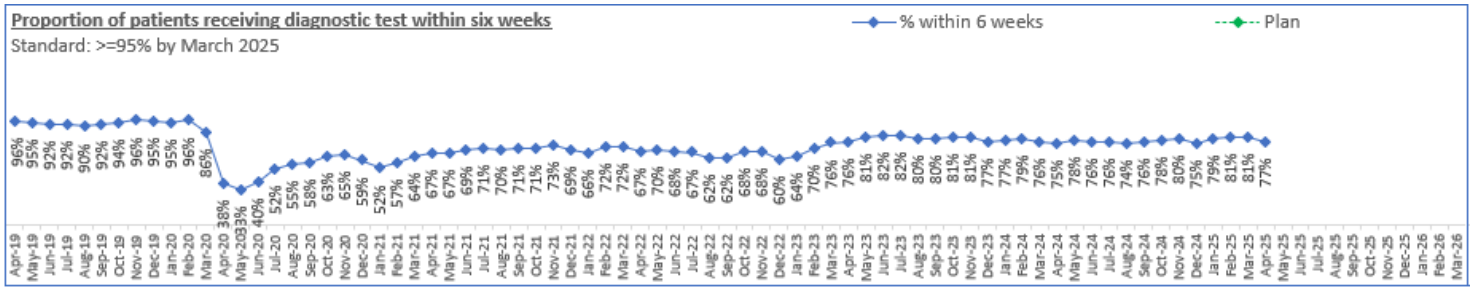
- Increase the percentage of patients that receive a diagnostic test within six weeks.

The following graphs show the total number of MSE registered population waiting 13+ and 6+ weeks across all providers to April 2025.





The graph below shows the proportion of patients receiving their diagnostic test within 6 weeks of their referral.



As of April 2025, 2,888 people were waiting over 13 weeks (standard: zero) and 77% 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.

Apr-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 Apr-25 / Breaches above plan / Plan March 2025
MSE patients at all providers				
Imaging	Barium Enema	0	80% (2)	
	CT	15	93.4% (214)	94%
	DEXA Scan	19	83.5% (195)	89%
	MRI	134	77.9% (1874)	93%
	Non-Obstetric Ultrasound	745	85.6% (1748)	97%
Physiological Measurement	Audiology Assessments	33	91.3% (104)	93%
	Cardiology Echocardiography	470	58.4% (1674)	82%
	Peripheral Neurophysiology	136	53% (239)	
	Respiratory Physiology Sleep Studies	118	39.8% (240)	
	Urodynamics - Pressures & Flows	11	59.6% (21)	
Endoscopy	Colonoscopy	619	54.9% (1045)	86%
	Cystoscopy	92	60.2% (121)	
	Flexi sigmoidoscopy	142	54.3% (262)	84%
	Gastroscopy	353	65.4% (653)	86%

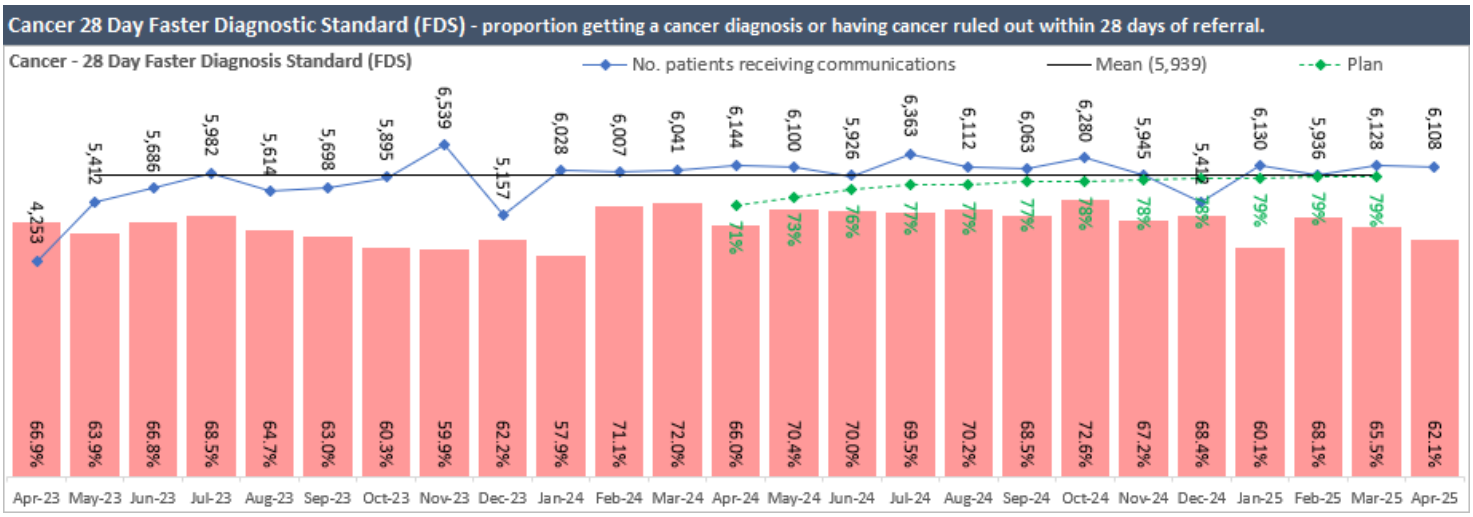
Cancer Waiting Times

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.

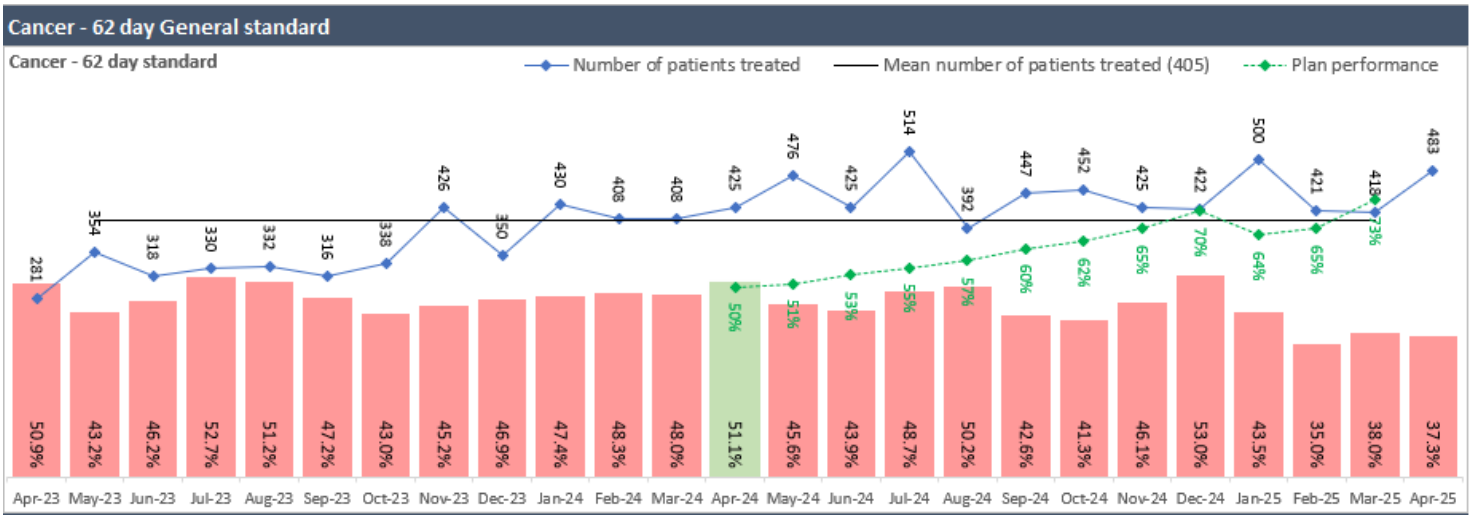
The waiting times for patients on a cancer pathway are not meeting the NHS constitutional standards.

The following graph shows the MSEFT monthly performance for the 28-day Faster Diagnosis Standard. The April 2025 performance at 62.1% did not meet the operational plan to achieve >= 72%.



The following graph shows the 62-day general standard performance. The April 2025 performance at 37.3% did not meet operational plan of >=55%. The constitutional requirement is 85%.

The Trust is in national oversight Tier 1 for cancer performance.



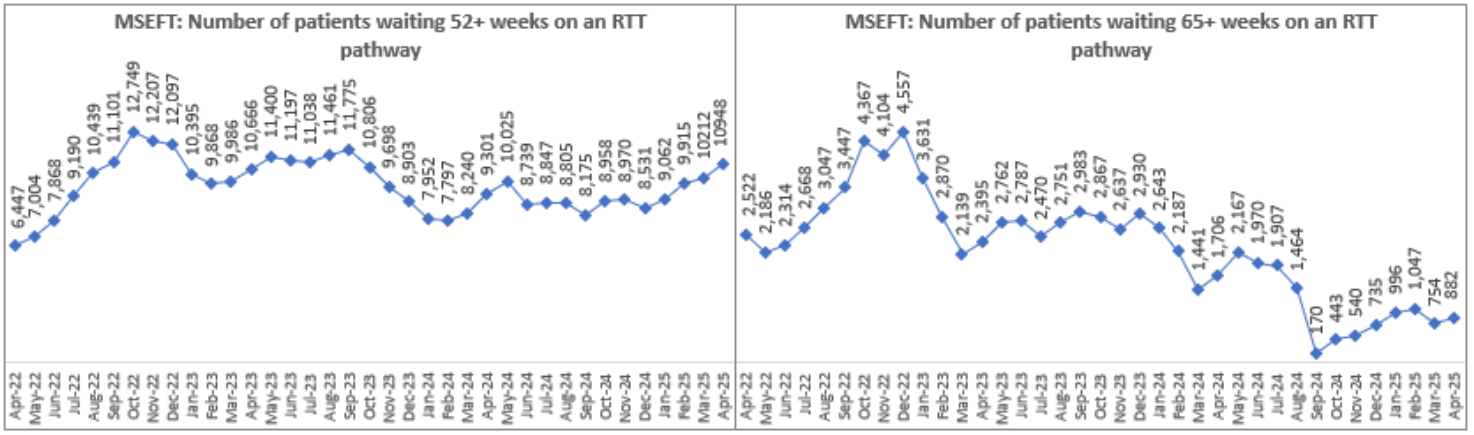
Referral to Treatment (RTT) Waiting Times

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 of April 2025, the following number of patients were on a RTT pathway:

- 882 patients waiting 65+ weeks.
- 10,948 patients waiting 52+ weeks.



The operational plan to have zero people waiting over 65 weeks by September 2024 has not been achieved.

The following table summarises the latest MSEFT referral to treatment (RTT) position (April 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	**172,731**	**19**	**50**	**47%**	**10,948**	**6%**	**1,047**	**0.6%**
General Surgery Service	8,809	19	53	47%	798	9%	64	0.7%
Urology Service	10,169	18	49	49%	616	6%	72	0.7%
Trauma and Orthopaedic Service	17,751	27	54	34%	1,844	10%	291	1.6%
Ear Nose and Throat Service	17,305	28	54	31%	1,910	11%	176	1.0%
Ophthalmology Service	13,794	16	46	54%	556	4%	9	0.1%
Oral Surgery Service	5,277	22	56	42%	612	12%	210	4.0%
Neurosurgical Service	85	30	55	33%	13	15%	1	1.2%
Plastic Surgery Service	5,300	19	48	48%	277	5%	29	0.5%
Cardiothoracic Surgery Service	1	-	-	100%	0	0%	0	0.0%
General Internal Medicine Service	2,376	13	37	62%	16	1%	0	0.0%
Gastroenterology Service	10,938	20	50	45%	694	6%	11	0.1%
Cardiology Service	9,987	11	33	67%	13	0%	0	0.0%
Dermatology Service	13,845	23	54	41%	1,278	9%	20	0.1%
Respiratory Medicine Service	4,337	15	36	57%	35	1%	0	0.0%
Neurology Service	6,006	22	51	40%	451	8%	12	0.2%
Rheumatology Service	3,015	16	44	54%	40	1%	0	0.0%
Elderly Medicine Service	779	7	21	88%	2	0%	0	0.0%
Gynaecology Service	14,309	20	45	44%	459	3%	29	0.2%
Other - Medical Services	14,627	13	42	62%	513	4%	28	0.2%
Other - Mental Health Services								
Other - Paediatric Services	4,064	25	54	35%	408	10%	43	1.1%
Other - Surgical Services	6,872	14	42	59%	261	4%	44	0.6%
Other - Other Services	3,085	14	48	57%	152	5%	8	0.3%

The Trust is in national oversight Tier 1 for RTT performance.

2.11 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: April 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 Mid and South Essex (latest position: April 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 note the Month 2 Finance & Performance Report and seek any further assurances required.

Part I ICB Board Meeting, 17 July 2025

Agenda Number: 12

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 Executive Committee has recently approved the ICB's response to the national planning requirements for an Action Plan for General Practice. In general, the actions we identify within this plan are those 'additional' actions we will be progressing in 2025/26 over and above existing approaches.

The template document requires detail on actions the ICB will undertake to strengthen each of the areas of focus, outcomes being sought, measurements, delivery confidence, risks/mitigations and resources to support implementation. A summary of key actions being undertaken is as follows:

Tackling Unwarranted Variation:

- Stratification and identification of an initial 10 practices to support in addressing areas of outlying performance and develop action plans to enable these to be addressed.
- Enable the implementation of patient feedback tools for practices to gain more timely feedback on overall satisfaction.
- Enabling practice access the wide range of initiatives within the overall Action Plan for General Practice response to maximise impact.

Improved Contract Oversight:

- Extend the scope of the Practice Risk Review Metric Report – to include: a summary of eDEC[1] responses, Advice and Guidance utilisation, proportion of consultations undertaken within 14 days of a patient contacting the practice and status of online consultation availability during core hours.
- Proactively enforce eDEC outcomes – We will complete a comprehensive review of the eDEC returns and then stratify actions to be addressed.
- Ensure that primary care contractual management is fit for purpose within the new structure
- Ensure consistency of approach to management of contractual concerns/risks through the restructure period.
- Actions to ensure compliance with the new contractual requirements:
    - Implementation of Advice and Guidance
    - Online consultation during core hours
    - Primary Care Network (PCN) Capacity and Access Improvement Payment (CAIP) requirements
    - Cardiovascular disease (CVD) prevention
    - Risk Stratification
    - Provision of GP Connect across all practices

[1] eDEC (General Practice Annual Electronic Self-Declaration) is a mandatory data collection which all GP practices in England must complete annually. The declaration covers eight areas, these being: practice details, practice staff, premises and equipment, services, information about the practice and its procedures, governance, compliance with Care Quality Commission registration, and information technology.

Improved Commissioning and Transformation:

- Actions to implement Commissioning and Transformation Support (CATS).
- Targeted support to improve access and move practices to Modern General Practice.
- Use of Peer Ambassadors to support transformational change.
- Enable practices requiring support to be compliant with the contractual requirements to access support.
- Ensure practices are utilising available tools particularly online consultation.
- Improve utilisation of Pharmacy First.

The key risks in the delivery of the action plan are largely capacity and focus on delivery during a period of organisational change. The oversight of the implementation of this plan will be through the Primary Care Commissioning Committee (PCCC).

In terms of activity, the first two months of 2025/26 saw an improvement in the number of consultations being undertaken within two weeks of contacting the practice. As of May 2026, the ICB is now better than the national average for this metric.

ICB	Apr	May	Total
MSE ICB	80.8%	81.9%	**81.4%**
Others	80.9%	81.8%	**81.3%**
Total	**80.8%**	**81.8%**	**81.3%**

There has been a slight reduction in year-on-year consultations:

Variance between years

Month	Variance	Variance %
Apr	-22,431	-3.9%
May	-28,116	-4.9%
Jun	0	
Jul	0	
Aug	0	
Sep	0	
Oct	0	
Nov	0	
Dec	0	
Jan	0	
Feb	0	
Mar	0	
Total	**-50,547**	**-4.4%**

Primary Care – Pharmacy

The initial Community Pharmacy Commissioning and Transformation Group meeting was held in May. This forum will help move forward the development of community pharmacy within the wider transformation of out of hospital care in mid and south Essex (MSE).

Tom Abell, Chief Executive, and William Guy, Director of Primary Care, met with representatives from the Local Pharmaceutical Committee (LPC) at a recent annual meeting held by the committee. Several opportunities for future service developments and ways of working were discussed. The LPC welcomed the proposed changes to ICB boundaries as these reflect their own boundary. However, they are also concerned about the instability that the changes will bring and whether there will be sufficient capacity within a new organisation to engage with Community Pharmacy effectively.

The project to delivery Diabetic Hybrid Closed Loop (HCL) technology is progressing well following Board approval January 2025. Benefits are being realised and we continue to capture the lived experience of the changes as well as the financial impact; a full report will be prepared for September 2025 board meeting.

General Practice Provider Collaborative (GPPC)

The GPPC has made significant progress in the establishment of its internal governance arrangements. They are implementing a place-based sub structure within an overarching MSE wide GPPC Board arrangement. Representatives from the GPPC participated in a Board Seminar session in June to set out their vision for the future and how they seek to support the transformation of primary care services and out of hospital care more generally. Representatives from the GPPC have been engaging with counterparts in north east and west Essex to better consider how they can support each other in any future state. The GPPC held their inaugural pan MSE Board meeting on 3 July 2025. It is now for the ICB in partnership with the GPPC to define the working relationship between the two organisations.

Primary Care – Dentistry

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 with most schools now covered within the pilot. 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. A key area of focus is how to improve engagement between parents/guardians where a clinical need is identified. Building a link between patients and local dental practices is critical to the success of this scheme.

A paper was recently approved by the Executive Committee on proposed developments to the head and neck cancer pathway to enable extended scope primary care professionals to deliver care in a primary care setting that would have previously only been available in secondary care. Through this model we are seeking to improve outcomes for patients, develop workforce and improve performance standards in secondary care.

Estates

As part of the Primary Care Medium Term Plan (MTP) Programme, an Estates workstream has been established. This seeks to:

- Build strong foundations by addressing legacy issues including NHS Property Services debt resolution, Lloyd George notes etc
- Expand capacity through the Utilisation and Modernisation Fund, effective use of existing S106 monies, progression of live issues e.g. Beaulieu, Ashingdon, Riverside Medical
- Oversee operational changes (impact on estates of technical changes to contracted providers e.g. branch closures etc
- Prepare for the future:
  - Understand primary care and left shift need and develop a strategy for this
  - Develop a funding model which better supports the delivery of the strategy

- Enables the estates impact of the health needs of large-scale residential developments to be better met

The estates, alliance and primary care teams are supporting practices with the next steps on accessing utilisation and modernisation funding in 2025/26. This resource will help practices undertake alternations to existing premises to increase usable clinical capacity.

Focus of Alliance Teams

Alliance delivery will be targeted to deliver integrated neighbourhood working and lead or support the delivery of the following MTP workstreams:

- prevention and proactive management in the community
- urgent and emergency
- primary care
- learning disabilities and autism
- mental health.

Integrated Neighbourhood Teams

Alliances will be prioritising at-scale delivery of frailty and improved end of life care via Integrated Neighbourhood Teams (INTs) to support the MTP. Progress so far as follows:

- Programme structure has been maintained and clear delivery goals and data sources defined for the scaling of the approach have been agreed.
- 15 out of our 24 INTs already have a full or partial focus on frailty and end of life (EOL) care within their model.
- 9 INTs currently have a focus on other areas such as mental health, children and young people or a disease specific focus.
- Our INT dashboard has been developed and published on Athena for wide system visibility of the metrics we are targeting.
- Peer support between clinical directors that have implemented INTs and those that have not have now been established which are proving to unblock some entrenched areas.

Our work over the last two months has been to support our 24 INTs to both support their existing good work and to ensure the focus on frailty and end of life care (EOL) is MSE wide. A support tool is being produced to facilitate this with INT leadership teams and engagement across the system continues.

Developing our approach to risk stratification using population health management continues to be a priority. Further progress has been made in trialling the case finding and risk stratification tool developed by AGEM (the ICB's former information technology (IT) provider). The next step is to roll out this tool to our INTs (via PCN teams) starting with those that have information governance sign up to Athena to allow the access, commencing in July.

Alliances across MSE continue to work within their governance and partnership arrangements to integrate care, reduce inequalities and transform how health and care is delivered. Examples of this work include:

Coastal Inequalities

Professor Chris Witty, Chief Medical Officer NHS England, published his annual report in 2021 highlighting the substantially higher burden of physical and mental health conditions in coastal communities. Whilst coastal towns represent a small part of a total ICS population, collectively they are a large and significant priority national population group (18.5%). The Coastal Navigators Network, (CNN), was created as part of a growing national movement to activate real change in coastal communities by addressing wider determinants such as employment, housing, education or lifestyle factors to improve health outcomes.

South-East Essex (SEE) Alliance recently submitted an expression of interest to join this programme with an ambition to focus activity on the two coastal communities in its geography, Southend and Canvey Island. Local Alliance partners will work with CNN to mobilise activity and generate collaboration to tackle long-standing issues faced by coastal communities. They will look to generate interest from national partners to work with SEE and stimulate opportunities to optimise learning and identify new opportunities to tackle these issues. The two priority areas we will focus on as part of this programme are as follows:

- Accelerating delivery of INTs to leverage a shift away from the acute to communities.
- Optimising care technology to increase independence, improve outcomes and complement how health and care services are delivering.

Southend and Canvey Island will benefit from shared learning and support to deliver real improvements in population health, turning ambition into action, delivering meaningful change to impact health and wellbeing.

In June, SEE and Basildon and Brentwood Alliance Directors, working with Essex Anchors Network, hosted an event focused on the integral connection between health and work. Lord Patel of Bradford, Chair of Breaking Barriers Innovation, delivered a keynote speech reflecting on his journey. The event also heard from Essex residents who had experienced life-changing intervention from the MSE Anchors programme to support them into work. These residents wanted to be contributing members of society, but without help were not able to find jobs and were left feeling isolated, depressed and in one especially poignant instance, at risk of suicide.

Health Inequalities (HI) and Trusted Partner (TP)

The 2025/26 Health Inequalities funding programme for South-East Essex has been launched by the designated Trusted Partner. Southend Association of Voluntary Services (SAVS), supported by Castle Point Association of Voluntary Services CAVS and Rayleigh Association of Voluntary Services (RAVS), will manage local funding to support targeted projects for adults, children, and young people.

Focusing on reducing health disparities through innovation and collaboration, all funding applications will be reviewed and moderated in September, with approved projects expected to begin by 31 October 2025. This programme of investment will run in parallel but align to the coastal communities network.

Better Care Fund (BCF)

The BCF teams completed the 2025/26 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. Planning for 2025/26 was informed by a review of existing projects being supported by the BCF, the data supporting these and evaluations completed over the year.

There is recognition that local authority (LA) re-organisation and devolution, and changes to ICB boundaries and responsibilities might affect funding flow and the work undertaken in the BCF space and some pre-planning around this is starting with LA colleagues on the basis of information currently available. 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.

We will concentrate on aligning resources to improve support across three focus areas:

- Neighbourhood Development
- System Flow
- Health & Social Care Inequalities.

Within the Essex County Council (ECC) facing part of the system, a key focus of the recent meeting was on the work to support the transition of our existing bridging capacity into a Home to Assess (H2A) model which continue to move forward. South east Essex has now gone live and joined the wider roll out in mid Essex and the continued implementation in south west Essex. The procurement of this new H2A model is live and being undertaken by ECC with the ICB's support and will be in place as a fully mobilised service by November 2025.

We have also maintained our overview of the other core funded projects within the BCF. In Southend refreshed mechanisms for reporting at scheme and system level have been established for better insight and evidence of the impact of the BCF programme on wider system priorities. In Thurrock, the evidence drawn from the line-by-line review is promoting better use of BCF and targeted funding for strategic developments for adults with learning disabilities, carers who are in crisis, and significant work on falls prevention. Additionally, focussed work on expanding services (generalist and specialist) supporting people who are palliative and nearing end of life, will be supported by BCF funding, as will increasing the number of frailty nurses in the borough to support the next phase of delivery through INTs and PCNs.

2. Recommendation

The Board is asked to note the Primary Care and Alliance report.

Part I ICB Board meeting, 17 July 2025

Agenda Number: 13.1

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.

Note: Strategic Objectives are being updated for 2025/26 and presented to the Board for approval.

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 on the Board Assurance Framework

At a Board Seminar and through working with the Executive Team, the Board Assurance Framework risks have been updated and now include seven strategic risks **all of which are rated red** (scored between 15 and 25):

- Workforce (16)
- Primary Care (16)
- Primary Care Estates (Capital) (16)
- Quality (Safe) Services (20)
- Access to Services (16)
- System Financial Performance (16)
- ICB Transition (16)

As of July 2025, all BAF risks were 'RAG' rated red. However, system financial performance had reduced from the previous report. The ICB Transition is a new risk.

Changes to the Board Assurance Framework included:

- Reframing of the Capital risk
- Replacing the UEC/System Coordinating, diagnostic, elective and cancer risk with an 'Access to Services' risk.
- Reframing the System Financial Performance Risk.
- Removing the Health Inequalities risk as this was now managed at corporate risk level and underpins all the work undertaken via commissioning.
- Replaced the Mental Health Quality Assurance Risk with an overall Quality (Safe) Service risk.

The Board's review of the BAF, including a review of the ICB's risk appetite, which has also been updated and is being presented to the Board for approval.

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. Recommendation

The Board is asked to note the content of this report and seek any further assurances required.

4. Appendices

Appendix 1 - Board Assurance Framework, July 2025.

NHS
Mid and South Essex

Board Assurance Framework

July 2025

www.midandsouthessex.ics.nhs.uk

Contents

- Summary Report
- Individual Risks – controls, barriers, assurance and actions
- Main Provider risks (MSEFT & EPUT)

BAF Risks – Summary Report

No	Risk and Key Elements	SRO(s)	Aligned Committee / Board Report	RAG
1.	**WORKFORCE:** There is a risk that the workforce within the system (MSEFT, EPUT, Primary Care) is not sustainable or affordable to effectively deliver services. | This is caused by inadequate strategic planning of the required workforce, coupled with difficulties in recruitment and retention leading to a heavy reliance on bank/agency staff. Services have ineffective succession planning/development, and the quality of workforce data is poor. | This could lead to patient safety issues/harm (safer staffing), poor patient experience and increased cost.	J Cripps	People Board / No specific Board report	**4 x 4 = 16** ⟺
2.	**PRIMARY CARE** There is a risk that the intentions of the primary care strategy and development of Primary Care Networks will not be realised. | This is caused by workforce pressures and demand outstripping capacity and difficulties in the recruitment and retention of primary care staff. | This could lead to patient experience and pathways not meeting the needs of our residents and a difficulty in delivering the 'left shift' of services from 'acute to community'.	P Green	Primary Care Commissioning Committee (PCCC) / Primary Care and Alliance report	**4 x 4 = 16** ⟺
3.	**PRIMARY CARE ESTATES (CAPITAL)** There is a risk that the primary care estate is not fit for purpose or holds sufficient capacity to deliver services appropriately. | This is caused by limited available of investment and changes to the ownership structures of surgeries over time. | This could lead to closure of primary care premises or services, poor patient experience and potential increase in acute hospital demand	J Kearton / P Green	PCCC / Primary Care and Alliance report	**4 x 4 = 16** ⟺
4.	**QUALITY (SAFE) SERVICES** There is a risk that patients experience poor quality of services, poor experience and negative outcomes or harm. | This is caused by services falling below expected clinical quality standards, the NHS Constitution and NHS Long Term Plan requirements; and the ICB not having sufficient oversight and intervention to be assured services improve. | This could lead to the ICB needing to manage additional demand on primary/acute hospital services, an increase in financial pressure, regulatory scrutiny and reputational damage.	G Thorpe	Quality Committee / Quality report	**4 x 5 = 20** ⟺
5.	**ACCESS TO SERVICES** There is a risk that patients experience poor access to services (health inequality), a lack of timely intervention (according to constitutional standards), deconditioning, poor experience and outcomes or harm. | This is caused by waiting list backlogs, non-delivery of operational planning requirements, lack of capacity in service delivery and supporting services such as diagnostics and poor data. | This could lead to reputational damage, regulatory scrutiny, increase demand on ICB functions and increased financial pressure.	S Goldberg	Finance & Performance Committee (FPC)/ Finance and Performance Monthly update report.	**4 x 4 = 16** ⟺
6.	**SYSTEM FINANCIAL PERFORMANCE** There is a risk that organisations within the system control total do not deliver the required financial plans / efficiency savings. | This is caused by grip and control, capacity to manage, unforeseen cost pressures and lack of join up across all functions within the organisations. | This could lead to increased scrutiny by regulators, reputational damage and a potential changes to service delivery.	J Kearton	FPC / Finance and Performance Monthly update report.	**4 x 4 = 16** ⇩
7.	**ICB TRANSITION** There is a risk that the creation of a new ICB geography and organisation at reduced cost will not be able to deliver core functions and transformational changes required by the MTP. | This is caused by an expected reduction in capacity, at a rapid pace that will detract staff from delivery as they engage in workforce redesign and consultation during a period of significant national change and cost saving requirements across the NHS. | This could lead to disengagement of staff, a failure to maintain strategic commissioning functions that could ultimately result in potential harm to residents, poor experience and reputation damage, with resulting increased regulatory scrutiny.	T Abell	Transition Committee / Chief Executive Report	**4 x 4 = 16** **NEW**

BAF

The risks that make up our BAF and their scores

	Workforce	4x4=16
53	Expansion of clinical capacity	4x4=16
54	Reduce non-clinical headcount	3x5=15
55	R&R to reduce B&A (Provider)	4x4=16
56	Reduce B&A for clinical rotas	4x4=16

	System Financial Performance	4x4=16
7	Efficiency Programme	4x4=16
14	System Financial Performance	5x3=15
42	ICB Financial Performance	4x3=12

	Quality	4x5=20
5	MH Acute quality assurance	4x4=16
6	Neurodivergent Children	4x4=16
11	AACC	4x4=16
15	Acute quality assurance	4x5=20
17	Maternity	4x4=16
127	AACC CQC	4x4=16

	Primary Care	4x4=16
3	PC Demand & Capacity	4x4=16
21	PC Workforce R&R	4x3=12

	Primary Care Estate	4x4=16
58	Insufficient Capital	4x4=16

	Access to Services	4x4=16
1	RTT	4x4=16
2	Diagnostics performance	5x4=20
13	Cancer performance	4x4=16
26	Ambulance Handovers	4x3=12
93	Mental Health patient flow	4x4=16

	Transition	4x4=16
	Critical Programmes/Decisions	4 x 4 = 16
	HR Capacity	4 x 4 = 16
	Financial Efficiency Savings	4 x 4 = 16

Risk Narrative:	**Workforce:** There is a risk that the workforce within the system (MSEFT, EPUT, Primary Care) is not sustainable or affordable to effectively deliver services. This is caused by inadequate strategic planning of the required workforce, coupled with difficulties in recruitment and retention leading to a heavy reliance on bank/agency staff. Services have ineffective succession planning/development, and the quality of workforce data is poor. This could lead to patient safety issues/harm (safer staffing), poor patient experience and increased cost.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Lead:	Jo Cripps, Executive System Recovery Director Siobhan Morrison, ICB HR Advisor / Chief People Officer (Provide)	Directorate: Board Committee:	People Directorate People Board
Impact on Strategic Objectives/ Outcomes:	Compassionate Leadership	Associated Risks on Datix:	ID Nos 53, 53, 55 and 56.

How is it being addressed? (Current Controls)

- Continued monitoring via the Finance & Performance Report to the Finance & Performance Committee and Board and via the People Board
- Strict controls over the use of bank and agency staff by providers.
- Scrutiny by ICB (triple lock) of all vacancies, contract extension requests against a predetermined criteria.
- Both EPUT and MSEFT embarking on corporate staffing review with significant headcount reduction.
- Primary care workforce hub continues to support activities in primary care.
- Health and Care Academy and Healthcare Assistant Academy are providing a strong pipeline for future health careers.

Barriers (Gaps)

- Compliance and controls will make a difference and is the right discipline.
- However, sustainable change will require significant decisions around size, shape and skill mix of future workforce aligned to MTP priorities.

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Reduction of percentage of workforce that is over–establishment and unfunded.
- Reduction in temporary staffing spend.
- Evidence of better value for money where temporary staffing continues to be needed.
- Improved productivity and staff morale as evidenced through NHS staff survey.

Next Steps (Actions)

1. Ongoing compliance and control tracking within provider organisations.
2. 2025/26 operational plan submission provides appropriate staffing levels and there is commitment to manage to that workforce plan.
3. People Board to take a greater role in assurance of workforce plans.
4. Opportunities for system working (eg workforce analytics) will be picked up via the system efficiency programme of the MTP.
5. Clarity on ICB running cost reduction programme. Requires national/regional decisions.

Is there anything else we need to know? What can't we see?

- Current lack of clarity on mechanisms for ICB running cost reductions.

Risk Narrative:	**Primary Care:** There is a risk that the intentions of the primary care strategy and development of Primary Care Networks will not be realised. This is caused by workforce pressures and demand outstripping capacity and difficulties in the recruitment and retention of primary care staff. This could lead to patient experience and pathways not meeting the needs of our residents and a difficulty in delivering the 'left shift' of services from 'acute to community'.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Lead:	Pam Green, Alliance Director Basildon & Brentwood (Primary Care)	Directorate: Board Committee:	Primary Care Directorate Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Commission and assure safe services / Focus on access and outcomes / Strategic Commissioner and System Leader	Associated Risks on Datix:	ID Nos 3 and 21.

How is it being addressed? (Current Controls)

- Primary Care Access Recovery Programme
- Primary Care Medium Term Plan
- Development of Integrated Neighbourhood Teams
- Primary Care Estates Programme
- Primary Care Workforce Hub

Barriers (Gaps)

- Continued work following collective action, particularly prescribing, continuous monitoring.
- Resource for investment in infrastructure especially for estates improvements.
- Increase in overall demand on primary care services.
- Primary/Secondary interface. Specific work programme in place.
- Overall funding of primary care.

Next Steps (Actions)

- Integrated Neighbourhood Teams – revised approach for the development of INTs included within the ICB's Medium Term Plan. This will be a key focus for Alliances in 2025/26.
- Transitional funding for practices – scheme will conclude by March 2025. Over 70 practices already supported with transitional funding.
- Continue engagement with Essex Local Medical Committee. Working through specific solutions e.g. prescribing of ADHD medications.
- Development of GP Primary Care Collaborative

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Patient Survey Results.
- Workforce retention rates (monthly data). Latest data indicates marginal improvement in GP retention rates.
- Improved Patient to GP Ratio (quarterly data).
- Consultation data (volume, speed of access), digital tool data (engagement and usage), monthly data currently showing upward trends.

Is there anything else we need to know? What can't we see?

- The changing role of the ICB and impact on system working.

Risk Narrative:	**Primary Care Estates (Capital) :** There is a risk that the primary care estate is not fit for purpose or holds sufficient capacity to deliver services appropriately. This is caused by limited available of investment and changes to the ownership structures of surgeries over time. This could lead to closure of primary care premises or services, poor patient experience, and potential increase in acute hospital demand.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Lead:	Jen Kearton, Executive Chief Finance Officer Pam Green, Alliance Director Basildon & Brentwood (Primary Care)	Directorate: Board Committee:	Finance and Estates Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Commission and assure safe services / Focus on Access and Outcomes	Associated Risks on Datix:	ID Nos 58

How is it being addressed? (Current Controls)

- Evolving Infrastructure Strategy and revised medium term prioritisation framework for pipeline of investments.
- Oversight by Finance & Performance Committee, System Finance Leaders Group, System Investment Group (SIG), and Executive Committee.
- SIG sighted on 'whole system' capital and potential opportunities to work collaboratively. Provider capital plans for 2025/26 being progressed through SIG and planning forums.
- Working with NHS England (NHSE) / Trusts to deliver the benefits associated with the sustainability and transformation plan capital.
- Prioritisation framework for primary care (PC) capital now established and under regular review.
- Alliance level estates plans being developed to support prioritisation, with initial focus on Rochford.
- Maximising use of developer contributions where available for general practice improvements.
- Development of proposals for 2025/26 ICB programme of work under the banner 'MSE Expand' aligned to national PC Modernisation Fund

Barriers (Gaps)

- Medium Term prioritisation framework to guide investment.
- Expectations of stakeholders outstrip the current available capital.
- Accounting rules relating to the capitalising of leases has resulted in greater affordability risk.
- Impact of system financial position ('triple lock' and reduction of capital departmental expenditure limits (CDEL).

Next Steps (Actions)

- Primary care projects review on-going.
- Promotion of available developer contributions to support affordable developments.
- Progress opportunity through PC Estate Utilisation & Modernisation Fund (March 25).
- Training for Board members & executives (senior managers) on capital funding framework (post approval of Infrastructure Strategy) and consideration of future capital requirements.

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Delivery of capital/estates plans.
- Progress reporting on investment pipeline.
- Monthly reporting of capital expenditure as an ICS to NHSE.

Is there anything else we need to know? What can't we see?

- The changing role of the ICB and impact on system working.

Risk Narrative:	**Quality Assurance of Services**: There is a risk that people experience poor quality of services, have a poor experience and negative outcomes or harm. This is caused by services falling below expected clinical quality standards, the NHS Constitution and NHS Long Term Plan requirements; and the ICB not having sufficient oversight and intervention to be assured services improve. This could lead to the ICB needing to manage additional demand on primary/acute hospital services, an increase in financial pressure, regulatory scrutiny and reputational damage.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Lead:	Dr Giles Thorpe, Executive Chief Nursing Officer	Directorate: Board Committee:	Quality and Corporate Services Quality Committee
Impact on Strategic Objectives/ Outcomes:	Commission and assure safe services / Focus on Access and Outcomes, Strategic Commissioner and System Leader	Associated Risks on Datix:	ID Nos 5, 6, 11, 15, 17 and 127

How is it being addressed? (Current Controls)

- Provider quality reports taken to Quality Committee, alongside monitoring via the Quality, Performance, Contracting Meeting (QCPM).
- System Quality Group focusses on the delivery of system improvements against any core quality concerns and issues
- Mental Health - check and challenge at weekly Complex Delayed Discharges Escalation meeting with EPUT, with regular Multi-Agency Discharge Events (MADE) to ensure good flow and capacity.
- Rapid Quality Reviews in place, chaired by ICB CNO, to address significant concerns/regulatory issues pertaining to provider challenges
- Quality Assurance Visits (QAV) to promote continued collaborative working, check and challenge, assurance of quality and patient safety, and compliance with regulatory requirements.
- Ongoing dialogue with Patient safety teams to allow for ICB communications and senior leadership notification, ICB patient safety specialist and quality team continue to work with Providers.

Barriers (Gaps)

- Data Quality issues and IT systems not yet in place consistently to allow for robust data capture and analysis.
- Workforce challenges impacting on all services (see Workforce Risk on slide 4).
- Ongoing issues related to governance frameworks, and proactive identification of emerging risks to safety, experience and quality result in ongoing harm.
- Flow across providers congested due to high demand, thereby impacting poor patient experience..

Next Steps (Actions)

- Mitigations against data quality issues identified, ICB increasing analytics capabilities to address provider shortfalls and offer system perspective
- Ongoing recruitment and retention across providers to support all aspects of care delivery
- Well Led review underway within MSEFT to highlight governance requirements, ongoing work to support primary care utilised PSIRF through ICB safety team, in line with national guidance.
- Rapid Quality Review in place to improve psychiatric liaison/flow/escalation across MSEFT/EPUT

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Improved quality and contract indicators which are embedded and sustained.
- Improved and sustained capacity and flow, reduced length of stay, and reduced OOA placements (for mental health).
- Outcome of Quality Assurance visits with embedded culture, quality, patient safety, and compliance with all contractual and regulatory requirements.
- Oversight of PFDR with the providers ensuring that all actions are embedded into practice.
- Reduction in requirements for enhance monitoring status of providers within the system

Is there anything else we need to know? What can't we see?

- Clarity on the full role of ICB/Regional accountabilities and responsibilities in relation to Quality oversight and assurance are yet to be finalised – Model Region Blueprint currently being developed
- Dash review of quality oversight within health and social care will impact further roles and responsibilities.
- Understanding of new providers into Greater Essex footprint will also determine capacity and demand risks, and reshape function and form of support to primary care, optometry and dental services across Essex.
- Redesign of system governance will be required to help maintain a focus on quality aspects of commissioning and planning cycles, focussed on demand utilisation, and to meet ambitions within 10 year plan.

Risk Narrative:	**Access to Services**: There is a risk that patients experience poor access to services (health inequality), a lack of timely intervention (according to constitutional standards), deconditioning, poor experience and outcomes or harm. This is caused by waiting list backlogs, non-delivery of operational planning requirements, lack of capacity in service delivery and supporting services such as diagnostics and poor data. This could lead to reputational damage, regulatory scrutiny, increase demand on ICB functions and increased financial pressure.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Lead:	Sam Goldberg, Executive Director of Performance and Planning	Directorate: Board Committee:	Performance and Planning Finance & Performance Committee
Impact on Strategic Objectives/ Outcomes:	Focus on Access and Outcomes	Associated Risks on Datix:	ID Nos 1, 2, 13, 26 and 93.

How is it being addressed? (Current Controls)

Operational Planning and Performance Monitoring
- Integrated Operational Plans aligned with national standards and local needs. | Escalation process for underperformance or missed targets via the performance review meetings, SOAC and F&PC.
- Regular performance reviews against constitutional standards: Weekly Elective Recovery & Transformation Board, bi-weekly Tier 1 Meeting for Cancer & Elective, and monthly UEC Oversight & Performance Meeting

Capacity and Demand Management
- Demand management tools, utilising Advice & Guidance to demand manage | Use of independent sector providers to reduce 65 week wait backlogs where appropriate.
- Service Design to implement community pathways to support demand management and maximise out of hospital pathways to reduce outpatient appointments and procedures.

Waiting List Management
- Validation and clinical triage of waiting lists to ensure accuracy and urgency. | Patient tracking systems to flag delays and trigger interventions.

Governance and Oversight
- Board-level oversight of access and performance metrics. | Risk registers and assurance frameworks to track and mitigate risks. | Internal reviews to ensure compliance and continuous improvement.

Barriers (Gaps)

- UEC: Demand management at initial assessment and triage, constraints to increase non-elective activity into SDEC due to bedded as escalation overnight capacity, specifically at Basildon and Broomfield hospitals.
- Elective & Cancer: Improved community models to reduce pathway. Inability to increase capacity in acute to support advice & guidance.
- Workforce challenges (See Workforce Risk slide).

Next Steps (Actions)

- Continuous monitoring of daily operations
- Quality Improvement Programmes at MSEFT to improve ED performance
- SDEC streaming
- Mobilising the ICTH

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Improvement in compliance with target standards via F&PC and Board Reports
- Achievement of operational plans / programmes of work
- Improvements in patient constitutional standards and associated performance delivered.

Is there anything else we need to know? What can't we see?

- Outcome from the NHSE Elective Operating Planning submission Peer Review
- Outcome from the ICB/NHSE UEC, Flow & Discharge Peer Review
- Outcome from the NHSE National UEC Missed Opportunities audit
- Elective Orthopaedic operating theatre capacity and strategy.
- Outcome of scoping and designing of community models for procurement for Dermatology, MSK & Pain and ENT and Audiology with all models providing a single point of access, consultant led MDT led services to reduce first outpatient appointments and procedures, scheduled for deployment in Q2-Q4.

Risk Narrative:	**System Financial Performance**: There is a risk that organisations within the system control total do not deliver the required financial plans / efficiency savings. This is caused by a lack of management capacity and capability and ineffective collaborative working. This could lead to increased scrutiny by regulators, reputational damage and a potential changes to service delivery.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Lead:	Jen Kearton, Executive Chief Finance Officer	Directorate: Board Committee:	Finance Directorate Finance & Performance Committee
Impact on Strategic Objectives/ Outcomes:	Deliver to the agreed budget / Strategic Commissioner and System Leader	Associated Risks on Datix:	ID Nos 7, 14 and 42.

How is it being addressed? (Current Controls)

- Escalation meetings with MSEFT, NHSE EoE Regional Colleagues and regular review with NHSE National team.
- Central PMO focus on efficiency delivery and new ideas for continued momentum across the medium-term planning period.
- Organisational bottom-up service and division review and improvement plans.
- Continued oversight by Chief Executive Officers, Finance Committees and Executive Committees across organisations and ICB.
- Control Total Delivery Group of System Chief Finance Officers established.
- Engagement across the system with all disciplines to escalate the importance of financial control, value for money and improving value.
- Additional workforce controls – please see workforce slide.
- Additional spend controls – triple lock arrangements.
- Investigation and Intervention work with local implementation of identified actions. Medium Term Plan being finalised to support movement to financial sustainability.

Barriers (Gaps)

- New and emerging financial challenges being driven by workforce challenges, performance, quality and delivery.
- System pressures to manage delivery (capacity).
- Capacity due to vacancy chill.

Next Steps (Actions)

- On-going monitoring of financial position.
- Delivery of system efficiencies programme/financial sustainability programme for 2024/25.
- Medium Term Plan developed with PA Consulting identifying 7 key programmes to drive system sustainability, to inform future planning.

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Delivery of the agreed position in-year and at year-end.
- Improved delivery throughout the medium term (5 years) to system breakeven.
- Being overseen by the Finance Committees and the Chief Executives Forum.
- Internal and External Audits planned.

Is there anything else we need to know? What can't we see?

- The changing role of the ICB and impact on system working.

Risk Narrative:	**ICB Transition:** There is a risk that the creation of a new ICB geography and organisation at reduced cost will not be able to deliver core functions and transformational changes required by the MTP. This is caused by an expected reduction in capacity, at a rapid pace that will detract staff from delivery as they engage in workforce redesign and consultation during a period of significant national change and cost saving requirements across the NHS. This could lead to disengagement of staff, a failure to maintain strategic commissioning functions that could ultimately result in potential harm to residents, poor experience and reputation damage, with resulting increased regulatory scrutiny.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Lead:	Tom Abell, Chief Executive Officer.	Directorate: Board Committee:	ICB Board Executive Committee
Impact on Strategic Objectives/ Outcomes:	Compassionate Leadership / Deliver to the agreed budget	Associated Risks on Datix:	ID Nos to be confirmed

How is it being addressed? (Current Controls)

- Establishment of ICB Transition Committee and Executive led subgroups, alongside establishment of a Greater Essex working group.
- Strong engagement plan, weekly staff updates, engagements with partners, staff support.
- Seeking procurement specialist advice to ensure that where possible we can future proof all procurements without impacting on the pace of change.
- Continuing to run programmes across the system, ensuring that provider plans are not impacted by the ICB transition (via MTP Delivery Board).
- CPMO continues to manage projects and report to the MTP Delivery Board.
- All information relating to priority programmes of work held on Aspire portal to provide continuity for programme management.

Barriers (Gaps)

- National policy will lead expected changes therefore certain actions outwith ICB control
- Current workforce change timescales and planning assumptions not yet confirmed (e.g. redundancy / MARS / SAE)

Next Steps (Actions)

- Reviewing resourcing arrangements against priority programmes of work for the next six months to consider areas that need strengthening / pausing / ceasing.

How will we know it's working? (Internal Groups & Independent Assurance & metrics)

- Future organisational form is accepted through external (Regional/National team) review during first round
- Workforce redesign is agreed within Q2
- Future functions align with ICB Model Blueprint

Is there anything else we need to know? What can't we see?

- 'Model Region' blueprint will support future function design – not yet finalised/drafted
- Funding stream for redundancy/MARS required to enable planning

Partner self-identified Red Risks (and scores)

MSEFT - 10 Red Risks (as per June 2025 BAF report to Trust Board).

- Financial Sustainability (25)
- Constrained Capital Funding Programme (25)
- Workforce Instability (25, ⇧)
- Capacity and Patient Flow Impacting on Quality and Safety (20)
- Estate Infrastructure (20)
- Data Quality and Clinical Documentation (16, new to BAF)
- Planned Care and Cancer Capacity (25 ⇧)
- Delivery of Clinical and Operational Systems to Support delivery of business objectives (16)
- Cyber security (20, ⇧)
- Organisational culture and engagement (16)
- Integrated Care system working (16, new to BAF)

Partner self-identified Red Risks (and scores)

EPUT red risks, as of May 2025 BAF report to Trust Board.

- Capital resource for essential works and transformation programmes (20)
- Use of Resources: control total target / statutory financial duty. (20)
- Statutory Public Enquiry (16)
- Organisational Development (16)
- Quality Governance (15) – superseding previous Safety risk (encompassing three facets of quality governance and outcomes: safety, effectiveness and experience)

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Part I ICB Board Meeting, 17 July 2025

Agenda Number: 13.2

Committee Terms of Reference

Summary Report

1. Purpose of Report

To seek approval of revised Board sub-committee terms of reference (ToR) following annual effectiveness reviews.

2. Executive Lead

Tom Abell, Interim Chief Executive Officer

3. Report Author

Sara O'Connor, Senior Manager Corporate Services

4. Responsible Committees

Each committee has considered its terms of reference and approved any changes recommending approval by the Board.

The Audit Committee maintains oversight of governance and considers the effectiveness of Board sub-committees as part of its terms of reference.

The Board retains responsibility for approving changes to committee terms of reference prior to them becoming effective.

5. Impact Assessments / Financial Implications / Patient or public engagement

Not applicable to this report.

6. Conflicts of Interest

None identified.

7. Recommendation(s)

The Board is asked to consider and **approve** revisions to the terms of reference of the following Board sub-committees or, where applicable, **note** that no revisions have been made for the reasons set out in this report:

- Audit Committee
- Remuneration Committee
- Clinical and Multi-professional Congress
- Finance and Performance Committee
- Digital Data and Technology Board

- Primary Care Commissioning Committee
- Quality Committee
- System Oversight and Assurance Committee
- Executive Committee
- Basildon and Brentwood Alliance
- Mid Essex Alliance
- South East Essex Alliance
- Thurrock Alliance

Committee Terms of Reference

1. Introduction

Each sub-committee of the Board is required to undertake an annual self-assessment of its effectiveness to determine whether it has met its objectives as set out within its terms of reference (ToR). This process includes a desktop review, a questionnaire sent to its members and a review of its ToR to ensure they remain current and appropriate.

2. Proposed Changes to Committee Terms of Reference

The outcomes of the committee self-assessments and proposed changes to ToRs were presented to and approved by each respective committee.

The table below highlights proposed changes to committee ToRs for approval by the Board.

Board sub-committee	**Summary of changes to terms of reference**
Audit Committee	• Inclusion of responsibility of Audit Committee to "seek assurance on the Individual Funding Request governance to ensure the process followed is robust and consistent".
Remuneration Committee	• Amendments allowing individuals deputising for committee members to vote. • Amendment to allow the Executive Chief People Officer to nominate nominated deputies to attend in their absence.
Clinical and Multi-Professional Congress	• No changes required at this time.
Finance & Performance Committee	• Attendees section 4.11 updated to "Where systems are in financial deficit the NHSE Regional Chief Finance Officer will be invited to attend Committee meetings".
Digital Data and Technology Board	• Membership updated to include the Integrated Care System BI Lead. • Data and BI Board Chair/Deputy Chair removed from list of attendees.

Board sub-committee	Summary of changes to terms of reference
Primary Care Commissioning Committee	• Sub-group structure showing groups reportable and accountable to the committee added, these being: Pharmaceutical Services Regulation Committee; Dental Commissioning and Transformation Group, Community Pharmacy Commissioning and Transformation Group, Local Dispute Resolution Panel and MSE Ophthalmology Transformation Board (this amendment also resulted in a similar structure being removed from S8.6 of the 'Accountability and Reporting' section). • Membership updated to remove Healthwatch. • Responsibilities of the committee updated to include maintaining "an overview of estate requirements (general practice) and consider requests for financial support under the Premises Cost Directions (2024) where these have a revenue consequence" and overseeing "the delivery of the Primary Care programme of the Medium Term Plan."
Quality Committee	• Reference to 'NHSE England / Improvement' updated to 'NHSE England'.
System Oversight and Assurance Committee (SOAC).	• Part I SOAC Membership of committee updated to: include the Executive Director of System Recovery (previously an 'attendee') and Executive Director of Performance and Planning; remove the Upper Tier Local Authority Partner representative; and move the Alliance Director representative and Executive Director of Strategy and Corporate Services to the 'Attendees' section. • Executive Director of Performance and Planning added as an additional attendee at Part II SOAC National Oversight Framework (NOF4) meetings. • Removal of the committee's responsibility for oversight of progress towards delivering the undertakings requirements place on Mid and South Essex NHS Foundation Trust which are now monitored separately.
Executive Committee	• The committee agreed its ToR would be reviewed once the Executive structure for the new ICB operating across Greater Essex ICB was agreed and appointments were made.

Board sub-committee	Summary of changes to terms of reference
Basildon and Brentwood Alliance	• No changes made apart from updating the ToR to reflect the appointment of an Independent Chair of the committee.
Mid Essex Alliance	• The committee's ToR were reviewed but not yet formally approved by the committee.
South East Essex Alliance	• The committee's ToR were reviewed to reflect the revised Alliance Delivery Plan and Governance. Membership was streamlined to Director level or above and formally approved by the committee.
Thurrock Alliance	• No changes have been made at this time.

3. Findings/Conclusion

Committee ToRs have been updated to ensure that they remain current and reflect the work of the committee, with most changes being minor.

As mentioned above, some committees have not yet reviewed, or formally approved, revised ToR for the reasons given. However, once the committee structure for the ICB, operating across Greater Essex has been agreed, all ToRs will be reviewed to ensure they reflect the structure and responsibilities of the new ICB.

Once approved, the updated ToRs will be published within the governance handbook on the ICB's website.

4. Recommendation(s)

The Board is asked to consider and **approve** revisions to the terms of reference of the following Board sub-committees or, where applicable, **note** that no revisions have been made for the reasons set out in this report:

- Audit Committee
- Remuneration Committee
- Clinical and Multi-professional Congress
- Finance and Performance Committee
- Digital Data and Technology Board
- Primary Care Commissioning Committee
- Quality Committee
- System Oversight and Assurance Committee
- Executive Committee
- Basildon and Brentwood Alliance
- Mid Essex Alliance
- South East Essex Alliance

- Thurrock Alliance

Part I ICB Board Meeting, 17 July 2025

Agenda Number: 13.3

Committee Effectiveness Reviews

Summary Report

1. Purpose of Report

To provide a summary report of committee effectiveness reviews to the ICB Board for oversight of governance arrangements across the sub-committees.

2. Executive Lead

- Name: **Tom Abell**
- Job Title: **Interim Chief Executive Officer**

3. Report Author(s)

- Name: **Nicola Adams**
- Job Title: **Associate Director of Corporate Services**

- Name: **Jane King**
- Job Title: **Corporate Services and Governance Support Manager**

4. Responsible Committees

Each sub-committee of the Board, as part of its terms of reference, is required to undertake an annual self-assessment of its effectiveness.

The Audit Committee maintains oversight of governance and considers the effectiveness of Board sub-committees as part of its terms of reference.

The Board retains responsibility for approving changes to committee terms of reference prior to them becoming effective and for considering the performance of its sub-committees when considering its own performance.

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.

6. Impact Assessment / Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not Applicable.

8. Conflicts of Interest

None identified.

9. Recommendation/s

The Board are asked to consider, discuss, and note the feedback from committee effectiveness reviews.

Committee Effectiveness Reviews

1. Introduction

In accordance with good practice guidance, each formal sub-committee of the ICB Board is required to undertake an annual review of its effectiveness. As a sub-committee of the ICB Board, the committee is charged with providing assurance to the Board that performance within the remit of the committee and the risks associated with committee business are managed appropriately and support the Board in the achievement of its aims and objectives.

The Committee's annual self-assessment of effectiveness (or effectiveness review) assesses how each committee has performed over the last year in accordance with the objectives set within its terms of reference (i.e. has it delivered what it set out to do) and how effective it has been in discharging those responsibilities.

The committee effectiveness review is carried out in three parts, an initial desktop assessment, a committee members survey and a committee review, described in more detail below.

2. Main content of Report

The purpose of the effectiveness review was to determine whether each committee met its objectives as set out within its terms of reference (TOR), and to identify ways in which the operation of the committee and its contribution to the ICB Board can be strengthened year on year.

Desktop Review

Desktop reviews of MSE ICB Committee Effectiveness 2024/25 have been undertaken for each committee by the Committee Administrator and the Chair of the Committee.

Each desktop review included the following:

- Assessment of whether the committee met the objectives set out within its terms of reference and as set out within its workplan.
- Highlight of the key achievements and work of the committee.
- Review of committee terms of reference.
- Review of the functioning of the committee, whether the committee has been kept up to date on relevant issues, did it meet often enough, were meetings quorate and any conflicts managed appropriately, papers circulated in good time and was decision making robust and agile with assurance provided back to the Board.
- Consideration of how the Committee had oversight of risks.

Members Survey

Surveys were sent to members for completion to gather their views as to how the committee has performed over the last year and how the committee might evolve over the coming year.

Members of the Committee were asked to complete a short survey to provide their views on:

- Whether they agreed with the desktop review.
- How the committee operated to meet the objectives of it's terms of reference.
- How the committee performed over the year.
- How reports to the Board from the committee could be improved.
- What members liked about the committee
- What members would like to see improve.
- Whether the committee effectively contributed to the aims, objectives and values of the ICB

The outcomes of the committee self-assessments, including the results of the survey, proposed changes to TORs and proposed development plans have been presented to and approved by each respective committee.

In summary, committees concluded that they have broadly met their objectives, according to their TOR.

The table below highlights the key outcomes for each committee:

Board sub-committee	**Summary of outcome**
Audit Committee (17th June 2025)	*The Audit Committee achieved the objectives it set out within its terms of reference, that the meeting had been administered and run well with a good breadth of topic areas discussed throughout the year. It was found that the committee provided good oversight of the ICB's governance, risk management and other internal control systems and was robust in its processes for decision making.* *Action Plan:* • *Include Committee workplan on Agenda* • *Heading on cover paper to provide assurance that ICB is meeting priorities around Equality, Equity, Diversity and Inclusion* • *Schedule transition risks on workplan for July 2025* • *Hold insight session on 2025/26 annual report*
Remuneration Committee (17th February 2025)	*The Remuneration Committee achieved its objectives, as set out within its terms of reference.* *Action Plan:* • *Committee members and Interim Chief People Officer to consider whether any risks within the remit of Remuneration Committee should be added to the ICB's risk register.* • *Although escalations to Board, or other appropriate forum already occur, 'Escalations to ICB Board or other appropriate forum' will be included as an additional agenda item from 2025/26.*

Board sub-committee	Summary of outcome
Primary Care Commissioning Committee (14 May 2025)	*The Primary Care Commissioning Committee (PCCC) achieved the objectives it set out within its terms of reference, the meeting had been administered and run well with a good breadth of topic areas discussed throughout the year. It was found that the committee provided good oversight of primary care matters and was robust in its processes for decision making.* *Action Plan:* • *ToR updated to reflect Medium Term Plan (MTP) and left shift into primary care.* • *Schedule regular update from MTP Programme Boards for matters relating to primary care* • *Schedule updates on work plan to ensure PCCC is sighted on the system response to the 'Red Tape Challenge', due to come into force from April 2025.* • *Identify and include key metric data for improvements through the transformation of primary care in future finance reports.* • *Provide a consistent oversight report for the MTP delivery to the Committee.* • *Midpoint committee effectiveness review following the publication of the updated Primary Care Strategy.* • *Increase agenda discussion time for items requiring decision* • *Include details of associated risks on cover papers*
Finance & Performance Committee (FPC) (6th May 2025)	*The findings of the effectiveness assessment concluded that the committee had broadly achieved the objectives it set out within its terms of reference, that the meeting had been administered and run well with a good breadth of topic areas discussed throughout the year. It was found that the committee provided good oversight of financial matters and was robust in its processes for decision making.* *Action Plan:* • *Exploration of the relationship between FPC and other system finance groups to better understand how FPC has oversight of system transformation and recommend if oversight need to be strengthened.* • *Update reports on contracting to be provided to the committee as per its terms of reference, this will also be added to the committee workplan.* • *Consider reflecting on the work of the committee and the business cases it has approved to seek assurance that decisions were acted upon and realising the intended benefits.*
System Oversight and Assurance Committee (SOAC) (27th June 2025)	*The committee effectiveness review concluded that overall, the committee had achieved the objectives it set out within its ToR, that meetings had been administered and run well with a good breadth of topic areas discussed throughout the year and that the committee fulfilled its oversight and assurance function.*

Board sub-committee	Summary of outcome
	Action Plan: • *One action to include a review of the effectiveness of each meeting to future agendas has been actioned.*
Quality Committee (27th June 2025)	*The committee effectiveness review concluded that overall, the committee had achieved the objectives it set out within its ToR, that the meeting had been administered and run well with a good breadth of topic areas discussed throughout the year. It was found that the committee provided good oversight of relevant matters and was robust in its processes for decision making.* • *There were no actions noted as a result of the effectiveness review.*
Clinical and Multi-professional Congress (28th May 2025)	*The overall findings of the effectiveness assessment concluded that overall, the committee had achieved the objectives it set out within its terms of reference, that the meeting had been administered and run well with a good breadth of work programmes discussed throughout the year with clinical feedback and recommendations made.* *Action Plan:* • *Review of effectiveness to be added as an agenda standing item* • *Add escalations to SOAC/ICB Board to the agenda as a standing item.* • *To ensure quoracy and improve attendance, consider an alternative date and/or time for the meeting.* • *Consider holding the meeting bi-monthly with the option to schedule an extraordinary meeting, if required* • *Chair to consider whether specific training is required for new members, following the ICB running cost reduction programme* • *Develop a standard report template for Congress, which will be clearly aligned with standard business case format, and highlight Congress focus on clinical, economic and strategic cases overall.*
People Board (6th March 2025)	*The desktop review undertaken by the committee administrator and shared with the committee Chair, concluded the committee had achieved its key objectives with the exception of:* • *How do we connect the People Plan, People Promise and Workforce Plan together in a more cohesive way.* • *Having established some of the reporting we need to now embed the data analysis within the People Board so that we can have a consistent understanding of how the ICB and Trusts / Local Authorities operate e.g. wellbeing* • *Not yet seeing consistent data and plan for gaps in our workforce and ensuring our workforce matches the population we serve* • *Somewhat lacking in understanding how the system supports leadership at all levels and lifelong learning*

Board sub-committee	Summary of outcome
	• *More to do in developing the data dashboard* • *Would be beneficial to be briefed on national guidance / changes etc. in a timelier fashion.* *Action Plan:* • *ToR to be reviewed and annually henceforth – clear objectives for committee and membership reviewed* • *Workplan to be reviewed for 25/26 (and bi-annually henceforth) and agendas prepared to meet our objectives* • *Function & Decisions map to be updated for onward cascade* • *Develop clear communications strategy* • *Improve timeliness of circulation of minutes and actions.*

3. Findings/Conclusion

A robust process to review committee effectiveness has been conducted with recommendations for each Committee to strengthen how they operate and to clarify their TORs ensuring that they are current and reflect the work of the committee, with only minor changes required.

The action plans put in place and approval of changes to the committees TORs will enable each committee to develop further in the coming year and provide more robust assurance to the Board that the ICB is meeting its objectives and adequately managing associated risks/issues.

4. Recommendation(s)

The Board are asked to consider, discuss, and note the feedback from committee effectiveness reviews.

Part I ICB Board Meeting, 17 July 2025

Agenda Number: 13.4

Revised Policies

Summary Report

1. Purpose of Report

To update the Board on policies that have been revised and approved by sub-committees of the Board.

2. Executive Leads

Dr Giles Thorpe, Executive Chief Nursing Officer
Siobhan Morrison, Interim Chief People Officer

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

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 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 last Part I 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
Quality Committee 27 June 2025	The committee approved the following new policies: • 055 Patient Choice Policy • 075 MSE Cross System Response Policy
Remuneration Committee 4 June 2025	The committee approved the following revised policy: • 086 Under and Overpayments Policy The committee also approved extensions to the review dates of the following policies: • 042 Grievance Policy • 045 Disciplinary Policy • 065 Managing Allegations Against Staff, Volunteers and People in Positions of Trust Who Work with Adults and Children Policy

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, 17 July 2025

Agenda Number: 13.5

Approved Committee Minutes

Summary Report

1. Purpose of Report

To provide the Board with a copy of the approved minutes of the following committees:

- Clinical and Multi-Professional Congress (CliMPC) – 26 March and 28 May 2025.
- Digital and Data Technology Board (DDaT): 8 May 2025
- Finance & Performance Committee (FPC) – 1 April, 6 May and 3 June 2025
- People Board (PB): 1 May 2025
- Primary Care Commissioning Committee (PCCC): 9 April, 14 May and 11 June.
- Quality Committee (QC): 25 April 2025.
- System Oversight and Assurance Committee (SOAC): 25 April 2025.

2. Chair of each Committee

- Dr M Sweeting, Chair of CliMPC.
- Barry Frostick, Chair of DDaT.
- Joe Fielder, Chair of FPC and PB.
- Prof. Sanjiv Ahluwalia, Chair of PCCC.
- Dr Neha Issar-Brown, Chair of QC.
- Tom Abell, Chair of SOAC.

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.

Clinical and Multi-Professional Congress 26 March 2025

The following issues were considered:

- Terms of Reference for the Improving Value Task and Finish Group were approved.
- An update was provided on the committee effectiveness review process for 2024/25.
  Horizon scanning topics for potential future discussion included Rhinosinusitis (Evidence based Intervention) and Septoplasty.

Clinical and Multi-Professional Congress, 28 May 2025

- Adoption of Evidence based interventions – kidney stones.
- Adoption of EBI intervention – bladder outflow obstruction.
- Review of committee effectiveness 2024/25, approval of terms of reference and updated workplan for 2025/26.
- Horizon scanning topics for potential future discussion included Tirzepatide; opportunities to standardisation as a result of the reorganisation of Essex ICBs.
- It was agree the nasal obstruction pathway would be discussed at the next meeting.

Digital Data and Technology Board, 8 May 2025

- Review of committee effectiveness 2024/25, revised terms of reference and workplan for 2025/26.
- The revised Digital Strategy 2025-28 was supported.
- Review of risks within the remit of the committee.
- Health and Social Care Network/Community of Interest Network (HSCN CoIN) update.
- Digital inclusion.
- Digital Social Care Record end of year report.
- Shared Care Record update.
- Patient Knows Best update.
- NHS England regional update.
- Integrated Care System Digital Dashboard update.
- Minutes of digital sub-boards were noted by the committee.

Finance and Performance Committee, 1 April 2025

The following items of business were considered:

- System Finance and performance report for month 11.
- ICB Budgets 2025/26.
- Deep dive on planning submission for the year ahead and capital briefing.
- Frequency of future committee meetings.

Finance and Performance Committee, 6 May 2025

The following items of business were considered:

- It was agreed the committee would continue to meet monthly during quarter one of 2025/26, to be reviewed in due course.
- System Finance and performance report for month 12.
- Planning 2025/26.
- Medium Term Planning update.
- Deep Dive on Performance – Referral to Treatment.
- Review of risks within the remit of the committee.
- The committee approved the revised Financial Allocations and System Reporting Policy.
- Review of committee effectiveness, terms of reference and committee workplan 2025/26.
- Minutes of the System Finance Leaders Group held on 20 January 2025 and 17 March 2025 and minutes of the System Investment Group held on 24 February 2025 were presented for information.
- The committee noted feedback from the Pharmacy Medicines Optimisation Committee for the treatment of heavy menstrual bleeding.

Finance and Performance Committee, 3 June 2025

The following items of business were considered:

- System Finance and performance report for month 1.
- Planning 2025/26.
- Deep Dive on Performance – NHS Constitutional Standards for Cancer.
- Medium Term Planning update.
- The minutes of the System Investment Group held on 31 March 2025 were presented for information.

Primary Care Commissioning Committee, 9 April 2025

The following items of business were considered:

- Update on NHS England changes and ICB cost reduction programme.
- Medium Term Plan update.
- 2025/26 contract changes.
- Primary Medical Services update.
- Review of risks within the remit of the committee.
- Primary Care Quality Update.
- Community Optometry Services.
- The minutes for the Dental Commissioning and Transformation Group meeting held on 5 February 2025 and 5 March 2025 were received.

Primary Care Commissioning Committee, 14 May 2025

The following items of business were considered:

- Update on NHS England changes and ICB cost reduction programme.
- Medium-Term Plan and Incentivisation Scheme.
- Integrated Neighbourhood Teams update.
- General Practice Provider Collaborative update.
- Health inequalities.
- Committee effectiveness review, approval of revised committee terms of reference and approval of the committee workplan for 2025/26.

Primary Care Commissioning Committee, 11 June 2025

The following items of business were considered:

- Update on NHS England changes and ICB cost reduction programme.
- Medium-Term Plan.
- Primary Medical Services contracts.
- Quarterly finance report.
- GP primary care performance reporting.
- Training Hub/workforce update.
- Review of risks within the remit of the committee.
- Pharmacy, optometry & dental quality update
- Community pharmacy update.
- General optometry update.
- Miinutes of the Dental Commissioning and Transformation Group meeting held on 2 April 2025 were received.
- The committee supported the case to continue commissioning the Gynaecology Local Enhance Service (Women's Health Hub).

Quality Committee, 25 April 2025

The following items of business were considered:

- A lived experience story relating to two users' experience of maternity services and a deep dive on the work of the Local Maternity and Neonatal System were presented to the committee.
- Executive Chief Nurse's update.
- Mental health update.
- Updates on the findings of the Greater Manchester Mental Health NHS Foundation Trust review and Nottingham Independent Investigation Report.
- Pharmacy, Optometry and Dentistry update.
- Safeguarding children update.
- Medicines management update.
- Quality impact assessments update.
- Review of patient safety and quality risks within the remit of the committee.
- Terms of reference for the Learning From Deaths Forum were approved.
- The committee considered the new Patient Choice Policy and agreed further work on its content was required. The committee also agreed an extension to the review date of the All Age Continuing Care Policy.
- An update on the process for the review of committee effectiveness for 2024/25 was provided.

- The committee agreed that a further deep dive on maternity services, focussing on perinatal mortality would be undertaken at the June committee meeting.

People Board, 1 May 2025

The following items of business were considered:

- Presentations on workforce challenges within social care, the hospice sector and charity sector.
- Medium Term Plan update
- Review of risks within the remit of the committee.
- Highlight reports from the chairs of the Clinical Capacity Expansion Education Innovation; Colleague Engagement, Wellbeing and Retention; and Culture workstreams were provided for information.

System Oversight and Assurance Committee, 25 April 2025

The following items of business were considered:

- The Executive Director of Finance advised that draft financial plans had been submitted and that the overall system deficit, pre-audit, was £16 million, consisting of £6 million from MSEFT and £10 million from EPUT.
- A deep dive on mental health services was presented and an update on care of mental health patients in acute hospital settings was received.
- Update on elective/cancer recovery plan.
- Update on community waiting lists.

3. Recommendation

The Board is asked to note the approved minutes of the above committee meetings.

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 26 March 2025 at 10.20 am – 11.30 am

Via MS Teams

Members

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Simon Griffiths (SG), Social Care.
- Krishna Ramkhelawon (KR), Public Health.
- Nisha Thakrar (NT), Senior Clinical Fellow.

Attendees

- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- Scott Baker (SB), Clinical Director of Allied Health Professions and Leadership, MSE ICB.
- Helen Chasney (HC), Corporate Services & Governance Support Officer (Minutes).

Apologies

- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Holly Middleditch (HM), Senior Clinical Fellow, MSE ICB.
- Feena Sebastian (FS), Mental Health.
- Fatemah Leedham (FL), Pharmacy.
- Owen Richards (OR), Resident Engagement.
- Rachael Marchant (RM), Primary Care

1. Welcome and Apologies

MS welcomed everyone to the meeting and apologies were noted as listed above. The meeting was not quorate.

2. Declarations of Interest

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

Declarations of interest made by Integrated Care Board (ICB) members are listed in the Register of Interests available on the ICB website.

3. Minutes

The minutes of the last Clinical and Multi-Professional Congress (CliMPC) meeting held on 29 January 2024 were not approved due to the meeting being non-quorate. The minutes will be presented for approval at the next CliMPC meeting on 28 May 2025.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 29 January 2025 would be presented for approval at the next CliMPC meeting on 28 May 2025.

4. Matters Arising/Action Log

MS referred to the Action Log and asked members to note that there were no outstanding actions. There were no further matters arising.

Resolved: The Committee noted that there were no outstanding actions on the Action Log.

5. Improving Value Task and Finish Group Terms of Reference

The Improving Value Task and Finish Group Terms of Reference were presented for noting by the Committee.

Outcome: The committee noted the Improving Value Task and Finish Group Terms of Reference.

6. This item was minuted confidentially

7. This item was minuted confidentially

8. Committee Effectiveness Review process

HC advised that the annual review of committee effectiveness had commenced. A desktop review would be completed by the governance team and shared with the Chair and Lead Executive, along with the Terms of Reference and workplan. Once finalised a survey would be sent to all Congress members to complete and return. The final assessment report would then be presented at the next Congress meeting.

9. Horizon Scanning

A discussion was held on possible areas of work for discussion at future meetings. The following was noted.

- Rhinosinusitis (Evidence based Intervention)
- Septoplasty

KR asked if the forward plan of Improving Value could be shared with directors of public health.

10. Escalation to SOAC/ICB Board

There were no escalations.

11. Any other Business

There were no items of any other business raised.

12. Date of Next Meeting

Wednesday 30 April 2025 at 9.30am – 11.30am via MS Teams.

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 28 May 2025 at 9.30 am – 11.30 am

Via MS Teams

Members

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Simon Griffiths (SG), Social Care.
- Krishna Ramkhelawon (KR), Public Health (up to item 5).
- Fatemah Leedham (FL), Pharmacy.
- Owen Richards (OR), Resident Engagement.
- Feena Sebastian (FS), Mental Health.

Attendees

- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- Scott Baker (SB), Director of Allied Health Professions and Leadership, MSE ICB.
- Kate Butcher (KB), Deputy Alliance Director, Mid Essex, MSE ICB.
- James Howard (JH), East of England Finance Team, NHS England.
- Helen Chasney (HC), Corporate Services & Governance Support Officer (Minutes).

Non-Attendees

- Olugbenga Odutola (OO), Primary Care.
- Babafemi Salako (BS), Primary Care.

Apologies

- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Ronan Fenton (RF), Acute Care.
- Holly Middleditch (HM), Senior Clinical Fellow, MSE ICB.
- Rachael Marchant (RM), Primary Care.
- Sarah Zaidi (SZ), Primary Care.
- Nisha Thakrar (NT), Senior Clinical Fellow.

1. Welcome and Apologies

MS welcomed everyone to the meeting and apologies were noted as listed above. The meeting was not quorate, so papers would be sent virtually to those not in attendance for their comments, which would be noted within these minutes.

2. Declarations of Interest

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

Declarations of interest made by Integrated Care Board (ICB) members are listed in the Register of Interests available on the ICB website**.**

FS declared an interest in item 5 (Community Services Decision Making Business Case) as Essex Partnership University Foundation Trust Held patient clinic services for mental health at St Peters Hospital.

3. Minutes

The minutes of the last Clinical and Multi-Professional Congress (CliMPC) meetings held on 29 January 2025 and 26 March 2025 were presented for comment due to the meeting not being quorate. PW requested the following amendment to the minutes for 26 March 2025.

This section has been minuted confidentially.

Following the meeting the minutes for the meeting held on 29 January 2025 and 26 March 2025 were presented virtually and approved, subject to the amendment above.

Resolved: The minutes of the Clinical and Multi-Professional Congress meetings held on 29 January 2025 and 26 March 2025 were approved, subject to the amendment noted above.

4. Matters Arising/Action Log

MS referred to the Action Log and asked members to note that there were no outstanding actions.

Resolved: The Committee noted that there were no outstanding actions on the Action Log.

5. This section has been minuted confidentially

6. Adoption of EBI interventions – Kidney Stones

SB advised that following a review of the evidence-based interventions, this area had been identified as having no service restriction policy in place. The policy presented was developed with clinicians who were already working with the methodology and was based on evidence-based guidelines.

It was highlighted that flexibility had been provided in the policy as the Trust did not currently have a lithotripter machine on every site, although this was being reviewed and would enable them to work more optimally in terms of clinical outcomes.

SG asked for clarity on why Shockwave lithotripsy (SWL) and ureteroscopy (URS) were both considered and could one process be offered if clear criteria had been provided. PW advised that was a fair point, but this was how NICE guidance was written and interpreted. The policy should include that the least expensive care setting and procedure that met the clinical needs of the patient would be used. The policy statements should include where particular types of procedures are unable to be done in one area and be specific to provide guidance to clinicians.

Following the meeting, members not in attendance supported the recommendation to endorse the Service Restriction Policy for Kidney Stones.

Outcome: The Committee supported the recommendation to endorse the Kidney Stones Service Restriction Policy.

7. Adoption of EBI intervention – Bladder Outflow Obstruction

SB advised that following a review of the EBIs, this area had been identified as having no service restriction policy in place. The policy presented was developed with clinicians who were already working with the methodology and was aligned to NICE guidance and EBI guidelines.

Both policies would be audited in a year for compliance and to identify if modifications were required.

OR suggested whether alternative wording should be used for shared decision making as the policy reflected that the decisions were one-sided. PW advised that shared decision making was encouraged, however was not always undertaken, possibly due to misunderstanding. Shared decision making should be informed with the expectation that the clinician was comfortable that this was right for the patient. It could help to state four decision making questions to enable a better understanding. The shared decision tools were useful as they enabled the patient to understand the relative benefits of the different procedures, rather than the actual. SB advised that the service restriction policies were audited for compliance and shared decision making had been identified. The shared decision-making tool was developed with patients, although it doesn't ensure that every person has an informed decision, but does limit the referrals to secondary care when someone doesn't want a surgical intervention and would prompt conversations of other options and management within the primary care setting. Clinicians' mindset, behaviours and attitudes need to be changed which would be a challenge, so currently the tools were the best way to create those conducive environments and conversations about patients' best options and provide them the opportunity be informed as possible.

In response to a query from MS, SB confirmed that specialised consultants in their respective fields had been involved.

MS asked if the SRPs for these interventions were similar in Northeast Essex and West Essex. PW confirmed that as these were threshold policies and based on EBI, they should be similar.

MS summarised that there were no major concerns. The language was noted with regards to shared decision making and an inclusion on whether ICBs in the area had similar SRPs in place. Compliance monitoring would be undertaken through normal channels.

SB confirmed that Herts and West Essex ICB and Suffolk and Northeast Essex ICB did not have an SRP for either Kidney Stones or Bladder Outflow Obstruction.

Following the meeting, members not in attendance supported the recommendation to endorse the Service Restriction Policy for Bladder Outflow Obstruction.

Outcome: The Committee supported the recommendation to endorse the Bladder Outflow Obstruction Service Restriction Policy.

8. Committee Effectiveness Review, Committee Terms of Reference and Workplan 2025/26

HC advised that Committee Effectiveness was completed annually to provide assurance to the Board that performance within the remit of Congress is managed appropriately and supports the Board in the achievement of its aims and objectives.

The combined results of the desktop review and the members online survey were included in the report with a number of actions identified.

The overall findings concluded that the Congress had achieved the objectives set out within its terms of reference, that the meetings had been administered and run well with a good breadth of work programmes discussed throughout the year with clinical feedback and recommendations made.

The key areas identified as action which required further discussion were as follows:

Frequency of meetings – Consider holding the meetings bi-monthly, with the option to schedule an extraordinary meeting, if required. One comment within the survey had asked for the meetings to remain monthly as could be difficult to commit to attending an unplanned meeting due to other work commitments.

Attendance and quoracy – Consider an alternative day and/or time and consider measures to address this, such as temporary membership for Urgent & Emergency Care and Community Care for next 6 months.

Membership – To be reviewed following the confirmation of boundaries to address the current gaps in Urgent and Emergency Care and Community Care, which would present an opportunity to bring in people form NE and West Essex.

Training/induction for new members – Would be considered following the ICB running cost reduction programme.

Congress was asked to note the effectiveness review for 2024/25 which would be reported to Audit Committee on 15 July 2025 and approve the terms of reference at appendix 1 and workplan for 2025/26 at appendix 2.

MS advised that meetings had been held monthly consistently recently due to the number of Service Restriction Policies that required Congress review to ensure compliance, however, there may not sufficient items in the future to necessitate a monthly meeting, but recognised that arranging an extraordinary could be a challenge. No major changes would be made at this moment due to the ICB running cost reduction process. One comment asked if there was enough check and challenge.

PW commented that the conversations held at Congress were incredibly useful in terms of commissioning. There should be a more informal way of considering NICE TAs through the system, particularly now investments were being prioritised. The NICE TAs were often with regards to services that need to be evolved or developed to manage those drugs appropriately and changes in pathway, rather than the drug.

FL highlighted that originally the group had representation from the provider which has slowly decreased and should the timing of the meeting be considered so that there could be better

engagement from the provider. MS advised that adjusting the timing could be a challenge to other clinicians in other areas of service delivery.

SG suggested that Congress continued as it was given the changes that were going to be undertaken. Following confirmation of the boundaries, the terms of reference would need to be reviewed again.

MS summarised that the monthly meetings would remain, at least for the next few months. Additional membership and changing the meeting to an afternoon would be considered and feedback into commissioning decisions following Congress discussion would be included as part of the meeting.

Following the meeting, members not in attendance supported the views.

Resolved: The Committee noted that no changes would be made to Congress currently and approved the draft workplan and terms of reference.

9. Horizon Scanning

A discussion was held on possible areas of work for discussion at future meetings. The following was noted.

- Tirzepatide item was being led on the implementation by Sarah Hurst and Emma Timpson and was being taken through governance processes. PW confirmed that the report would be on the approach to integrated weight management services and would linked with the Bariatric Surgery SRP.
- Boundary changes for ICBs in Essex provided the opportunity to standardise across the whole of Essex. Work was ongoing in the region with regards to the possibility of three ICBs and the standardisation of those preventative types of work could increase the intensity of the work for Congress significantly.
- Nasal obstruction pathway for the next meeting.

10. Escalation to SOAC/ICB Board

There were no escalations.

11. Any other Business

This paragraph has been minuted confidentially.

JH provided his reflection of the meeting and found the meeting extremely interesting from a professional detailed perspective. The meeting provided an oversight into the consideration with balanced arguments that was given to a service.

There were no items of any other business raised.

12. Date of Next Meeting

Wednesday 25 June 2025 at 9.30am – 11.30am via MS Teams.

Minutes of the Digital Data and Technology Board (DDaT)

Held on Thursday 8th May 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*
- Martin Callingham (MC), Chief Information Officer, Mid and South Essex Foundation Trust (MSEFT)
- Peter King (PK), Director of Digital Services/Deputy Chief Information Officer (CIO), (MSEFT)
- Janette Leonard (JL), Director of ITT, Business Analysis & Reporting Essex Partnership University Trust (EPUT)
- Jane Marley (JM), Head of Information Governance (IG), MSE ICB
- Mandy Moore (MM), Head of Business Intelligence (BI), Thurrock Council
- Belinda O'Brien (BO),
- Rebecca Pulford (RP), Director of Nursing and Chief Nursing and AHP Information Officer, EPUT
- Phillip Richards (PR), Chief Finance Officer, Provide
- Les Sweetman (LS), Deputy Director of Digital Technology, MSE ICB
- Adam Whiting (AW), Deputy Director of Digital & Business Partner, EPUT (*for ZT*)

Other attendees

- Catherine Bartram, Head of Integrated Platforms, MSE ICB
- Josh Brewster (JB), Digital Business Partner, MSE ICB
- Jess Flack (JF), Digital Inclusion Lead Officer, ECC
- Stephen Gallagher (SG), Director of Data & BI, MSE ICB
- Sadie Plunkett (SP), Head of Assurance & Oversight, MSE ICB
- Clare Steward (CS), Programme Director – Digital Transformation, MSE ICB
- Charlotte Tannett (CT), Digital Business Manager, MSE ICB – *Minute Taker*

Apologies

- Peter Fairley (PF), Director for Strategy, Planning and Innovation, ECC
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB
- Emily Hough (EM), Executive Director, Strategy & Corporate Services, MSE ICB
- Ian McLernon (IM), IT Business Portfolio Manager, Southend Council
- David Pike (DP), Assistant Director of Healthcare Informatics, North East London Foundation Trust (NELFT)
- Paul Scott (PS), Chief Executive, (EPUT) – *Chair*

- Sarah Stone (SS), Acting Assistant Director of Digital Transformation, NHS England (NHSE)
- Zephan Trent (ZT), Director for Strategy, Transformation & Digital, EPUT
- Chris Wright (CW), Director of Programmes & Digital Development, Provide

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.

3. Minutes

The minutes of the last meeting on 13 February 2025 were reviewed and approved.

Outcome: The minutes of the meeting held on 13 February 2025 were approved.

4. Action log

The action log was reviewed and updates provided.

Outcome: The DDaT Board agreed to

5. Review of Committee Effectiveness including:

- Annual review of Terms of Reference

- Committee Workplan 2025/26

BF summarised the committee effectiveness review process which included a desktop analysis conducted by BF, CT and PS, assessing the effectiveness of the DDaT against its workplan and Terms of Reference in 2024/25. Additionally, a survey of members was completed to gather feedback on how the committee is functioning and areas for improvement.

Board members were asked to:

- Support the findings of the effectiveness review.
- Provide any additional feedback not already captured.
- Review proposed minor changes to the Terms of Reference, which were based on survey comments.
- Approve the workplan for 2025/26

CS raised the importance of ensuring the revised digital strategy and any upcoming governance changes were appropriately represented in the forward work plan.

MC emphasised that the effectiveness review should account for adaptability to future changes. He highlighted the risk of defining the effectiveness of structures that may no longer exist due to NHS structural changes. MC asked for flexibility in the Terms of Reference to allow for the expected changes.

BF agreed with both points, noting that the current review was completed before the announcement of changes in the NHS landscape. He suggested that the committee conduct a follow-up review of the Terms of Reference in three months, once the broader system changes had become clearer.

Outcome: The DDaT Board supported the findings of the effectiveness and supported the minor changes to the Terms of Reference and 2025/26 workplan subject to future review considering NHS structural changes.

Action: A formal review of the ToR/workplan to be carried out in 3 months, to include necessary changes following structural changes.

6. Revised Digital Strategy 2025-2028

BF provided a high-level summary of the revised Digital Strategy and its vision, noting the various engagement activities that had taken place with partners over previous months.

Board members were asked to provide feedback on and support the revised strategy.

AW expressed support for the strategy and highlighted the importance of clearly embedding system-led groups within organisational governance.

BF confirmed this work was planned and would begin on a shadow basis, following strategy endorsement, to develop and test the structure before formal implementation.

BO confirmed full support for the revised digital strategy. She highlighted that ECC Adult Social Care was drafting a complementary strategic approach to digital data and technology, which aligned well with the overall strategy. Belinda also expressed appreciation for the ongoing engagement throughout the strategy development.

MC supported the overall concept of the strategy but raised concerns about the lack of detail on how the strategy would be delivered. He highlighted key issues including funding, delivery mechanisms, outcome measurement, and resource alignment across partners. MC stressed the importance of acknowledging potential constraints and challenges, such as organisational redesign and ongoing NHS reorganisation, which may affect the pace and coordination of implementation. He suggested including a clear framing of these risks and constraints to provide a balanced view.

JM highlighted ongoing discussions within the IG and Cyber security groups, noting the critical need for closer collaboration to meet upcoming compliance requirements, particularly related to CAF DSPT. She proposed starting a trial of joint working between these groups in June 2025 to address shared challenges. JM suggested that findings and potential issues could be brought back to the July or September DDaT meetings for further consideration.

PR confirmed his full support for the strategy and praised its comprehensive scope. He echoed earlier concerns about the “how” of delivery, noting that the strategy makes clear there’s no ask for new resources. He emphasised the importance of reprioritising and collaborating across digital teams to achieve system-wide goals with existing resources.

PR also highlighted the ongoing challenge of clinical engagement, especially given the current pressures on clinical teams. He suggested this remains a key blocker to progress and must be addressed to realise the benefits outlined in the strategy.

BF clarified that the "how" would be shaped by various sub-groups, who would be empowered to define delivery plans and business cases, including any investment requirements and that organisational alignment would be essential for these delivery approaches to be viable.

BF acknowledged the concerns raised around clinical engagement and noted that there was strong support from clinicians, but capacity remained a challenge.

Outcome: The DDaT Board supported the Revised Digital Strategy 2025-28 subject to appropriate empowerment of sub-groups, alignment of governance processes across organisations and better clinical engagement to support delivery.

Action: IG/Cyber Security Steering Group proposal and Terms of Reference to come to a future meeting for approval.

Action: Sub-groups (in shadow form) to be empowered and governance processes to be aligned across organisations.

Action: Challenges around clinical engagement to be addressed.

7. Risk Register/Framework

SP introduced the draft DDaT Risk Register Framework, noting that it had previously been circulated for feedback, but no comments had been received. She outlined the framework was intended to establish a system-level approach to risk oversight for DDaT which was now a formal committee of the ICB Board.

PR raised the importance of defining a consistent system-wide risk appetite to avoid inconsistent escalation. SP confirmed that a session with partners was being planned to define this.

PK questioned how risks escalated to the DDaT Board would be managed, particularly when root causes like resourcing remained under organisational control. SP clarified that while the DDaT board may not directly resolve such issues, it would guide system-level prioritisation to minimise impact.

MC echoed the importance of linking the risk framework to the wider strategy and noted the need for clearer integration between programme risk and strategic delivery.

Outcome: The DDaT Board endorsed the approach to developing a system-level DDaT Risk Register, subject to incorporation of feedback and alignment with the strategy.

8. HSCN CoIN Update

AW provided an update on HSCN contract planning. The programme was ready to go to market for a long-term solution. Due to mobilisation timelines, a 1-year contract extension (plus optional 6+6 months) was proposed to ensure continuity.

AW confirmed that extension pricing had now been received and reviewed at Programme Board level. While the overall contract value had reduced by £68,000, this was primarily due to some partners exiting the agreement. For remaining partners, costs had increased. These costs were not yet final, and negotiations with Capita were ongoing.

There was also potential for some previously exiting partners to opt back in, which would improve pricing.

BF highlighted the specific ask to all partners to support project delivery by identifying the below resource:

- Senior Project Manager
- Network Architect
- Engineer
- Project Support Lead

AW noted that this ask had already been socialised at Partner Board level but recognised that uncertainties around timing and duration had made it difficult to secure commitments. Work was underway within EPUT to clarify when resources would be needed and for how long.

If internal capacity could not be secured, a system-wide cost of around £350,000 was expected to sustain an external delivery team (as previously done for the HSCN upgrade).

Outcome: The DDaT Board noted the HSCN CoIN update.

Action: DDaT members to support the ask around identifying resource to support the HSCN CoIN project via their respective partner boards.

9. Digital Inclusion/Care Essex

JF provided an update on ECC's digital inclusion initiatives, she highlighted key challenges with digital exclusion in Essex and noted that the NHS app required a broad range of essential digital skills, many of which users currently lacked, making it difficult for some to use effectively.

Current initiatives included the provision of devices through the Digital Divide Programme, distribution of free SIM cards via partner charities, and promotion of social broadband tariffs to improve internet affordability.

JF also introduced the recently launched Digital Help Finder tool, which assisted users in assessing their digital skills and signposting to local support services. Community digital hubs and volunteering models were being developed, alongside exploration of a shared digital inclusion service with Hertfordshire.

JF emphasised the ongoing need for device donations, particularly end-of-life laptops that can be refurbished as Chromebooks for those in need. She discussed the forthcoming national charter for responsible device donation and encouraged local organisations to participate.

MSE had recently secured a £3,500 grant aimed at improving digital inclusion and research access for underserved communities. A Digital Inclusion Coordinator role has been established to coordinate efforts across Southend and Mid & South Essex.

PK raised a question regarding digital inclusion work related to elderly care charities, specifically around dementia. PK highlighted the challenge of managing digital inclusion for individuals who regress from digital literacy and the need to consider how carers interact digitally on behalf of these patients.

BF acknowledged the importance of this point and noted that Patient Knows Best allowed carers to take ownership of the patient's digital records.

RP suggested it would be helpful for JF to attend stewardship groups, including frailty and dementia teams, to raise awareness and promote digital upskilling. RP also suggested connecting digital inclusion efforts with undergraduate programmes and workforce planners to support diverse community needs and workforce development.

Outcome: The DDaT Board noted the Digital Inclusion/Care Essex update.

10. Digital Social Care Record – end of year report

CS provided an update on the social care digitisation programme, noting that the programme was drawing to a close and had achieved significant success. Uptake had reached approximately 84%, exceeding initial expectations. The programme initially provided funding for two years into Essex and Southend local authorities to support digital adoption in care homes and ancillary services.

CS highlighted the strengthened collaboration between local authorities as a key success factor, which was also influencing other programmes such as the Shared Care Record. The current phase of the programme involved tapering activity, finalising any remaining applications, and managing leftover grant funding.

CS was now working one day per week with DHSC and NHS England to help shape the forthcoming 3-year plan.

BF thanked CS and the local authority partners, acknowledging the strong performance and improvement since the programme's inception.

Outcome: The DDaT Board noted the DSCR end of year report.

11. Shared Care Record Update

CB reported a significant milestone with the go-live of Essex's data into the Shared Care Record, marking the first of its type of integration after several months of work since October 2024. This achievement had drawn interest from other ICSs who were keen to learn from the experience, positioning the team as leaders in this area.

CB also highlighted that several organisations had recently expressed interest in gaining access to the Shared Care Record, and work was underway in collaboration with IG teams and partners such as EPUT and ICF to enable direct access.

CB shared that the team has identified £3.6 million in efficiencies linked to the Shared Care Record. A recent line-by-line review indicated approximately 75% of these benefits are sufficiently developed to allow for validation with partner organisations. Efforts would be made to re-measure baseline data to confirm whether teams were working differently and whether benefits could be formally realised.

CS added that PR had played a key role in the financial aspects, particularly in securing funding carry-over between financial years.

Outcome: The DDaT Board noted the Shared Care Record update.

12. Patient Knows Best Update

JB reported that both MSEFT and EPUT continued to develop and expand the Patients Know Best (PKB) platform. Recent enhancements included integration of Recovering Quality of Life (ReQoL) questionnaires via the Ecotherapy and Learning Disability & Autism Services. Development efforts were also focusing on additional clinical teams, such as cancer and maternity, and expanding technical functionalities, including pathology integration and automated questionnaire workflows.

Some challenges included resource limitations in integration support, data extraction difficulties from legacy systems and broader service transformation requirements affecting delivery timelines.

The current PKB contract ran to February 2026 and preparations were underway to extend it to February 2027.

Outcome: The DDaT Board noted the Patient Knows Best update.

13. NHSE Regional Update

The NHSE Regional Update report was taken as read. No representative from NHSE was present to provide a verbal update and there were no queries raised.

Outcome: The NHSE Regional update was noted.

14. ICS Digital Dashboard

SP provided an update on the system's performance relating to Information Standards Notices (ISNs) and confirmed good progress was being made in this area. Southend, Thurrock, and EPUT had updates and escalations outstanding.

NHSE had been linked into the ISN system, and a demonstration had been scheduled to support this.

SP noted a digital contracts register was under development and asked for partner organisations to provide names of their contracts leads so that this could be further developed.

Outcome: The DDaT Board noted the ICS Digital Dashboard.

Action: Partners to provide the names of their contracts leads to assist in population of the digital contracts register.

15. Minutes of the Digital Sub-Boards

The minutes of the digital sub boards were noted.

RP provided an update on the evolving structure and role of the Professional Design Authority (PDA), particularly in light of changes to ICB functions and the departure of several key clinical digital leads from primary care.

RP noted that the PDA had gradually expanded to include a broader cross-section of practitioners, including representatives from social care, and had focused on interconnectivity, risk mitigation, and clinical input into digital transformation. A recent engagement exercise confirmed continued value in the forum and a desire among some clinicians to sustain the structure.

However, a gap remained in primary care representation, with current constraints on capacity. RP expressed her support for the continued development of the PDA and stressed the need to agree on a sustainable structure that avoided overextension and ensured meaningful engagement.

BF confirmed that clinical capacity to support the design and function of the PDA would be appreciated and agreed to follow up with primary care leads to ensure appropriate representation.

Outcome: The DDaT noted the Minutes of the Digital Sub-Boards and RP's update.

Action: BF to follow up with primary care leads to ensure appropriate representation at the PDA.

16. Items for Escalation

There were no items noted for escalation.

17. Date of Next Meeting

The next meeting was scheduled for:

Thursday 10th July, 09:00-10:30am, Via MS Teams.

Minutes of the ICB Finance and Performance Committee Seminar Held on 1 April 2025 at 2.00pm

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
- Jo Cripps (JC) Executive Director of System Recovery, MSE ICB
- Laura Davis-Hughes (LDH) Local Authority representative, Essex County Council (ECC)
- Sam Goldberg (SG) Executive Director of Performance & Planning, MSE ICB
- Emily Hough (EH) Executive Director, Strategy & Corporate Services, MSE ICB
- James Howard (JH) Finance Apprentice, NHS England (observing)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB

Other attendees

- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and Introductions

The Chair welcomed everyone to the meeting and conducted introductions. The Committee was confirmed quorate.

The purpose of the meeting was to sign off the ICB budgets, receive an update on Month 11 Finance and Performance and be briefed on the 27 March 2025 planning submission.

2. Declarations of Interest

There were no declarations of interest raised.

3. System Finance and Performance Report – Month 11

The Month 11 year-to-date position was £24.6m off plan, this was an improvement of £3.3m on the Month 10 position. The ICB was forecasting breakeven, MSEFT improved its position by £4.8m and EPUT saw a deterioration of £1.5m.

Despite a deterioration within EPUT for Month 11, JK reported good progress within the organisation on the utilisation of bank and agency.

The System received deficit cash support of £16m from NHS England in Month 10. The cash support was allocated pro-rata against organisation deficit shares with MSEFT in receipt of £13m and EPUT £3; this would be reflected in the Month 12 position.
JK confirmed the ICB had delivered its cash balance for 2024/25.

Discussion was held regarding the level of confidence that the System would deliver the year-end position for 2024/25.

JK highlighted work would continue into the new financial year to support the shift of System efficiencies to recurrent to enable sustainability in future years. The ICB Board had sought further assurance to increase confidence in the delivery of plans and had requested Project Initiation Documentation (PID) and associated impact assessments.

Outcome: The Month 11 System Finance and Performance Report was noted.

4. ICB Budgets 2025-26

JK presented the ICB Budgets noting that the Board had delegated authority to approve the ICB budgets for 2025/26 to the Finance and Performance Committee. Once approved budgets would be uploaded to the ICB ledger.

KE summarised the System allocation for 2025/26 and changes from the previous year. The total confirmed System allocation for 2025/26 was £3.255 billion.

KE provided a detailed breakdown of the ICB budgets for 2025/26 by directorate including planned expenditure, adjustments and efficiencies.

It was noted no demographic growth had been applied to the plan. Growth funding would only be applied where growth had been evidenced by providers.

For the first time NHS England had advised the System in advance of its allocated deficit support funding, this had been factored into plans. A further £87m of Elective Recovery Funding had been allocated.

The funding gap of £28.5m provided the ICB efficiency target for 2025/26. £4.3m of efficiencies was unidentified within the ICB, further work would take place to identify the full efficiency requirement.

The funding formula used nationally to inform the System funding allocation deemed MSE was overfunded. As a result, a [convergence] adjustment of £11.8m had been applied (capped at 0.5%). The distance from target for MSE was 4.29%. Following a query from JF on the construct of the convergence adjustment, JK agreed to share a document outlining the breakdown of changes this year. Areas of deprivation was noted as contributing factor.

LDH informed members that a fair funding review was underway within local authority; this was the process to allocate funding for local authorities. JK welcomed a report to a future Finance and Performance Committee to understand how Essex overall was measuring across the whole of Health and Social Care.

Due to the prior year deficit, £11.76m had been deducted from the System allocation, it was noted repayment of the deficit would fall to the organisation where it was accrued.

The ICB was a part of the Integrated Single Financial Environment (ISFE) and had a prescribed leger and chart of accounts it was mandated to use. JK advised the team were considering more user-friendly reporting for future. The new ISFE was expected to commence in October 2025, there was an encouragement for Providers to adopt the same system to enable consistency.

Outcome: The Finance and Performance Committee <u>approved</u> the ICB budgets for 2025/26 for uploading to the ICB ledger.

5. Deep dive on planning submission for the year ahead and Capital briefing.

The System had submitted its planning return on 27 March 2025 for Finance, Workforce, Performance and Capital. An ICB Board Seminar took place on the 26 March 2025 to review the Board assurance statements requested as part of the planning submission. The ICB Board issued a Qualifying Statement following concerns on the ability to deliver performance standards.

In response to JF, SG clarified the ICB was working with its provider partners to assess how the System would deliver performance within the financial resource available and how this triangulated within plans.

Systems requiring national intervention would be escalated week commencing 14 April 2025. It was anticipated a further planning return would be required on 30 April 2025.

JK welcomed suggestions on areas of future reporting to the Finance and Performance Committee and was keen to share detail on the activity delivered under specific fixed contract arrangements.

KE shared the 2025/26 Integrated Planning Return template and provided a detailed overview of the contents of the 27 March 2025 submission. The submission presented a balanced position, deficit cash support available for the financial year had already been captured within the figures.

JF encouraged consistency in reporting between ICB and trust Finance and Performance Committees and suggested the inclusion of work taking place within Alliances as a potential area to report upon.

Outcome: The Committee noted the update on planning and the planning submission of 27 March 2025.

6. Frequency of future meetings

There was a discussion on the frequency and content of Finance and Performance Committees for 2025/26. It was suggested meetings take place bimonthly and are held on alternate months to Board meetings. A further discussion would take place at the Finance and Performance Committee on 6 May 2025.

Outcome: The discussion on frequency of meetings was noted.

ACTION: Frequency of future meetings to be discussed at the Finance and Performance Committee on 6 May 2025.

Minutes of the ICB Finance and Performance Committee

Held on 6 May 2025 at 2.00pm

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)
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Dave Hughes (DH) Non-Executive Director, Mid and South Essex NHS Foundation Trust (MSEFT) (Microsoft Teams) (attending on behalf of Julie Parker)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Sam Goldberg (SG) Urgent Emergency Care System Director, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Julie Smith (JS) Managing Director Broomfield Hospital, Lead for RTT, MSEFT
- James Howard (JH) Finance Apprentice, NHS England (observing)
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate. He reminded the Committee of the confidential nature of some papers and asked papers were not shared outside of the Committee.

Apologies were received from Julie Parker (JP) Non-Executive Director MSEFT noting Dave Hughes was attending on her behalf and Diane Leacock, Non-Executive Director, EPUT.

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.

DH declared an interest in agenda item 12 in his role as NEM for MSEFT and would leave the meeting at the point the agenda item was discussed.

Outcome: The Register of Interests was noted.

3. Minutes of previous meetings

The minutes of 4 March 2025 and 1 April 2025 (Finance and Performance Committee Seminar) were agreed as an accurate record.

Outcome: The minutes of 4 March 2025 and 1 April 2025 were approved.

4. Action Log / Matters arising

JF referred to action 53 and asked if there was a collective acceptance of the risk. (The broader risk on reliance upon frameworks outside of the ICBs control). It was anticipated the risk would be mitigated by a potential change in responsibilities with forthcoming changes posed on ICBs and NHS England. It was agreed the risk was closed.

Feedback from the Provider Selection Regime (PSR) Review Group

The first PSR Review Group was held on 14 March, a further meeting took place on 26 March 2025 following a procurement representation (formally known as a challenge) for the Community Dermatology Service. MB advised the PSR review group reviewed the process in detail to determine whether the representations had merit. Consequently, the procurement has been rewound to the bid assessment stage.
The group identified lessons for future procurements.

A paper setting out the learning and recommendations on how the ICB's processes could be improved would be presented to the Executive Committee. JK took an action to share the paper with the Finance and Performance Committee.

Frequency of future meetings

Following discussion on the frequency of future meetings the Committee agreed meetings continue to take place monthly during quarter one. The frequency of meetings would then be reviewed considering the position on Finance and Performance and in light of any anticipated changes over coming months for ICBs.

Outcome: The action log and updates on matters arising were noted.

Action: Paper on Lessons Learned from the PSR Representation Process to be shared with the Finance and Performance Committee.

Assurance

5. System Finance and Performance Report – Month 12

JK presented the Month 12 report and confirmed the 2024/25 year-end accounts were being finalised and reviewed by the ICB Auditors. The ICB had delivered its financial plan with a surplus of £26k for 2024/25. EPUT had delivered a £10.5m deficit and MSEFT a deficit of £6m. The position reflected the receipt of £16m national funding received towards the latter part of the financial year and was allocated based on the proportion of deficit accrued. Of that funding MSEFT received £13m and EPUT received £3m.

Work was underway to present the System's underlying position and run rate in future reporting.

JK highlighted 60% - 65% of the efficiency schemes delivered during 2024/25 were non-recurrent and spoke of a focus for 2025/26 to identify recurrent schemes.

LDH queried the movement from £85,267 in Month 11 to £142,809 in Month 12 for MSEFT Pay (actual). JK anticipated a peak in March due to the timing of receiving final invoices for bank and agency and took an action to clarify.

SG presented the performance element of the report and advised System led tumour groups for Breast, Urology and Skin were being mobilised to review pathways to improve the number of patients seen within 62-days for Cancer services.

There was a slight improvement to the faster diagnostic standard for all specialties except for head and neck services. A deep dive was taking place across the region to support improvement.

SG highlighted a slight deterioration in performance for Urgent and Emergency Care (UEC). Several actions were underway including enhanced governance arrangements and validation led peer reviews.

Outcome: The Finance and Performance Committee noted the Month 12 System Finance and Performance report.

Action: JK to clarify the movement from £85,267 in Month 11 to £142,809 in Month 12 for MSEFT Pay (Actual).

Action: System run rate to be included in future Finance and Performance reports.

6. Planning 2025/26

JK explained that the System plan submitted on 27 March did not demonstrate the 5% delivery required for referral to treatment (RTT) and consequently an escalation was made to NHS England for intervention. In addition, the plan did not demonstrate sufficient mitigation to risks and efficiencies. Resubmission of the plan on the 30 April showed fuller compliance for RTT performance, it was noted further work was required to fully address Cancer performance. There was greater confidence in the delivery of efficiencies for MSEFT in the 30 April submission, this saw an improvement in the overall risk position.

To enable compliance for RTT performance MSE would outsource additional activity to the independent sector. This would have an impact to the MSE financial position, mitigation was underway, and a paper would be presented to a future meeting.

There was a deterioration in the risk position for EPUT for the 30 April resubmission to account for the financial impact of the Lampard Inquiry and out of area placements. It was noted EPUT had seen a significant improvement from Month 10 for temporary workforce.

The national MSE planning meeting took place on 30 April 2025, further changes to the plan were not anticipated.

The Finance and Performance Committee were asked to approve the funding envelope of £114.612m for the Better Care Fund (BCF) for 2025/26, this included a national uplift of 1.7%. Members discussed the funding mechanisms and governance for BCF, noting the specific allocation within the ICB Plan.

During the autumn of 2024, the Government announced £100m Capital funding to support improvements to General Practice estate across England. Following an ask from NHS England in February 2025 on requirements in MSE, the System submitted a return identifying a funding requirement for over 40 schemes totalling £4.6m. A national review of submissions took place on 30 April 2025, MSE received approval of funding for £2.6m for 27 schemes.

Outcome: The Finance and Performance Committee

- **noted the update on Planning for 2025/26**

- **approved funding of £114.612m for the Better Care Fund (BCF) for 2025/26**

Sign off and investments would follow defined BCF governance routes as required.

7. Medium Term Planning update

JC noted that the Medium-Term Plan (MTP) had been approved by the ICB, MSEFT and EPUT Boards.

In May, there would be a focus to rebase the MTP modelling reflecting the updated position of the 30 April resubmission to access the feasibility and phasing of associated plans.

The communications and engagement plan were underway, and work was being finalised on the potential governance arrangements to support delivery of the MTP, which could include the development of a Joint Committee across the contributing system partners.

There was a discussion on the commonality between Systems in other areas in recognition of the potential changes anticipated within ICBs and their geography in the coming year.

Outcome: The Finance and Performance Committee noted the verbal update on Medium Term Planning 2025/26.

8. Deep Dive on Performance – Referral to Treatment (RTT)

JS, Managing Director of Broomfield Hospital and lead for RTT (MSEFT) provided an overview of actions undertaken within the Trust to improve the constitutional standards for Elective Recovery and RTT.

Governance arrangements had been enhanced and a clear reporting structure established. Following the receipt of additional funding, MSEFT had commissioned a number of new initiatives to enable the Trust to meet RTT metrics within the 2025/26 planning cycle and support patients who required a more urgent pathway of care. The Trust was aiming to have no patients waiting more than 65 weeks for treatment by the end of quarter 1.

The percentage of patients who were meeting the RTT waiting time target within 18 weeks was 54%, against the target of 67%.

6.7% of patients were waiting 52 weeks or more for treatment. The Trust had agreed with NHS England to reduce this to 3% by March 2026 (the national target was 1%).

MB asked how MSEFT would maintain performance once funding had been fully utilised. JS highlighted there was clear ownership from speciality leads to sustain core capacity.

JK recommended Primary Care representation was included on the ICB Elective Transformation Group to ensure full System ownership and momentum.

MS flagged the importance of clinical validation to risk stratify patient care.

Outcome: The Finance and Performance Committee noted the update on RTT.

Financial Governance

9. Finance Risk Register

The Committee were presented with the latest position on ICB financial risks. NA advised an additional column was included on the Risk Register to provide clarity on why risks were being reported to the Finance and Performance Committee as whilst some risks were not owned by the

finance team, there was a financial or performance impact from the risk.

The Committee were advised the risk rating for risk ID14: System Financial Performance / Governance had increased since the last report as uncertainty regarding the risk had increased as a result of the ICB entering a new financial year and plans to manage the risk were in their infancy. JF suggested the risk on the underlying run rate position was incorporated into risk ID14.

Following a query from JF on the Capital risk profile for 2025/26, JK highlighted the key risk was to ensure capital spend was managed effectively and within the available funding allocation.

JC queried if risks included under section 7 of the report (moved risks) were being reported to the appropriate Committee now that they did not fall under the remit of the Finance and Performance Committee. NA took an action to clarify.

MB encouraged a trend analysis on how the risks trend had changed overtime to determine if current actions were having the desired impact.

Outcome: The Finance and Performance Committee:

- **Noted the most recent updates on risks within the remit of the Committee as set out in Appendix 1**
- **Noted there were 9 risks rated red**
- **Noted no risks have been closed since the last report to the Committee**

Action: NA to clarify which Committee the following risks are being reported to:

Risk 6 - Quality Assurance of Autism Spectrum Disorder (ASD) assessments, Risk 27 - Palliative and End of Life Care, Risk 28 – Stroke Services and Risk 43 Community Beds.

10. Financial Allocations and System Reporting Policy

The Financial Allocations and System Reporting Policy had been reviewed in line with its planned review date, an updated version was presented to the Committee for approval.

JF queried the progress on service line reporting. JK advised NHS England were looking at service line reporting/budgeting within Trusts at a national level. There continued to be an ambition within the ICB to look at the next steps on programme budgeting to identify spend on areas such as prevention.

Outcome: The Finance and Performance Committee approved the Financial Allocations and System Reporting Policy.

11. Committee Effectiveness, Terms of Reference and 2025/26 Workplan

The desktop review had been undertaken by the Committee administrator to assess if the Committee had met its key objectives and had worked effectively during 2024/25. An anonymous questionnaire had been circulated to obtain views from members of the Committee; NA encouraged all members to complete the questionnaire by 15 May 2025.

NA discussed the three areas of suggested improvements to further strengthen the operation of the Committee; a final report of findings would be shared with the Committee. The findings would be presented to the Audit Committee who had oversight of ICB governance and feed into the Board effectiveness to ensure the Board had discharged its own responsibilities and duties through its sub-committees.

It was noted there were minor amendments to the Terms of Reference following its review.

Outcome: The Committee

- **noted that a short anonymous questionnaire is required to be completed by members of the Finance and Performance Committee, the results of which will be included in the final report on committee effectiveness.**
- **approved the draft Finance and Performance Committee Work Plan for 2025/26.**
- **approved the updated terms of reference**

Business Cases

12. This item has been minuted confidentially

13. Triple lock ratification

No items presented for this meeting.

14. Feedback from System groups

The minutes of the System Finance Leaders Group (SFLG) held on 20 January 2025 and 17 March 2025 and minutes of the System Investment Group (SIG) held on 24 February 2025 were presented for information.

Outcome: The minutes of the System Investment Group was noted

15. Any other Business

Nothing raised.

16. Items for Escalation

MB provided feedback from a recent Integrated Pharmacy Medicines Optimisation Committee (IMPOC) for the treatment of heavy menstrual bleeding. It was noted the cost of the procedure was more cost effective than the cost of medication, but recognition patient choice was the key consideration for the preferred route of treatment.

17. Date of Next Meeting

Tuesday 3 June 2025
2.00pm - 4.30pm
Microsoft teams meeting.

Minutes of the ICB Finance and Performance Committee

Held on 3 June 2025 at 2.30pm

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)
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Julie Parker (JP) Non-Executive Director, Mid and South Essex NHS Foundation Trust (MSEFT)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Sam Goldberg (SG) Executive Director of Performance and Planning Director, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Andrew Pike (AP) Chief Operating Officer, MSEFT (for agenda item 8 - Deep Dive on Performance – Cancer)
- 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 Diane Leacock (DL), Non-Executive Director, EPUT and Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.

2. Declarations of interest

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

There were no declarations of interests raised.

Outcome: The Register of Interests was noted.

3. Minutes of previous meetings

The minutes of 6 May 2025 were agreed as an accurate record.

Outcome: The minutes of 6 May 2025 were approved.

4. Action Log / Matters arising

JF noted deep dives on performance for Referral to Treatment (RTT), Urgent and Emergency Care (UEC) and Cancer had been scheduled to the Committee workplan for 2025/26. It was clarified there was the flexibility to undertake deep dives in other areas as required throughout the year.

JK suggested a deep dive on Mental Health and Out of Area Placements was scheduled to a future meeting.

JK and JC took an action to identify areas of deep dives for future meetings in accordance with the Medium-Term Plan where System working was taking place.

JF welcomed an update on the prioritisation of estate schemes at a future meeting following approval of NHS England Capital funding of £2.6m.

Following a discussion on the contract management process within the ICB, JK provided assurance the Audit Committee had sight of the procurement pipeline, waivers and the register of procurement decisions. JK was content steps within the procurement pipeline were being taken by the ICB at the appropriate time; the new Provider Selection Regime regulations provided further grip and control.

JK would present a paper at a future meeting on the progress of contract management over recent years.

Outcome: The action log and updates on matters arising were noted.

Action: Deep dive on Mental Health and Out of Area Placements to be scheduled to a future meeting.

Action: JK and JC to consider future deep dives where System working was taking place to include on the Finance and Performance Committee workplan for 2025/26.

Action: An update on the prioritisation of estate schemes following approval of NHS England Capital funding of £2.6m to be presented at a future meeting.

Action: Paper to be presented at a future meeting on the progress of contract management.

5. Financial Governance

No items this meeting

Assurance

6. System Finance and Performance Report – Month 1

KE reported the System were £2m off its financial plan at Month 1. The Month 1 position consisted of a deficit of £2.1m for MSEFT and a surplus of £73k for EPUT. The ICB were on plan.

The main driver of the deficit for MSEFT in Month 1 was Pay costs, MSEFT had anticipated a higher level of reduction in costs for temporary staffing.

For Month 1, MSEFT were £1.6m off plan in its delivery of efficiencies, the ICB were on plan and EPUT were £165k behind plan.

As the System were off plan in Month 1, NHS England held a meeting with the ICB and MSEFT to obtain assurance the financial position would be brought back in line with the agreed plan.

NHS England had released a 2025/26 Integrated Financial Reporting template that included monthly reporting on run rate and risk at a provider level; this would be reflected in future reporting.

SG provided a verbal update on performance and advised the number of patients waiting less than 18 weeks from referral to treatment was 47% against the target of 51.2%. Patients waiting over 52 weeks for treatment was 6.3% against the target of 6.7%. Patients waiting 18 weeks for their first outpatient appointment was 51% as per the plan.

Outcome: The Finance and Performance Committee noted the Month 1 System Finance and Performance report.

7. Planning 2025/26

The Committee were presented with correspondence from NHS England received during the planning process to develop the 2025/26 System financial and operational plan. The letters were presented for information as the Finance and Performance Committee was the responsible Committee for overseeing planning within the ICB.

JP referred to the letter dated 21 May 2025 that outlined the establishment of an MDT approach with finance and workforce teams to monitor staffing levels and encouraged clinical input to ensure a triangulated approach.

Outcome: The Finance and Performance Committee noted the update on Planning for 2025/6

8. Deep Dive on Performance – Cancer

AP provided an overview of the actions undertaken within the Trust to improve performance against the constitutional standards for Cancer.

Taskforce groups had been established for four priority speciality areas: Breast, Skin, Urology and Treatments with a focus to improve and sustain performance. AP discussed further the actions required in each of the specialities.

For Breast, there was a focus on workforce to ensure equal service provision for radiology across all three hospital sites. The utilisation of community pathways for breast pain, additional clinics to increase capacity and a review of estates were flagged as additional areas of focus.

It was noted there had been improvements in performance for Skin, further work was required to streamline the pathway of care to ensure patients who required a procedure were treated quickly.

JP suggested utilisation of patient initiated follow-up appointments for patients who were able to assess themselves.
AP highlighted Urology was an area that had seen the largest growth in referrals. MSEFT had recruited four additional Consultants to support demand.

AP reported a number of Trust actions were underway to support capacity within head and neck services; funding for an additional post had been secured.

Service capacity resilience was a challenge for Treatments. Work was taking place to align plans to demand, and workforce needs for Oncology and Surgery.
Following a query from MS on the progress of Cancer Harm Reviews, SG advised this work would be complete by the end of August 2025.

AP agreed to share the presentation slides.

Outcome: The Finance and Performance Committee noted the update on Cancer.

Action: Presentation slides for the deep-dive on Cancer performance to be circulated to the Finance and Performance Committee.

9. Medium Term Planning update

JC advised governance arrangements for Portfolio Boards were being refreshed and attendance streamlined, a series of deep dives would take place to focus on progress in specific areas.

The feasibility of a Joint Committee across System partners was being considered to oversee the delivery of the Medium Term Plan. There was a discussion regarding the added complexity of potential changes to responsibilities within ICBs and their geography over the next year together with local government reform.

Outcome: The Finance and Performance Committee noted the verbal update on Medium Term Planning 2025/26.

10. Business Cases

No items this meeting.

11. Triple lock ratification

No items presented for this meeting.

12. Feedback from System groups

The minutes of the System Investment Group (SIG) held on 31 March 2025 were presented for information.

Outcome: The minutes of the System Investment Group was noted

13. Any other Business

Feedback from the Provider Selection Regime (PSR) Review Group

The PSR Review Group was held on 27 May 2025 following a procurement representation for Adult Mental Health Talking Therapies. MB advised the PSR review group reviewed the process in detail and concluded the representations had no merit. The group did identify lessons for future procurements.
JK explained a tool had been developed for those initiating procurements to review previous lessons learned.

14. Items for Escalation

No items raised for escalation.

15. Date of Next Meeting

Tuesday 1 July 2025
2.00pm - 4.30pm
ICB Headquarters

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 9 April 2025, 1.00pm–3.00pm

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleksandra Mecan).
- Ashley King (AK), Director of Finance and Estates (nominated deputy for Jennifer Kearton).
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality (nominated deputy for Viv Barker).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Deputy Director of Commissioning.
- Jane King (JKi), Corporate Services and Governance Support Manager (minutes).
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Michelle Cleary (MC), South East Essex Alliance Delivery & Engagement Lead.
- Sheila Purser (SP), Chair, Local Optical Committee.

Apologies

- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Viv Barker (VB), Director of Nursing.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee (Item 5 only).
- 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. For Item 7 (national contractual settlement for primary medical services and settlement for community pharmacy for 2025/26) Dr Anna Davey, Local Medical Council (LMC) and Local Pharmaceutical Committee (LPC) representatives were contract holders or represented providers affected by the national settlements, however, there was no material conflict in relation to the paper or the recommendation and therefore those members were not excluded from discussions.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 12 March 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 12 March 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (173 and 175) were within timescales for completion.

Outcome: The updates on actions were noted.

5. NHS England changes / ICB Running Cost Reduction Programme

Following the recent announcement that NHS England (NHSE) would be brought more closely under the control of the Department of Health and Social Care (DHSC) and the national requirement for Integrated Care Boards (ICBs) to make significant reductions on running costs, SA queried what the potential impact would be on primary care.

WG explained that detail was awaited on the future footprint, core function and statutory responsibilities of ICBs and that the new model of working would be implemented from October 2025. The ICB would need to undertake a comprehensive structure review to identify where cost savings could be made, as well as consider how it worked differently with other ICBs within the system.

MA highlighted that a reorganisation of local government was taking place in Essex and queried the potential impact this could have on primary care and ICB cost reduction programme. WG commented that consensus was for local authority boundaries to be aligned with a single ICB. It was not expected that primary care would be affected.

In response to SA, WG expected there would be opportunity for the committee to engage on the change process.

SA requested a verbal update on the NHSE changes and the ICB's running cost reduction programme as a standing item on the committee's agenda.

ACTION: Add NHS England changes and ICB running cost reduction programme to the committee work plan.

Outcome: The Committee NOTED the update on NHSE changes and ICB Running Cost Reduction Programme.

6. Medium-Term Plan

WG advised that a number of workstreams within the primary care element of the Medium-Term Plan (MTP) had been identified. Since the last committee meeting, workstream leads had met to develop the project initiation documentation. Although the schemes had longer-term ambitions, in view of the anticipated changes within ICBs in 2025/26, the focus of the work would be on deliverables within the next 3-6 months. An update would be provided at each PCCC meeting on workstream progress, risks and outcomes which would also feed into the wider MTP governance.

SA noted the report mentioned a 'moderation of ambitions' and asked WG to explain what this meant. WG explained that whilst the ICB was undergoing a period of change, a focus on smaller in-year deliverables was required e.g. decisions on longer term capital revenue consequences were not possible at this time.

JH queried whether the primary care budget remained the same as for 2024/25. WG advised that for 2025/26 there was increased investment opportunity available for small premises schemes than previously available and that core primary care budgets were protected. Changes had been made to the ringfenced Service Development Funding (SDF) which would affect the primary care and primary care workforce budgets, and requests for funding in these areas would be competing against other ICB priorities. Ringfenced SDF budgets had previously funded the Connected Pathways Programme, winter funding and practice resilience schemes. WG highlighted that around £1m funding needed to be identified in 2025/26 for mandated GP online video software which was not nationally funded.

AD queried whether the Training Hub support programmes, e.g., nurse practitioners Master's Programme and Additional Roles Reimbursement Scheme (ARRS) workforce training would be impacted by the changes to SDF. WG advised that the extent to which the Training Hub would be affected by the SDF changes was not yet known, however they would not receive a ringfenced SDF budget in 2025/26. The Training Hub would identify a list of priorities which would be added to the central ICB list of priorities for consideration.

SW highlighted that there were 7 workstreams linked to the MTP, each with different leads, and queried whether all areas were taking the same view on primary care. WG explained that there was an ask for senior responsible officers for each workstream to identify where there was cross-over with other programmes. The Primary Care team were represented on a number of workstreams. Some of the stronger ambitions outlined in the MTP involving primary care were longer-term and not 2025/26 schemes.

WG stressed the need for MTP workstreams to be aware of the combination of asks of providers to ensure providers had a clear and realistic programme of work.

JS advised that programme leads for all MTP workstreams would be required to complete an ICB Primary Care Impact Assessment.

Outcome: The Committee NOTED the Medium Term Plan update.

7. 2025/26 Contract Changes

WG presented the report outlining the national contractual settlement for primary medical services and the settlement for community pharmacy for 2025/26.

The changes broadly aligned with the ICB's priorities within the MTP, emerging Primary Care Strategy and Primary Access Recovery Plan. The Primary Care team would seek to optimise community pharmacy opportunities through the newly established Community Pharmacy Commissioning and Transformation Group which would report in to the committee.

KSS highlighted two inaccuracies in the paper relating to community pharmacy, advising that the single activity fee had increased by 19 pence to £1.46, not by 119 pence, and also that pharmacies would need to be registered to provide the contraception service as well as the hypertension service if they wished to continue to provide the Pharmacy First service.

KSS added that there was a mandated requirement for pharmacies to deliver Ambulatory Blood Pressure Monitoring (ABPM) from October 2025. However, there was also a commissioned ABPM Local Enhanced Service (LES) with GP practices which could prevent pharmacies accessing global sum funding available for the service, that could impact the Pharmacy First service. WG confirmed that ABPM would be picked up in the LES review planned for Q1.

PW highlighted to members the link between the new community pharmacy agreement and ICB prescribing spend, explaining that part of the community pharmacy contract was based on an element of 'retained margin,' a profit pharmacies can earn on dispensing medicines through cost effective purchasing. The April 2025 Drug Tariff Category M pricelist included a margin increase which would result in an overall reduction in reimbursement to community pharmacy and, as a result, would affect ICB prescribing spend and community pharmacy sustainability.

In response to SA, AK suggested adding financial sustainability of community pharmacy and prescribing spend to the forward planner for the next meeting and would work with PW on the intricacies of community pharmacy funding.

ACTION: JK to add financial sustainability of community pharmacy and prescribing spend to committee workplan and liaise with AK on appropriate timing.

Outcome: The Committee NOTED the 2025/26 Contract Change update.

8. Primary Medical Services

JS provided an update on primary medical service contract activity for assurance and information. From April 2025, there would be a revised focus on primary care projects due

to the ICB's cost reduction programme and future reports to the committee would vary slightly.

All service changes previously approved by the committee had now been enacted.

As from 1 April 2025 there were 143 GP contracts, plus the Special Allocations Service contract. There were 27 Primary Care Networks (PCNs) across MSE; noting that from 1 April, SS9 PCN had split into SS9 North and SS9 South but would still work together on the Integrated Neighbourhood Team programme.

Work was underway, supported by the General Practice Provider Collaborative (GPPC) and LMC, to implement a new Advice & Guidance Enhanced Service which would be funded from an elective care recovery budget.

JS highlighted quality and performance issues with 3 practices where specific concerns were raised and how the practices were being supported.

There were 2 practices whose landlords had given notice to terminate lease agreements. The first lease termination would take effect from September 2025 and it was hopeful that the practice would find alternative accommodation, the second was due to take effect from March 2027.

A large number of applications had been received for estates & capital funding which were being reviewed as part of the MTP programme of work.

Members noted an update on the Connected Pathways programme was also included in the paper.

PW was pleased to share that the Community Pharmacy Independent Prescribing Pathway would be funded until December 2025. There was an opportunity for interested sites to bid to take part in Lipid optimisation and the team would be looking at how this could be progressed.

SA expressed concern on how important work would be managed through the ICB transition period to ensure there were no gaps and patient care would not be affected. WG gave assurance that the MTP was built on existing workstreams, national priorities, contractual settlements and recovery plans etc., with identified leads. It must be acknowledged however that, as with any transition, a degree of subject matter knowledge could be lost therefore and an assimilation process would be required to bring a standardised approach to a new organisation. WG was confident that through the committee and other forums, a great deal of knowledge would be retained.

SA enquired whether the ICB transition should be raised as a risk. WG would check with the Senior Manager, Corporate Services whether there was an overarching organisational risk around the impact of organisational change.

ACTION: WG to check whether there is an overarching organisational risk included on the Board Assurance Framework on the impact of organisational change.

JS highlighted that the Connected Pathways Programme was funded until December 2025. The Primary Care team had intended to review how the transition of the Connected Pathways work would be managed, however expected this to be more challenging with the wider ICB changes ahead. ICB's were required to submit an action plan to NHSE by

30 June 2025, outlining how contract oversight, commissioning and transformation would be improved. The exercise would also help identify risks and provide opportunity to raise potential issues to NHSE.

Outcome: The Committee NOTED the Primary Medical Services update.

9. Primary Care Risk Management

An overview of the primary care risks included on the ICB's risk register and Board Assurance Framework was presented to the committee. The committee noted there were 11 active risks relevant to the work of the committee. There was 1 red rated risk related to Primary Care Demand and Capacity and 6 rated amber. Since the last report to the committee, no further risks had been opened and no risks had been closed.

WG highlighted that ratings had decreased for the GP Collective Action and Community Pharmacy risks. PW commented that the impact of the GP Collective Action had not stopped entirely as the completion of referral proformas was still not happening.

SA was pleased to note risks had not increased for primary care.

Outcome: The Committee NOTED the Primary Care Risk Management update.

10. Primary Care Quality Update

The ICB Quality Committee was responsible for oversight of Primary Care quality issues and received a report on a quarterly basis for Primary Medical Services, and bi-annual basis for Pharmacy, Optometry and Dentistry Services. The Primary Care Quality Committee papers were provided to the Committee for information. There were no escalations to the PCCC from the Quality Committee in that regard.

11. Community Optometry Services

The Community Optometry update was presented to the committee which provided an update of the contractual activities in relation to primary care optometry services and local development issues in optometry services. Ophthalmology Transformation was overseen by the Mid and South Essex Ophthalmology Transformation Board.

PW highlighted that the FP10 (NHS prescription forms) prescribing issues, previously reported to the committee, had been resolved and a process was in place to support future prescribing. As part of this work, the ICB reviewed the NHS formulary and some medications that were recognised as specialist could now be prescribed by Optometrists if commissioned to manage the associated conditions.

AD queried whether the Minor Eye Condition Service (MECS) clinicians would prescribe on FP10s. SP explained that Community Optometrists already had the ability to prescribe certain drugs, however only Optometrists who had undertaken Independent Prescribers additional training would be able to prescribe from the redacted formulary list agreed by the ICB. This move was expected to have a positive impact and would alleviate some of the pressure from GPs and hospitals on eye conditions.

PW stressed the need for optometry services to be clear to patients on the difference between private services and NHS services and the cost implications on private prescriptions that cannot be converted to an FP10 prescription.

Outcome: The Committee NOTED the Optometry update.

12. Minutes of Dental Commissioning and Transformation Group

The minutes for the Dental Commissioning and Transformation Group meeting held on 5 February 2025 and 5 March 2025 were received.

13. Items to Escalate

Escalate to BAF – check whether an overarching organisational risk is included on the Board Assurance Framework on the impact of organisational change.

14. Any Other Business

There was no other business.

15. Effectiveness of meeting

SA thanked contributors for the papers and member's contributions to useful discussions.

16. Date of Next Meeting

9.30 – 11.30am, Wednesday 14 May 2025
Via Microsoft Teams

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 14 May 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.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleksandra Mecan).
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Ashley King (AK), Director of Finance and Estates (nominated deputy for Jennifer Kearton).
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality (nominated deputy for Viv Barker).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Michelle Cleary (MC), Alliance Delivery & Engagement Lead.
- Dr Sarah Crane (SC), Training Hub Senior Responsible Officer Clinical Lead.
- Jane King (JKi), Corporate Services and Governance Support Manager.
- Emma Timpson (ET), Associate Director Prevention and Health Inequalities (Item 9 only).
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.
- Sheila Purser (SP), Chair, Local Optical Committee.
- Emma Spofforth (ES), Clinical Lead, Local Optical Committee.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee (Item 5 only).

Apologies

- David Barter (DBa), Head of Commissioning.
- Viv Barker (VB), Director of Nursing.

- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Nicola Adams (NA), Associate Director of Corporate Services.
- 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.

In response to SA, JKi advised that, in accordance with the ICB's Management of Interests Policy, staff were required to review and update their declaration of interest on a yearly basis and that an annual review was underway.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 9 April 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 9 April 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (173 and 175) were all within timescales for completion.

Outcome: The updates on actions were noted.

5. NHS England changes and ICB Cost Reduction Programme

PG provided an update on the NHS England (NHSE) changes and the ICB's Cost Reduction Programme. NHSE had published a draft Model ICB Blueprint which set out the future role and purpose of Integrated Care Boards (ICB).

The blueprint aimed to build stronger commissioning skills to improve health and reduce inequalities, focus on shifts from sickness to prevention, hospital to community and analogue to digital. ICBs were required to achieve significant reductions in running costs with a target of £18.76 per head of population and explore larger operational footprints to benefit from efficiencies of scale. The preferred model identified by ICBs across the East of England region included a Greater Essex footprint which aligned with the reorganisation of local government in Essex, this was subject to National consideration.

The blueprint specified a guideline population size for ICBs to operate effectively within the new cost constraints. ICBs needed to submit plans to NHSE by 30 May 2025 outlining how the target would be met.

ICBs are required to review functions and activities that might be safely transferred to other parts of the system over time, including primary care operations and transformation, estates, workforce and medicines management. The development of neighbourhood and place would transfer to emerging neighbourhood health providers, however this would be dependent on provider maturity. ICBs would continue to be responsible for GP contracting and delegated commissioning of pharmacy, optometry and dentistry.

The ICB's statutory duties remained in place until the legal process for a new organisation was complete.

The committee discussed the draft Model ICB blueprint and the potential implications on primary care.

It was agreed that 'providers' must be considered in totality throughout left shift discussions and decision-making processes should include primary care impact assessments.

For transfer of responsibility, providers should be prepared for a 'readiness to receive' assessment and demonstrate maturity to receive functions.

To ensure an appropriate level of infrastructure was available to support neighbourhood and prevention working in Essex, identification of assets within the ICB's provision was required and aligned with areas of strength already in place across local authorities, communities, primary care and pharmacy, optometry and dental providers.

The changes would enable best practices to be rolled out across the new system footprint e.g., successful dental pilots undertaken in mid and south Essex would benefit the whole of Essex.

Work is required to build relationships within and between primary care providers. The local representative committees would be able to undertake some of this work, however support and oversight from the wider system would be required.

SA stressed that the new model of care must be straightforward for patients to navigate, to avoid presentation at urgent care and fragmentation of patient care. PG agreed, emphasising that any changes to care models must be clearly articulated to stakeholders throughout the change process. The principles of the PCCC discussions would be collated and provided as a primary care response to the draft blueprint, and would represent pharmacy, optometry and dental services as well as primary medical services.

PG stressed that there was a great deal of talent within the ICB working across primary care whose knowledge would support the changes in infrastructure required.

As the Executive lead, PG was assured that primary care was well represented in the change process with AD, Primary Care Board Member, also heavily involved in change discussions. There was also ICB engagement with the GP Provider Collaborative (GPPC), primary care leaders across East of England, greater Essex and place locally, as well as with all local representative committees.

PG highlighted the speed at which the changes were required and the volume of work to implement the changes.

Outcome: The Committee NOTED the update on the NHSE changes and ICB Cost Reduction Programme.

6. Medium-Term Plan & Incentivisation Scheme

WG provided an update on the schemes within the Primary Care work programme of the Medium-Term Plan (MTP) which aims to support the transformation of primary care services, building on the provisional primary care strategy discussions. The initiatives also seek to deliver upon contractual changes and NHSE Operating Plan requirements for 2025/26. All schemes have commenced early stages of delivery.

Formal reports outlining the progress of the MTP and its schemes would be regularly presented to the ICB Board and PCCC once the reporting cycle and requirements were agreed.

Details of the Primary Care Incentivisation Scheme project were shared with the committee, setting out potential 'blueprints' for the left shift into primary care, namely a Primary Care Led Model, Specialist Community Provision and Integrated Team Model. Once determined, the MTP requirements and the 'blueprint' type they fell into would be considered.

ES was frustrated and concerned by the lack of optometry included in the MTP update. JS explained that the initial ask of the MTP was to look at services funded within primary medical to review how they aligned with the INT commissioning plan. JS gave assurance that consideration would be given to whether a left shift was more appropriate to a provider outside of primary medical services.

Outcome: The Committee NOTED the Medium Term Plan & Incentivisation Scheme update.

7. Integrated Neighbourhood Team

SW presented the Integrated Neighbourhood Team (INT) paper which provided an update on progress made since the last report to the committee.

INT programme governance had been reviewed and formalised as part of the MTP work and data and metrics reviewed to support the development of an INT dashboard.

A Frailty and End of Life (EoL) case finding tool was being trialled by an INT within the South East Essex Alliance which would eventually be rolled out more widely.

The INT Maturity Matrix was updated to provide a more consistent overview of INTs to support development. A support resource guide was in development which would be trialled for PCN use.

To support ongoing INT conversations across the system, with particular emphasis on Frailty and EoL, a wider stakeholder engagement plan had been developed.

PG highlighted that INTs played a crucial role in implementing the MTP and the onus was on this delivery model for the future.

In response to SA, PG advised that to enable INT working to be mainstreamed within the commissioning framework, a baseline assessment was required to identify services that should be covered by a commissioned arrangement and what was already in place across MSE.

JS added that the potential 'blueprints' to support left shift included an Integrated Team Model, delivered through INTs. The ICB must ensure there was a firm footing for primary care contribution that aligned to local authority plans.

WG explained there was a MTP workstream, involving partners, creating commissioning models to enable left shift. There had so far been a primary medical focus, but the team would ensure a broader diagnostic approach to consider who the provider(s) might be.

SA queried whether there was a risk of confusing patients as to who service providers are, with the large number of organisations within primary care. WG explained that learning would be taken from the Connected Pathways work to ensure patients were aware who was treating them and be able navigate through the system easily.

From AD's experience as a GP, she explained that patients were frequently struggling to navigate the complex healthcare system, unsure who would be providing the treatment and how the service was related to the GP, e.g. PCN pharmacists undertaking pharmacy reviews. Communication and engagement with the population on the changes taking place within primary care were essential.

Outcome: The Committee NOTED the Integrated Neighbourhood Team update.

8. General Practice Provider Collaborative update

AD provided a verbal update on the progress of the General Practice Provider Collaborative (GPPC) who met on a monthly basis. The last meeting was at system level, where Advice & Guidance (A&G) was discussed. Also discussed were issues with radiology systems (ICE and IREFER) which had since been resolved and work undertaken by the Diagnostic Stewardship Programme to look at how GPs ordered diagnostic patient investigations.

There were four GPPC Boards, each aligned to a mid and south Essex Alliance. The system level GPPC Board was in the final stages of development and was expected to be in place soon.

KSS enquired whether there was a timeline for the GPPC to develop into a Primary Care Collaborative. AD hoped to provide an answer once the governance was sorted for the GPPC system group.

SA enquired whether the GPPC had considered how it would fit into the new landscape of greater Essex and was concerned that as a consequence from the change process, multiple new organisations would be created and would bring cost, bureaucracy, complexity, governance and risk.

AD acknowledged that the GPPC needed to consider how it worked with GP organisations in North East Essex and West Essex as the region steered towards a greater Essex footprint. The GPPC was the only organisation of GPs in mid and south Essex and represented the combined voice of GPs at Practice, PCN and place level. North East Essex had other arrangements in place which included a large scale GP Federation and

GPPC. In West Essex there was a GP Federation, AD was unsure whether there was a GPPC.

Outcome: The Committee NOTED the Primary Care Collaborative update.

9. Health Inequalities

ET presented the paper setting out the Cardio Vascular Disease (CVD) 2 year prevention support package for Primary Care which would aid delivery of the Quality and Outcomes Framework (QOF) and deliver improved outcomes for the ICB's population.

The gap in healthy life expectancy in mid and south Essex was 13 years between those living in the most and least deprived wards, with CVD being the biggest contributor to the gap in overall life expectancy.

The scheme was built on insight and engagement from GP practices, community pharmacy and neighbouring ICBs already delivering similar population health management approaches. The focus was on hypertension but also promoted a holistic approach to long term conditions by taking the opportunity to support those conditions closely linked to blood pressure.

ET confirmed that the Executive Committee had approved utilisation of specific health inequalities funding of £461,300 for the CVD prevention scheme.

KSS commented that as part of the community pharmacy blood pressure check, there was a contractual requirement to follow raised blood pressures with Ambulatory Blood Pressure Monitoring (ABPM) for diagnosis, however details of where this service sat within the GP AMPM Local Enhanced Service were not confirmed.

KSS advised that the provider of Community Pharmacy Services in Essex also held the contract for NHS Health checks with Essex County Council and suggested that the invite to NHS Health Checks should also be included within the NHS community pharmacy contract.

ES noted that optometry services were not involved in the CVD prevention work, however highlighted that the service was well placed to support opportunistic blood pressure monitoring. Hertfordshire and West Essex (HWE) ICB had involved optometry services in their CVD programme which had been successful in targeting all areas of health inequalities.

ET explained that the outcomes of the mid and south Essex pilot were awaited before considering wider provider involvement but would link in with HWE regarding their scheme.

JH enquired how the scheme interacted with the targeted CVD Local Enhanced Service (LES). ET explained the CVD LES targeted Primary Care Networks with high levels of deprivation and low uptake by certain ethnic groups ended in March 2025 and the outcomes were being analysed.

JH suggested that future schemes gave more emphasis to deprived areas. JH added that the ICB was trying to secure money for innovation to look at related area of kidney disease as there was overlap with CVD.

At the request of SA, ET would share the results of the CVD LES at the next health inequalities update to the committee, identifying the successful and unsuccessful aspects and what could be integrated into the ICB's delivery model.

ACTION: Outcomes of the targeted Cardio Vascular Disease Local Enhanced Service to be shared at the next scheduled health inequalities update.

Outcome: The Committee NOTED the Health Inequalities update and SUPPORTED the Cardio Vascular Disease (CVD) 2 year prevention support package for Primary Care.

10. Committee Effectiveness Review

WG presented the final Committee Effectiveness report for 2024/25, which combined the results of the desktop review and members survey.

The overall findings concluded that the committee had achieved the objectives it set out within its terms of reference, the meeting had been administered and well run with a good breadth of topic areas discussed throughout the year. The committee provided good oversight of primary care matters and was robust in its processes for decision making.

Recommendations to improve the committee were set out in an action plan. The outstanding actions would be added to the overarching committee action log.

The terms of reference were updated to include the development of the MTP (elements that were either led by primary care, or integrated with primary care) and left shift into primary care as a specific requirement of the committee. The establishment of the Community Pharmacy Transformation Group and provision for Local Resolution Dispute Panel. No further changes were required to the terms of reference.

A draft work plan was represented with the caveat that, due to the organisation change, the workplan would be continually under review for the period to ensure effective governance in a changing organisation.

WG and SA thanked the Governance Team for the work undertaken on the review.

AK highlighted that work was underway in respect of action reference 4 (identifying key metrics) and would be led by primary care team.

Given the forthcoming organisational changes, SA enquired whether there was a timeline on a decision for the work of the committee and where it sat in the overarching frame of changes being proposed.

WG advised that although the timeline for the changes was not yet known, if moving to a greater Essex footprint, the ICB was likely to exist in name for the remainder of the financial year therefore there was a legitimate role for the committee in some form. The NHSE changes and ICB cost reduction programme was a standing agenda item where the committee would be kept regularly informed of updates.

Outcome: The Committee SUPPORTED the review of Committee Effectiveness 2024/25 and NOTED the outcome of the effectiveness survey.

Outcome: The Committee APPROVED the draft committee work plan for 2025/26, with the caveat that it would be continually reviewed.

Outcome: The Committee APPROVED the terms of reference.

11. Items to Escalate

- Outcome of the committee self-assessment to be reported to the Audit Committee.
- Updated terms of reference to be presented to Board.

12. Any Other Business

There was no other business.

13. Effectiveness of meeting

The Chair commented that the committee had a rich conversation and thanked members and attendees for their participation.

14. Date of Next Meeting

3.00pm, Wednesday 11 June 2025
Via Microsoft Teams

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 11 June 2025, 3.00pm–5.00pm

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.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Ashley King (AK), Director of Finance and Estates (nominated deputy for Jennifer Kearton).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleksandra Mecan).
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality (nominated deputy for Viv Barker).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Head of Commissioning.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Dr Sarah Crane (SC), Training Hub Senior Responsible Officer Clinical Lead.
- Jane King (JKi), Corporate Services and Governance support Manager.
- Kathryn Perry (KP), Head of Primary Care Workforce (Item 10 only).
- Ashley Paul (AP), Primary Care Workforce Project Manager (Item 10 only).
- Ali Walker (AW), Programme Manager (Item 17 only).
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Sheila Purser (SP), Chair, Local Optical Committee.
- Emma Spofforth (ES), Clinical Lead, Local Optical Committee.

Apologies

- Dr James Hickling (JH), Deputy Medical Director.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Viv Barker (VB), Director of Nursing.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.

- Dr Matt Sweeting (MS), Executive Medical Director. Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.

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 14 May 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 14 May 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions 173 (2024/25 Action Log), 7 and 9 were all within timescales for completion.

Outcome: The updates on actions were noted.

5. NHS England changes and ICB Cost Reduction Programme

PG explained there was no further update on the ICB transition timeline. A high-level submission to NHS England (NHSE) had been submitted by all ICBs for review. Structures of a new ICB were not included in the submission. The ICB continued to work closely with partners in Greater Essex, neighbouring ICBs and other primary care leaders to ensure relationships were progressive. Pharmacy, Optometry and Dental arrangements were covered in those discussions.

Outcome: The Committee NOTED the update on the NHSE changes and ICB Cost Reduction Programme.

6. Medium-Term Plan

WG presented an update on the schemes within the Primary Care work programme of the Medium Term Plan (MTP), highlighting that the first meeting of the Primary Care MTP Programme Board had taken place. Progress had been made on all schemes.

A monthly engagement forum for Alliance Clinical leads to input into both the primary care MTP meetings and wider MTP meetings had been established. The group would also link in with the GP Provider Collaborative.

Work was being undertaken to understand the potential impact of wider MTP schemes upon primary care, including Primary Care Impact Assessments for all proposed schemes.

MTP work undertaken by the ICB would likely form the basis for the new organisation's plan, incorporating elements from the MTPs covering West Essex and North East Essex. ICB colleagues were in discussion with counterparts in neighbouring ICBs to identify common challenges and look at consistent ways to address them.

SA enquired whether there were financial targets for the primary care programme.
WG explained there was no imposed financial target linked to the primary care programme.

Outcome: The Committee NOTED the Medium Term Plan update.

7. Primary Medical Services Contracts

JS provided an update on primary medical service contract activity for assurance and information.

It was highlighted that on page 8 of the report, the reference to 'fortnightly reviews of the position with NHSPS' under section 17, related to section 16 (NHSPS Debt Resolution Programme).

The NHSE 2025/26 Operational Planning Guidance set out further contractual management expectations for primary care.

Several potential service changes were reported to the committee, including relocation of premises, opening of new branch surgeries, boundary changes and merger requests, some of which were not yet in the public domain.

Following an ICB application process, NHSE had confirmed provisional funding support for 27 practice led schemes for delivery in 2025/26 through NHSE's Primary Care Utilisation and Modernisation Fund (UMF), totalling almost £2.7m. The practices identified for funding would be required to submit a Project Initiation Document (PID) for consideration. Following this submission, confirmation would be given on the funding of schemes.

The 2025/26 contractual arrangements were in place for all historical and new locally commissioned schemes (LES) and services. A review of schemes would be undertaken as part of the MTP programme.

Members noted the Connected Pathways update on national and local priority programmes.

KSS enquired whether the ICB had recommissioned the Ambulatory Blood Pressure Monitoring (APBM) LES, highlighting that the committee were previously advised that a APBM service formed part of the Community Pharmacy core contract with set targets and funded by the Community Pharmacy Global Sum at no cost to the ICB. WG confirmed an APBM LES was commissioned for 2025/26, however remained under review.

ES was concerned that some Community Optometry enhanced services could be at risk due to a lack of funding, resulting in an increased cost to the overall system and inappropriate redirections causing additional pressure on GPs, pharmacies and urgent care.

WG/JS agreed to follow up with the ICB Ophthalmology lead to look into the concerns raised.

ACTION: WG & JS to follow up with the ICB Ophthalmology lead regarding concerns raised by ES that some Community Optometry enhanced services could be at risk due to a lack of funding, and provide an update to the committee.

SA commented that a transparent and consistent approach to managing capital spend in primary care was required, particularly given the large value of funds available.

WG advised there was an MTP primary care subgroup looking at primary care estate with the key objective to manage current and future estate needs. The group were looking at the scope and development of a new estates strategy that included left shift. A summary outlining the planned estates approach, including current needs, key steps and associated issues would be brought to the next meeting.

SA stressed that a focus must be kept on reducing estate inequities.

ACTION: A summary outlining the planned estates approach, including the current, key steps and associated issues to be presented at the next meeting.

In response to MA, AK explained that MTP estates work would consider Local Development Plans.

AK explained the £2.7m UMF was a maximum amount and utilisation would be managed by NHSE, and the ICB must progress the projects identified. Capital spend was within the portfolio of the Finance and Performance Committee, PCCC's role was to identify the impact that a lack of capital or investment would have on a future primary care model and integrated neighbourhood team (INT) model. Estates schemes previously approved by NHSE would be reviewed to ensure they still aligned with the ICB deliverability priorities.

SA suggested the estates paper should include distinction and balance between expediency, and need of capital programmes and consideration of how Section 106 monies could be combined with the UMF to maximise benefits.

JS confirmed stakeholders and practices would be advised of the available funding pots and process to access funds.

Outcome: The Committee NOTED the Primary Medical Services update.

8. Quarterly Finance Report

AK presented the finance report which provided an overview of the financial performance of the ICB in respect of its investments in, and directly influenced by, primary care during 2024/25 and the anticipated Month 2 budgets following initial post planning adjustments for 2025/26.

The ICB used circa £614.05m across the whole Primary Care portfolio in the 2024/25 financial year which was just below available resource. This contributed towards the ICB's closing position.

The opening Primary Care portfolio budget for 2025/26 was £621.66m. The committee were asked to note that the majority of funding previously received as Service Development Funding (SDF) was included in the ICB's opening baseline and that the ICB received its full Additional Roles Reimbursement Scheme (ARRS) allocation for 2025/26, whereas in previous years an element was retained centrally to drawdown once local allocations were exceeded.

GP Prescribing and Premises Costs were identified risk areas that might impact in-year financial performance and future ability to make new investments into Primary Care for 2025/26.

A cross-portfolio risk between the GP prescribing budget and the delegated fund for community pharmacy was highlighted. This was as a consequence of the national community pharmacy contract and commitment to deliver retained margins which could see drug prices adjusted as a way of meeting community pharmacy contractual obligations.

The delegated pharmacy spend would be split out to better understand pharmacy costs and identify cost pressures.

The levels of risk outlined for GP prescribing and premises costs would not destabilise services.

In response to ES, AK confirmed the opening allocation for delegated ophthalmic services had been advised as £12.77m, however, this could change in-year to reflect any national contractual or remuneration settlements.

Outcome: The Committee NOTED the Finance update.

9. GP Primary Care Performance Reporting

WG provided an update on the development of the NHSE GP Primary Care Dashboard which was designed to support ICBs with effective commissioning of Primary Medical Care services, specifically in the areas of GP access, workforce, clinical outcomes and care quality, medicines management and screening and vaccinations.

The dashboard used national data to enable ICBs to identify performance variation, assess risk and inform contract reviews and improvement initiatives. Although populated with publicly available information, the dashboard was not public facing.

The dashboard was live and in its early stages of development. Refinements would be made to improve user experience and additional functionality would be added over time. As the dashboard was developed, reporting to PCCC would demonstrate how the information would be integrated into contract management and quality oversight.

SA was concerned that a reliance on dashboard metrics could replace contract performance and quality assurance conversations.

WG explained that data was used to inform an oversight approach and any actions required were subject to discussion with practices.

JS was confident that the ICB had established contract management processes in place to consider the issues discussed, however suggested that data led enquiries from NHSE could be brought to the committee for guidance.

SA acknowledged that the dashboard was useful to cut data at different levels, e.g., by alliance or local authority which could provide opportunities for population health management.

Outcome: The Committee NOTED the GP Primary Care Performance Reporting update.

10. Training Hub/Workforce update

KP provided an update on the primary care workforce, workforce data, and the planning and implementation of recruitment and retention initiatives across primary care.

The Primary Care Training Hub, funded by NHSE, was made up of System Development Funding (SDF) and non-SDF funding. The initial 3-year Training Hub contract was awarded until 31 March 2025, with the flexibility to extend for a further 2 years. NHSE extended the service contract for a further year to the end of March 2026. Confirmation on whether this would be extended until end March 2027 was awaited.

The Training Hub was the 'go-to' place for primary care for support with recruitment, retention and development, it also supported primary care transformation by developing the current and new workforce required to deliver world-class patient care. Local workforce challenges were an ageing workforce, increasing population and proximity to London which made it hard to recruit and retain staff – especially clinicians.

Since 2024/25 SDF funding was no longer ringfenced for Training Hubs and it was necessary to compete with other ICB work programmes for funding. An application outlining the SDF funding required for 2025/26 to support the initiatives planned and proposed and to meet the Training Hub key performance indicators (KPIs) had been made to the ICB. Confirmation was awaited from NHSE on allocation of non-SDF funding for the Training Hub.

The Training Hub continued to offer a wide range of workforce initiatives to support recruitment, development and retention of primary care staff which included GP and General Practice Nurse Fellowships, GP Peer Support Networks, Portfolio Development Scheme and Educator and Training Practice Expansion, Mentoring, and Admin and Non-Clinical Training.

The GP Dashboard provided limited workforce information which was available to the hub. JS suggested it would be helpful to obtain local data on staff sickness, attrition and retention rates which was not currently available.

SC raised concerns that experienced GPs could be released from practice funded contracts in favour of employing newly qualified GPs funded in their first two years after qualification from ringfenced Additional Roles Reimbursement Scheme (ARRS) budgets.

SA enquired whether employment terms and conditions for ARRS roles was similar to those of staff employed directly through practices.

JS said that consideration needed to be given to the variation and non-standardisation of terms and conditions across primary care and what this would mean for primary care at scale.

SA was concerned about the certainty of long-term funding available for the Training Hub and queried whether there was conversation at ICB level should NHSE withdraw funding. The committee should consider whether this was an emerging risk and whether a case should be made to the ICB to provide funding for the Training Hub and how the committee could influence to support or contribute to decision making.

KP advised it was likely that the hubs would be funded for another year however there was uncertainty around where they would sit in the future amidst the ICB transition.

WG highlighted that there were significant competing demands on ICB running costs with the reduction in funding for ICBs. Until certain functions moved to providers, as set out in the ICB model blueprint, the primary care transformation agenda would continue and consider how primary care workforce development could be funded.

AD commented that the Training Hub was a vital function in primary care and thought should be given to its relationship with the GP Provider Collaborative (GPPC) and other ways of supporting training for primary care.

SC advised that although the majority of hubs were hosted by ICBs, some were hosted by federations or providers.

PG agreed, as the Executive responsible for primary care, to raise the committee's concerns regarding the future and funding of the Training Hub with the Executive Team. PG mentioned there was a positive feeling about moving workforce and the hub closer to primary care.

ACTION: PG to raise the committee's concerns regarding the future and funding of the Training Hub with the Executive Team and provide an update at the July meeting.

Additional Roles Reimbursement Scheme (ARRS) Funding Utilisation

AP provided an update on the utilisation of funding related to the ARRS, the largest funding component of the Network Contract Directed Enhanced Service. ARRS enabled Primary Care Networks (PCNs) to expand their workforce through new, reimbursable roles.

Since the introduction of ARRS, changes to budgets and new roles had been introduced, most recently GP ARRS, Practice Nurses and a broader range of Advance Practitioners, with the ARRS workforce showing steady growth year on year. While ARRS staff were primarily employed by PCNs, roles were also employed via other providers and ICB partners. Over the past five years, the allocated budget had increased steadily, accompanied by a consistent rise in utilisation rates, reaching 96% in 2024/25.

ARRS continued to play a pivotal role in expanding the primary care workforce across PCNs. In mid and south Essex, uptake had steadily increased, with 692 (610.37 whole time equivalent) staff in post as of April 2025. Growth was especially strong in the areas of clinical pharmacists, care coordinators, general practice assistants, and paramedics.

Fully optimising the use of ARRS funding and deployment was essential to strengthening primary care capacity and delivering integrated, population-focused care.

MA enquired how PCNs were utilising ARRS roles from a neighbourhood health perspective and noted a variance in ARRS roles between areas. AP explained a workforce planning exercise was underway to provide this insight.

JS commented that the role of PCNs was to support the sustainability of practices, improve access to a range of appointments and the interface with INTs. Each PCN worked differently depending on its practices and population. Anglia Ruskin University were looking into the optimisation of ARRS roles and also undertaking research looking at the effect of ARRS on personalised care roles.

PW commented that as we moved towards an integrated neighbourhood model, more focus was required on evolving and developing clinical pharmacists and pharmacy technicians

within PCNs to efficiently support GPs. A holistic approach to care was needed to reduce number of appointments and specialisms.

KP welcomed the comments from PW and agreed to discuss how the training hub could support pharmacy training outside of the meeting.

Outcome: The Committee NOTED the Training Hub/Workforce update.

11. Primary Care Risk Management

An overview of the primary care risks included on the ICB's risk register and Board Assurance Framework was presented to the committee. There were 11 active risks, one of which was rated red (Primary Care Demand and Capacity) and 5 rated amber. No additional risks had been opened and none were closed since the last committee meeting

WG highlighted that PCCC report covers had been updated to include the risks that related to the paper and linked how actions would address the risks.

SA noted that the risks were mostly aligned to Basildon and Brentwood Alliance. WG explained this was because the Primary Care directorate sat within the Basildon and Brentwood Alliance, however the risks were largely system wide. A request would be made to the risk team for future iterations of the primary care risk register to differentiate between system and local risks.

ACTION: Sara O'Connor/Chris Cullen to arrange for future iterations of the corporate risk register to differentiate between system and local risks.

Outcome: The Committee NOTED the Primary Care Risk Management update.

12. Pharmacy, Optometry & Dental Quality update

The ICB Quality Committee was responsible for oversight of Primary Care quality issues and received a report on a quarterly basis for Primary Medical Services, and bi-annual basis for Pharmacy, Optometry and Dentistry Services. The Primary Care Quality Committee papers were provided to the Committee for information. There were no escalations to the PCCC from the Quality Committee in that regard.

Outcome: The Committee NOTED the Pharmacy, Optometry & Dental Quality update.

13. Community Pharmacy

The Q4 2024/25 Pharmacy Services Regulations Committee (PSRC) update for mid and south Essex was presented to the committee which provided an update of the contractual activities in relation to community pharmacy services. The PSRC oversaw formal regulation activities for community pharmacy providers on behalf of all six East of England ICBs and is hosted by NHS Hertfordshire and West Essex ICB (HWE ICB).

The first Pharmacy Transformation Group meeting took place on 8 May 2025. A copy of the papers, which included Pharmacy First and Independent Prescriber Pathfinder data, was shared with the committee for information.

ES queried the appropriateness of independent pharmacies prescribing anti-infective eye preparations. KSS explained that Independent Prescribing Pathfinders (IPPs) were commissioned to prescribe above the nationally commissioned Pharmacy First model.

PW added that although IPPs were able to prescribe within their competencies, it would be helpful to broaden knowledge of the Minor Eye Conditions Service (MECS) so IPPs were aware of the service and, where appropriate, refer into MECS, particularly as Ophthalmic Independent Prescribers were able to issue FP10 prescriptions. PW agreed to put ES in touch the IPP pharmacy team.

ACTION: PW to put ES in touch with the IPP pharmacy team.

Outcome: The Committee NOTED the Community Pharmacy Regulatory and Pharmacy Transformation Group update.

14. General Optometry

The Q4 2024/25 Community Optometry update was presented to the committee which provided an update of the contractual activities and local development issues in relation to primary care optometry services. The management of the General Ophthalmic Service (GOS) was hosted by HWE ICB on behalf of the 6 ICBs in the East of England.

Outcome: The Committee NOTED the General Optometry Services update.

15. Minutes of the Dental Commissioning and Transformation Group

The minutes for the Dental Commissioning and Transformation Group meeting held on 2 April 2025 were received.

16. Items to Escalate

PG to raise the committee's concerns regarding the future and funding of the Training Hub with the Executive Committee

17. Any Other Business

Women's Health Hub Local Enhanced Service

WG explained that uncertainty around future funding for the Women's Health Hub (WHH) Local Enhanced Service (LES) remained. It had become apparent that prior to the forming of the health hubs, a significant amount of unfunded work had been undertaken since NHSE funding was withdrawn from the service.

AW advised that the WHH service had received positive feedback from patients and clinicians. If funding for the service was stopped, the associated work was likely to transfer to secondary care, incurring a cost pressure on acute services of circa £518k per year. The cost of the LES was estimated to be £346k, including prescribing costs.

The committee were in support of continuing the WHH LES, agreeing that it was cost effective and supported the left shift to move care closer to home. Due to the associated cost pressures of the service, a WHH LES paper would be presented to the Executive Committee for approval.

Outcome: The Committee SUPPORTED the case to continue commissioning the Gynaecology LES (Women's Health Hub).

18. Effectiveness of meeting

The Chair thanked attendees for the comprehensive and rich discussion, noting the good quality of committee papers and data presented.

19. Date of Next Meeting

9.30 am to 11.30 am Wednesday, 9 July 2025, Via Microsoft Teams.

Minutes of MSE ICB Quality Committee Meeting

Held on 25 April 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.
- Prof. Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- 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 12).

Attendees

- Viv Barker (VB), Director of Nursing for Patient Safety, MSE ICB.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- Victoria Kramer (VK), Senior Nurse for Primary Care Quality, MSE ICB.
- Sara O'Connor (SOC), Senior Manager Corporate Services, MSE ICB.
- Gemma Hickford (GH), Consultant Midwife, MSE ICB.
- Ines Paris (IP), Designated Lead Nurse for Safeguarding, MSE ICB (deputising for Yvonne Anarfi).
- Eleanor Sherwen (ES), Deputy Director of Nursing, MSE ICB.
- Karen Flitton (KF), Patient Safety Specialist, MSE ICB.
- Angela Wade (AW), Director of Nursing, EPUT (deputising for Ann Sheridan).
- Deborah Goldsmith (DG), Director of Midwifery, MSEFT (present up to item 8).
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company (present up to item 7).
- Laura Rose Thorogood (LRT), Maternity and Neonatal Voices Partnership Lead (MNVP), MSE ICB (present up to item 8).
- Anna Cheeseborough (AC), Interim Head of Midwifery, Southend Hospital, MSEFT (present up to item 8).
- Lindsay Carpenter-Oliver, (LCO), Deputy Lead of MNVP, MSE ICB (present up to item 8).
- Julie Davis (JD), Complaints Clinical Support Officer, MSE ICB.
- Fiona Crump (FC), Patient Safety Partner, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.

- Ann Sheridan (AS), Executive Nurse, Essex Partnership University NHS Foundation Trust (EPUT).
- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex, MSE ICB.
- Wendy Dodds (WD), Healthwatch Southend.
- Stephen Mayo (SM), Director of Nursing for Patient Experience, MSE ICB.
- Ross Keily-Cracknell (RC), Senior Nurse for Mental Health, Learning Disabilities and Autism, MSE ICB.

1. Welcome and Apologies

NIB welcomed everyone to the meeting. Apologies were noted as listed above. The meeting was confirmed as quorate.

2. Declarations of Interest

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

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 28 February 2025 were reviewed and approved, subject to the following amendments.

Item 6 Dental Deep Dive, paragraph 7- to include the words ‘pathfinder pilot’ in the sentence ‘however there were four community pharmacy independent prescribing *pathfinder (pilot)* sites in MSE’.

Item 11 Sodium Valproate Update, paragraph 8 – to include the word ‘initially’ and replace Neurologist with ‘specialist’ in the following sentence ‘remained responsible for *initially* prescribing the choice of prescription, and the annual check/review should be completed by a *‘specialist’.*

Resolved: The minutes of the Quality Committee meeting held on 28 February 2025 were approved, subject to the amendments noted above.

4. Review of Action log

The action log was reviewed, and updates were noted.

Resolved: The Committee noted the Action Log.

5. Lived Experience Story – Maternity Services

GH presented a lived experience story which related to two service users’ experience of the maternity service.

The first story was a mother who had different experiences when giving birth to her two

children at Southend Hospital, the first in 2022 and the second in 2025. There were concerns with the lack of communication from the midwives and the lack of patient choice. However, the care provided by the consultant could not be faulted during caesarean sections for both births. With the second birth, the provision of care had improved and the post-natal midwives were proactive and responsive, which enabled a quicker and smoother discharge. The birth reflection service supported both parents with the trauma of the first birth and discussed their options if they were to have another child. The support provided from the mental health visitor was also an important part of the journey. During both births the ward environment was extremely hot and uncomfortable with minimal ventilation. Although there were minor issues, the care provided overall by Southend Hospital could not be faulted.

The second story was from a father of three children, who spoke of his experience of the maternity care he and his wife received at Broomfield Hospital and the bereavement support following the tragic loss of his son shortly after birth. The experience of the foetal medicine, antenatal and scan appointments was extremely positive and were mostly inclusive. During the day of delivery, relevant opinions were quickly sought when there were concerns regarding the baby's breathing and the care provided in the neonatal ward was exceptional and outstanding. The experience of the bereavement care team and the rainbow sessions were positive.

GH summarised that the experiences highlighted were from different perspectives and raised some important points for consideration. The areas for improvement were patient choice and decision making, communication, partner involvement and the postnatal ward environment. The positive feedback received was the proactive and responsive care, the positive medical involvement, birth reflections service, health visiting, post-natal ward care, rainbow bereavement care and the neonatal unit care.

DG advised that listening to patients' feedback was important to drive improvement. The number of requests for induction of labour and caesarean section births had significantly increased. It was positively noted that the experience shared from the mother had improved from her first birth to her second birth and also the positive feedback on the bereavement team at Broomfield Hospital.

SP asked what had been done to improve communication and was that sustainable; and were fans provided if the ward environment was too warm.

AW commented that the patient stories were inspirational. The birth reflection service was commendable and provided the opportunity to take learning forward which could be adapted and adopted in other work areas.

NIB asked how support services, such as the birth reflection service, were communicated and were they widely accessible. GH advised that the birth reflection service was universally offered to anyone who has had a baby, and was recommended nationally, although knowledge and awareness of the service varied. Many women received information on the service upon discharge. The provision had been standardised and promoted through social media channels. In most instances, midwives signposted women to those services if required. The accessibility of services to people for whom English was not their first language, and those who struggled digitally, could be a challenge, but staff provided support if needed and translation services could be accessed. NIB and SP suggested a targeted review for those who were unable to access the service easily and for

further detail to be provided in a future report.

Action: GH to include an update on the targeted review for people who were unable to access the support services in a future report.

6. Deep Dive – Local Maternity and Neonatal System

GH gave an overview of the timeline of maternity services from 2021 to 2025 which included key areas, such as Care Quality Commission (CQC) inspections and the issue and removal of Section 31 (S31) notices. The Maternity Safety Support Programme (MSSP) Maternity Improvement Advisers were supporting the Mid and South Essex NHS Foundation Trust (MSEFT) to ensure steady progress.

An increase in the RAG (red, amber, green) rating for neonatal death rates and a deterioration in the benchmarking against other similar sized organisations was noted which was statistically significant. Work was recently undertaken to understand the rationale for the increase and a thematic review of the cases of neonatal deaths within the Trust had been completed. Stillbirth rates had increased, however, in the local Trust data for 2024 there had been a significant reduction, and the expectation was that an improvement would be realised in the next published perinatal mortality data. This reduction had been influenced by thematic reviews and focused work on the Saving Babies Lives Care Bundle (SBLCB).

DG advised that the outcome report from the deep dive of neonatal deaths was awaited. Initial findings had not identified any occurring themes. Since 2023 the Trust had been compliant with the 10 safety actions for Clinical Negligence Scheme for Trusts (CNST) which demonstrated improving outcomes.

DG advised that four actions on the MSSP required completion before the programme could be exited, which were in progress. The actions were: to align the diabetes pathway across MSE; develop a maternity strategy that aligned to the three-year plan; develop a Patient Safety Incident Investigation (PSII) action tracker; and exit the S31 notice on the Broomfield site. Discussions were being held in May on the exit criteria for the S31 notice. Improvements made as part of the SBLCB was a change in the pathway for babies that were small for their gestational age and transforming scanning services. A safety tool had also been implemented that alerted clinicians if a baby's weight deteriorated or if there were concerns about the baby.

AC advised that Element 5 of the SBLCB consisted of 32 recommendations which predicted women at risk of pre-term birth, how that could be prevented and how to optimise outcomes for the baby. There had been significant improvement with overall compliance during the year and the target for Quarter 4 was 100%. The 'at risk areas' included having discussions on the plan of care with parents, which was a challenge when labour and delivery was quick, and being in the most appropriate place for a quick birth, particularly if the hospital site was not equipped to deal with pre-term babies. The pre-term birth rate target was 6% which had been achieved for three months out of the last six.

Details were provided on the interventions taken to improve all elements, as stated in the report, such as separating the role of preterm birth midwife and maternal medicine midwife on each site. A preterm birth version of Avoiding Term Admissions into Neonatal units (ATAIN) was being developed, which reviewed avoidable and unavoidable term admissions

and highlighted areas to be targeted for improvement. The three audit tools currently used were being merged and information had been received from Suffolk and North East Essex Integrated Care Board (SNEE ICB) on recognising preterm labour signs which would be distributed to pregnant women and staff.

GH gave an overview of the Maternity and Neonatal Independent Senior Advocacy Pilot. A case example highlighted the importance of the role and how an advocate could play an important part in families' care, particularly for new parents. The pilot was funded by NHS England (NHSE) as part of a recommendation from the Ockenden Report until March 2026 and a formal evaluation was being undertaken. Details were provided on the different activities in the role to provide this service, such as providing practical support, liaising with Trust staff and signposting to other services. The role worked closely with the maternity governance lead to translate any themes identified.

LCO advised that the role of MNVP was to work with service users to gather feedback to co-produce change working with the Trust. The MNVP led bereavement workstream supported families whilst sharing their experiences. A working group had been developed with bereaved families looking at the positives and negatives of their experiences. A survey was then sent out and the responses received were received to implement changes, such as including service user videos in training for the early pregnancy unit and the emergency departments. A further working group reviewed processes on the care received by families following the death of their baby and the impact that could have on their psychological and emotional wellbeing.

LRT gave detail on the MNVP led-infant feeding workstream which was highlighted as an area of concern from service user feedback. An in-person event was held at Basildon, which resulted in a 160+ point action plan. LRT detailed the work completed with training and staffing, improved access and equity and support and resources.

NIB suggested a further maternity deep dive at the next committee meeting to enable a robust discussion to be held. The slides would be recirculated before the next meeting.

AW commented that the presentation was really comprehensive and highlighted the experience and effectiveness domains. There was a good opportunity to consider the data interpretation to the impact from the safety domain to provide the whole quality picture.

Action: HC to invite the deep dive presenters to the next meeting and recirculate the slides prior to the next meeting being held.

7. Executive Chief Nurse Update

7.1 Safety Quality Group – Escalations

There were no escalations reported.

7.2 Emerging Safety Concerns/National Update

VB advised that work was ongoing with regards to the ICB reorganisation. A national working group was focused on the future functions of ICBs including clarity on where the quality assurance statutory function would be situated.

The East of England Chief Nurses were working through local functions to consider new

ways of working as requested by national teams.

Work was ongoing with MSEFT on core regulatory and quality actions including areas such as paediatrics service improvement, psychiatric liaison service and maternity assurance.

There had been three recent deaths in rapid succession at EPUT and immediate actions and learning were being implemented.

Work was ongoing on the system level risk management, led by the Associate Director of Corporate Services.

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. EPUT / Mental Health Update

AW presented the current position with regards to patient flow and capacity, suicide prevention and the CQC.

The current position for out of area (OOA) placements was 24 in appropriate placements and 52 in inappropriate OOA placements and remained a significant concern. The amount of time in OOA placements was being reviewed to reduce to a minimum and would bring people back to their local community, supported by a dedicated flow team. There were currently 65 delayed discharges, of which 34 were system delays and 6 were OOA placements. The main reason for delay was waiting for supported accommodation and the social impact of being discharged from an inpatient mental health bed.

Length of stay remained a concern, which had almost doubled from where it should be. For acute adult inpatients this was 116 days and 120 days for older adults. There were 16 patients who had been within the inpatient area for over a year. The daily bed management meetings were now held in local areas to bring together inpatient and community services to review from a local population perspective and share the risk in terms of purposeful admission and effective discharge.

The main reason for delayed discharges and system delays was local authority capacity and supported accommodation. Transparency of capacity across services remained problematic and presented blockers for discharges so was an area for improvement working together with local authorities.

EPUT remained fully registered with CQC and following recent visits within forensic and secure services in Brockfield House, the ‘Good’ rating was retained. Factual accuracy on the report was completed and the final publication was awaited. Clifton Lodge Nursing Home had an unannounced visit in January 2025 and their rating had improved from ‘Requires Improvement’ to ‘Good’. The report had been published. There was an unannounced visit in inpatient and Psychiatric Intensive Care Unit (PICU) services in November/December 2024 which focused on safety and well led domains and the report was awaited. 95% of actions had been completed on the CQC Improvement Plan and 53% had been approved for closure through the evidence assurance process.

Suicide prevention was identified as a quality priority within the effectiveness domain in the quality-of-care strategy delivery programme. There was also an enhanced focus on psychological support for people who repeatedly self-harmed to improve their trauma awareness care planning. The psychological services team had completed audits to understand the position of the psychological support offer and had a focused approach to improve trauma informed care.

A target to reduce non-fixed ligature areas in inpatient areas was set at 10%. There had been significant reduction in the level of harm reported and a significant change between incidents with fixed and non-fixed ligatures. The areas of high prevalence of self-harm by ligature were in children and adolescent units. Work was ongoing with the national Quality Improvement Collaborative to understand self-harm from a child's and young person's perspective, and the ligature risk reduction approach. Within the children and adolescent areas, a significant correlation with people who had neurodivergent conditions was identified and would be an ongoing focus.

The STORM (personalised approach to safety planning) training target had been achieved by the urgent care teams and would be broadened across inpatient community and urgent care with an aim to achieve a realistic level of 75%.

A focus for the year ahead was meeting the requirements to have a change of approach for suicide risk and safety planning in accordance with the recently published national reports. All mental health organisations should have this in place by March 2026. EPUT presented their case for a fundamental change in the approach to risk assessment and clinical guidelines to support best practice, training programmes and impact measures across the organisation. There would be a continual focus on self-harm reduction where there was a risk of death, and an additional 10% reduction was set for the following year.

SP asked if EPUT linked in with other system providers to identify ligature risks beforehand. AW advised that a steering group had been developed for suicide prevention and reduction of self-harm with representation from broader system partners, including local transport police, community services, third sector, local authorities and people with lived experience who were integral to setting out the approach.

MS noted that a clinical director had recently been appointed to support out of area placements and asked if there were any signs of improvement. AW advised that the clinical director was working with consultant colleagues on the risk appetite, in partnership with the community consultants. One of the key areas was the constitutional change in the daily oversight meetings to enable the transition of care to be reviewed jointly. The clinical director role would be integral to support the change of perception to risk.

Resolved: The Committee noted the EPUT Mental Health update report.

9. Independent Reviews Update

9.1 Greater Manchester Mental Health NHS Foundation Trust

ES advised that the Greater Manchester Mental Health NHS Foundation Trust report was commissioned following the panorama programme on the Edenfield Centre and detailed 11 key recommendations.

EPUT and North East London NHS Foundation Trust NEFLT) had provided evidence of

their response to the ICB and detailed submissions were provided within the papers. The following highlights were provided:

Recommendation 1: Engagement with families and carers – NELFT and EPUT had increased their engagement with people who had lived experience.

Recommendation 2: Strengthening Clinical Leadership - EPUT were reviewing their leadership roles following a gap analysis and the patient safety team were refining their approach. NELFT had undertaken a significant organisational restructure which supported the enhanced clinical leadership.

Recommendation 3: Organisational Culture - EPUT and NELFT had increased work in this area, and embedded Freedom to Speak Up Guardians.

Recommendation 4: Workforce Planning and Risks - EPUT had strengthened the connection between their Board, Senior Leadership Team and frontline staff and ensured a consistent approach with staff reviews. There was a focus on reducing vacancies and the reliance on agency staff. NELFT had targeted workstreams including ongoing support of recruitment of international nurses and the retire and return programmes.

Recommendation 5: Estates – NELFT had appointed a Director of Estates to drive improvement.

Recommendation 6: Governance Framework – EPUT and NELFT had rationalised internal meetings, governance structures, updated pathways and utilised digital tools.

Recommendation 7: Clinical Care model - Both organisations had enhanced transparency and reporting. NELFT had transitioned to a clinically led model with National Institute for Health and Care Excellence (NICE) informed care and robust audit.

Recommendation 8: Improvement and Planning - EPUT had prioritised sequenced work co-produced by staff and service users. NELFT were utilising their CQC Assurance Group.

Recommendation 9: Assurance on safety risks, including ligature risks and learning from deaths – EPUT were triangulating lived experience with incident quality data to inform improvements. NELFT have had active staff engagement.

Recommendation 10: Review of Provider Collaborative - EPUT continued their partnership with system leaders and ICB oversight and focused on compassionate leadership and shared accountability. NELFT had proactive strategic engagement across provider collaborative to support joined up care.

Recommendation 11: System wide learning – NELFT had hosted a learning event and EPUT had requested clarification on the role of the Greater Manchester Adult Secure (Northwest) Provider Collaborative from NHS England.

Both areas had provided assurance and through other forums of continued work and EPUT were commended for their engagement with the ICB.

ES suggested a further update on the progress and outcomes at Quality Committee in June.

AW advised that the mental health intensive support team had completed their work with

Greater Manchester and part of the summary document included conditions for success in terms of quality improvement. EPUT had included them in their 2025/26 plan to adopt as an overarching leadership commitment. In the first instance, a gap analysis would be undertaken with a current position statement.

9.2 Nottingham Independent Investigation Report

ES advised that the report primarily pertained to the care and treatment provided and there were key areas of concern which were included in the report.

ES requested that EPUT and NELFT provided a formal update on the report to the June meeting.

Resolved: The Committee noted the update reports on the Greater Manchester Mental Health NHS Foundation Trust and the Nottingham Independent Investigation Report.

Action: EPUT and NELFT to provide a further report to be provided on the Manchester and Nottingham Reviews at the Quality Committee meeting in June.

10. Pharmacy, Optometry and Dentistry Update

VK highlighted the following key points.

The funding for the community pharmacy independent prescribing (CPIP) was extended until December 2025. Quality assurance visits would be undertaken for the four providers involved at the end of summer 2025 and support would be provided, if required.

The Pharmacy First data showed that respiratory consultations were slightly higher for MSE. PW advised that all indicative targets set by NHS England for uptake were being met. One pharmacy was unable to further provide the Pharmacy First service, however the impact would be minimal and supported locally, as required.

An update was provided following the deep dive on dentistry at the last committee meeting. The assurance toolkit had been completed and sent to NHS England to ensure inspection guidelines had been met and would be rolled out across MSE for any practices who wished to take part. Bespoke offers from the Safeguarding Team and the Infection Prevention Control (IPC) Team had been provided to dental providers in terms of safeguarding and IPC support.

SP commented that optometry quality complaints would be directed to the General Optical Council and suggested developing a link so that there were no blocks in the pathway. PW advised that there was very limited NHS commissioning for optometrists. Pharmacies link directly with the General Pharmaceutical Council (GPhC) when there were any issues relating to professional standards. GPhC would not inform the ICB if any areas of concern were reported directly to them. PW suggested the inclusion of primary eye care services in the next report. SP and VK will discuss offline.

MS thanked the team and commended Pharmacy First as an excellent initiative which was well utilised in MSE.

Resolved: The Committee noted the Pharmacy, Optometry and Dentistry update

report.

Action: SP and VK to discuss including primary eye care services in the Pharmacy, Optometry and Dentistry Update report.

11. Safeguarding Update - Children

IP highlighted the following key points.

The British Dental Association had approached the Safeguarding Team to deliver a two-hour training course, scheduled for June.

A further vacancy in the designated doctor roles had arisen due to retirement and alternative options were being explored.

There had been significant escalations with regards to the management of medical neglect, particularly with differing opinions of health professionals and colleagues in social care, which had created significant tension.

An update was detailed in the paper with regards to the backlog of paediatric liaison and Emergency Department attendances at Southend Hospital. A meeting was scheduled week commencing 28 April 2025 to discuss how the risk could be mitigated and contained.

MS asked if the doctor vacancy in safeguarding was being progressed or were any escalations required. IP advised that doctors were being approached to cover the current work. Herts and West Essex ICB and Suffolk and North East Essex ICB had also been approached to ask if they could spare capacity which had resulted in telephone cover for the child death review.

SP asked if the training could be extended to optometrists in both Cambridge and Essex. IP confirmed that Pharmacy, Optometry and Dentistry (POD) had been added to general practice strategic leadership and could be extended to optometry.

NIB asked if there was any work ongoing in the country that joined the areas of POD and Safeguarding together, such as schools. IP advised that it was an undeveloped area nationally.

AW requested clarity on the Mental Capacity Act compliance action plan and asked if the completed status on the action ID1 referred to the resources to fund and manage the recovery of backlog of the Deprivation of Liberty applications and if so, was there a timeline. IP understood that the funding for resources to manage the backlog had been agreed, however recruitment was pending. An update would be brought back following discussion with All Age Continuing Care who were the action owners. AW advised to would be beneficial to know the recovery trajectory from EPUT's perspective.

Resolved: The Committee noted the Safeguarding update report.

Action: IP to provide an update on the recovery trajectory and recruitment on the backlog of Deprivation of Liberty applications.

12. Medicines Management Update

It was agreed a written medicines management update report would be added to the

agenda for the Quality Committee meeting in June.

PW provided a verbal update on Sodium Valproate confirming primary care guidance was discussed at the Pharmacy and Medicine Optimisation meeting and work continued with EPUT to reflect the mental health element. The guidance would be distributed to all GPs to provide clarity on how patients could access support required.

Work was ongoing with opioids with regards to primary care support for patients dependent on opioids and related medications. Information had been received on a Primary Care Network who had utilised their Additional Roles Reimbursement Scheme (ARRS) funding and linked in with Open Road. The Executive Committee considered a paper on whether that model could provide wider support that could be rolled out to other parts of MSE. There had been a reduction on the number of people on high dose opioids.

Resolved: The Committee noted the verbal update on Sodium Valproate and Opioids Use.

13. Quality Impact Assessments Update

ES advised that the report provided an update on quarters 3 and 4.

Nine quality impact assessments (QIA) had been approved, the majority related to mergers and closures of primary care, and the remainder related to service provision.

VB advised that there was a draft national guidance on quality impact assessments which detailed how they would be managed in the future. The draft guidance requested that each QIA was reviewed by a multi-disciplinary panel, that QIAs were reviewed iteratively through the change process and 6-12 months after the change to understand the perception and reality of the impact.

Resolved: The Committee noted the Quality Impact Assessments update report.

14. Patient Safety & Quality Risks

SOC highlighted the following key points.

There were currently 27 risks within the remit of Quality Committee, which was a substantial increase due to changes in the Executive portfolios.

There were no outstanding updates and ongoing Datix support was provided to staff.

One new risk (ID 127) had been opened which related to CQC registration issue in relation to All Age Continuing Care.

One risk (ID 116) had been recommended for closure which related to the use of PEACE in the Mid and South Essex Integrated Care System.

The quality related Board Assurance Framework slides were appended to the report.

Two workshops had been held with regards to the assessment of complex and dynamic system risks, which had good attendance and engagement from system partners. The outcomes were being drafted and would be reported to a future Quality committee meeting.

Resolved: The Committee noted the Patient Safety and Quality Risk report and approved closure of risk ID 116 (Use of PEACE in Mid and South Essex Integrated Care System not in line with NHS England East of England Region).

15. Terms of Reference

15.1 Learning from Deaths Forum

The Learning from Deaths forum Terms of Reference was presented to the Committee for approval.

No comments were received.

Resolved: The Committee approved the Terms of Reference for the Learning from Deaths Forum.

16. Nursing and Quality Policies and Procedures:

16.1 Review of Nursing and Quality Policies:

The committee were asked for comments on the new Patient Choice Policy (Ref 005).

PW requested clarity on whether the policy was a guidance or a policy as the policy was written in an operational guidance format and patient choice was a national policy. An offline discussion would be held with EH.

SOC advised that policies should be high level and supported by guidance.

AW suggested that the policy should align with national requirements and supported with a Standard Operational Procedure (SOP).

The Patient Choice Policy and guidance document would be resubmitted to the committee for approval before being finalised.

Resolved: The committee requested that the Patient Choice Policy was presented at the committee meeting, following the suggested amendments by committee members.

16.2 Extension of existing policies

A review date extension was requested for the All Age Continuing care Policy (Ref 068) to June 2025.

Resolved: The committee approved extending the review date of the All Age Continuing Care Policy the Patient Choice Policy.

17. Review of Committee Effectiveness Update

SOC gave a verbal update on the progress of the review of committee effectiveness for Quality Committee.

A desk top review had been completed by the governance team, setting out the main objectives of the committee, attendance and items discussed during the year, which had been shared with the Chair and Executive Lead. A short online survey, with the desktop

review, terms of reference and committee attendance, would be sent to committee members and attendees to complete. Any feedback would be considered in the final assessment report.

NIB urged committee members and attendees to provide feedback and complete the survey.

Resolved: The committee noted the verbal update on the review of committee effectiveness.

18. Discussion, Escalations to ICB Board and agreement on next deep dive.

18.1 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.

18.2 Agreement on next deep dive

NIB confirmed that the deep dive for the June meeting was a continuation of the maternity deep dive presented at this meeting.

SP suggested that the deep dive should include preterm mortality.

MS suggested highlighting the top three actions or headlines so could be easily recalled in further meetings or with other colleagues. Detail of the five years within the MSSP and how this could be exited should be included as was a national concern. Detail should be explained as not all committee members would have knowledge in this area. GH advised that the points made were valid and the report was a compromise between balancing data with the operational side at ground level. The challenge was choosing a focused key area. The format of the next report could be focused more on perinatal mortality, as the deep dive presented today gave oversight into the other areas. The summary on the next report could concentrate on those important areas of concern from the MSSP following today's meeting.

19. Any Other Business, including discussion on effectiveness of meeting

NIB noted that the meeting had held a balanced discussion with good participation.

SP advised that the dentistry report was taken to the last Board meeting and was positively received.

There were no further items of any other business raised.

20. Date of Next Meeting

Friday, 27 June 2025 at 10.00 am to 1.00 pm via MS Teams.

Minutes of People Board Committee Meeting

Held on 1st May at 11:00am

via Microsoft Teams

Attendees

Members

- Joe Fielder (JF), Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB) – Chair
- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB
- Andrew McMenemy (AMc), Chief People Officer, Essex Partnership University NHS Foundation Trust (EPUT)
- Lee Brown (LB), Deputy Chief People Officer, Mid and South Essex NHS Foundation Trust (MSEFT) – *Deputy for Selina Dundas and Lorraine Hammond Di-Rosa*
- Siobhan Morrison (SM), Group Chief People Officer, Provide CIC
- Anna Davey (AD), ICB Partner Member (Primary Care), MSE ICB
- Viv Barker (VB), Director of Nursing, MSE ICB – *Deputy for Giles Thorpe*
- Eileen Marshall (EM), Chief Executive, St Luke's Hospice, Hospice Representative

Other attendees

- Rachel Sestak (RS), Head of Systems Workforce, MSE ICB
- Sharon McDonald (SMcD), Head of Systems Workforce, MSE ICB
- Amy Evans (AE), Business Manager, MSE ICB – Secretariat (minutes)
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB
- Fiona Wilson (FW), People Business Partner, Essex County Council
- Kathryn Perry (KP), Head of Primary Care Workforce, MSE ICB
- Lee Mummery (LM), Head of Eastern Region, Skills for Care
- Ru Watkins (RW), Chief Executive, Hamelin Trust
- Grace Osborne (GO), Director of People and Corporate Services, Hamelin Trust
- Jenni Aylen (JA), Director of People and Change, Essex Cares Limited

Apologies

- Lorraine Hammond Di-Rosa (LHD), Director of Culture & OD, MSEFT
- Di Sarkar (DS), Chief Nursing & Quality Officer, MSEFT
- Selina Dundas (SD), Chief People & Organisational Development Officer, MSEFT
- Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB
- Sarah Crane (SC), Associate Medical Director for Development, MSE ICB

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. Introductions were made for new attendees.

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 6th March 2025 were received and the group approved as an accurate record.

Outcome: The minutes of the meeting held on 6th March 2025 were approved as an accurate record.

The action log was reviewed and updated.

4. Presentations on Workforce Challenges

i. Skills for Care – Social Care

LM from Skills for Care presented on the National Workforce Strategy for Adult Social Care. The strategy has been developed by key stakeholders from across the health and care sectors. It contains commitments and recommendations to government and health and care stakeholders to deliver change for the social care sector and to support the integration of health and care systems. LM provided an overview and shared updates relating to how health and care systems across the region and country are supporting implementation of the strategy.

ii. Hospice Sector

EM presented to the group on behalf of St. Luke's Hospice, Havens Hospices, Saint Francis Hospice and Farleigh Hospice. The presentation outlined the primary challenges facing the Hospices at present, including recruitment, alignment of Agenda for Change (AfC) and Terms and Conditions and national skill shortages.

iii. Charity Sector – Hamelin Trust

RW presented a proposal for model to building an integrated approach to a social and

health care workforce. The presentation covered how the model could be implemented and in what ways it would benefit health and social care. RW confirmed the model is scaleable and can be progressed quickly if required.

Action: JC, SM and RS to follow up with RW regarding the potential of implementation.

5. Medium Term Plan Update

JC gave an update to the group regarding the Medium Term Plan (MTP). Generated from continued challenges with performance, finance, quality and workforce within Mid and South Essex and MSEFT entering NOF4, the highest level of system oversight as part of the exit criteria. The MTP identifies £150 million in savings and vast amounts of improvements in the outcomes patients and residents will experience over a 5 year period. In the process of implementing 7 strategic change programmes and have identified Executive Leads and SROs for each, who will look at the initial work programmes and look at how to make realtistic and achievable savings. AMc is the Executive Lead on the Supporting Services programme alongside Jen Kearton, who will have oversight of any identified workforce implications arising from the MTP and making connections between system partners. A strategic intent has been issued to providers which can be shared with any members of the group if required, which sets out the intention for the first year of the MTP. AMc added that the meeting was very positive and the group want to ensure there are practical solutions identified rather than aspirations. AMc would like the People Board to have an item on an upcoming agenda to look at plans, reflect on progress and invites challenge to develop plans moving forward. JF was keen to hear from Primary Care representatives, AD stated that there are issues with where investment sits in Primary care in terms of new workforce, and most all new staff into General Practice in the last 5 years has come in in via Primary Care Networks (PCNs), who have their own issues to tackle. KP added concerns around the future of training hubs with the pending changes.

6. People Board Risk Report

JF thanked NA for the work put into refreshing and cleaning up the Risk Report by working with colleagues with the Governance Team. NA shared that whilst working with KB on the report, a number of risks seemed duplicative and therefore have been reviewed and suggested the closure of Risk 4 and 56, due to being covered by others on the report. The main People Board owned risks are expansion of clinical workforce, reducing headcount and reduction of use of bank and agency, therefore improvement of recruitment and retention. The risks are red rated which translate into a risk which sits on the Board Assurance Framework, which Board will have oversight of. The Board should be assured that the People Board are addressing the risks via workstreams. NA confirmed a conversation with GT who was happy to close the duplicate risks as per a previous concern. JF was pleased to see the refreshed report and thankful People Board members are alert and aware of the risks, despite currently being red rated. JF appealed to all members to stay diligent regarding any risks.

7. Highlight Reports from Workstream Chairs

The reports for Clinical Capacity Expansion Education Innovation Workstream (CCEI), Colleague Engagement, Wellbeing and Retention (CEWR) and Culture were taken as read by the group.

Outcome: Members noted the reports.

8. Any Other Business

JA asked that anyone wanting to have a conversation around displaced international workers to make contact, as ECL are currently running a pilot and would be grateful for any shared knowledge. RSe stated she would make contact as they are doing work around AHPs which may be relevant.

9. Items to Escalate

No items to escalate.

10. Date of Next Meeting

3rd July 2025, 11:00 – 13:00 – In person

Part I System Oversight & Assurance Committee (SOAC)

Minutes of Part I meeting held 25 April 2025 at 1.00 pm to 2.30 am via Teams

Attendees

Members

- Jennifer Kearton (JK), Chief Finance Officer, MSE ICB (chaired committee on behalf of Tom Abell)
- Matthew Hopkins, (MH), Chief Executive, Mid and South Essex NHS Foundation Trust (MSEFT).
- Zoe Pietrzak, (ZP), Regional Director of Finance, NHS England (East of England).
- Simon Wood (SW), Regional Director for Strategy & Transformation, East of England, NHS England.
- Paul Scott (PS), Chief Executive, Essex Partnership University NHS Trust (EPUT).
- Sam Goldberg (SG), Executive Director of Performance and Planning, MSE ICB.

Other Attendees

- Lucy Wightman, Chief Executive Officer Provide, CIC.
- Rebecca Boyes, Provide CIC.
- James Wilson, Community Collaborative.
- Pam Green, Alliance Director, Basildon and Brentwood and ICB Primary Care Lead
- Alfie Bandakpara-Taylor (ABT), Deputy Director Mental Health, LD, Spec Comm
- John Walter (JW), Director of Operations - All Age Continuing Care, MSE ICB (attending on behalf of Dr G Thorpe) – present for items 1 to 8.
- Fiona Ryan (FR), Director of operations CG1 – Local Services and MSE Specialist Medicine, MSEFT.
- Sara O'Connor (SO), Senior Manager Corporate Services, MSE ICB.

Apologies Received

- Tom Abell (TA), Chief Executive and Committee Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB.
- Dan Doherty (DD), Alliance Director Mid Essex, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Dawn Scrafield (DS), Chief Finance Officer, MSEFT.
- Rebecca Jarvis (RJ), Alliance Director South East Essex.

1. Welcome and Apologies (presented by J Kearton)

JK welcomed everyone to the meeting. It was confirmed the meeting was quorate. Apologies were noted as above.

2. Declarations of Interest (presented by J Kearton)

JK noted 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 raised.

3. Minutes (presented by J Kearton)

The minutes of the last SOAC meeting held on 28 February 2025 were reviewed and approved with no amendments requested.

Outcome: The minutes of the committee meeting held on 28 February 2025 were approved.

4. Action log and Matters Arising (presented by J Kearton)

The following updates were provided on outstanding actions:

- **Action 194:** JK advised that she planned to bring an update on progress with Investigation and Intervention (I&I) actions to the June P1 SOAC meeting.

- **Action 201:** JK advised that she had received an update from Aleks Mecan (AM) which would close this and action 204 below. AM had regularly met with Julie Smith, the new lead for Community Diagnostic Centres, and envisaged that once the System Diagnostics Board met on 19 May, an update which would include workforce and GP procurement issues, would be brought to SOAC in June 2025. Action closed.

- **Action 204:** See action 201 above. Action closed.

- **Action 205:** Caroline Baker had circulated an updated information pack on the outpatients programme / clinical utilisation via her email dated 24 April 2025.

Outcome: Members noted the updates on the action log.

5. Financial Recovery (presented by J Kearton)

JK advised that draft financial plans had been submitted and that the overall system deficit, pre-audit, was £16 million, consisting of £6 million from MSEFT and £10 million from EPUT.

Resolved: The committee noted the verbal finance update.

6. Deep Dive – Mental Health (presented by A Bandakpara-Taylor)

ABT shared a presentation on mental health (MH) services across mid and south Essex (MSE) which focussed on delivery of the Joint Forward Plan, Southend, Essex and Thurrock (SET) Mental Health Strategy, Medium Term Plan (MTP and the Long Term Plan (LTP).

ABT noted that some quality and contract indicators, including serious mental illness (SMI) health checks and out of area (OOA) placements, were currently sub-optimal. There were also continuing challenges relating to the wider multi-disciplinary team (MDT) pathway, autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) demand and capacity, and with regard to the right to choose. ABT highlighted the key MH risks currently on the ICB's risk register.

Transformation of MH services was supported by collaborating with local authority partners and the voluntary, community and social enterprise (VCSE) sector and alignment with the work of Primary Care Networks (PCNs) and Integrated Neighbourhood Teams (INTs).

There were some long waits currently experienced by patients between their first and second appointment for Talking Therapies, with South East Essex having the longest delay (66% of patients waiting 90+ days) against a standard of just below 10%, although other areas within MSE were performing better. There were circa 29 patients currently placed OOA.

On average over 50% of people were in recovery which was slightly above standard, with 69.8% moving into the group of reliable improvement. Thurrock had the largest group of recovery and the South East the lowest, with ongoing action in place to improve this.

Within primary care, there were differences in the percentage of those with a SMI receiving health checks, with Southend achieving the highest percentage and Mid Essex the lowest. Several PCNs were being targeted to improve delivery.

There had been a significant increase in open referrals to community MH services and this warranted further investigation via Community First work. There was a focus on preventing individuals experiencing a MH crisis.

Slide 14 of the presentation summarised what the analysis of data meant for MSE residents, and slide 15 noted current risks and system challenges including concerns raised by primary and secondary care colleague, including poor patient flow leading to long lengths of stay and OOA placements. ABT highlighted that quality improvements were necessary to ensure services were outcome focussed.

There were different arrangements across Alliance for provision of NHS Talking Therapies, with an ambition to address variations in the offer going forward.

Slides 18 and 19 summarised opportunities being explored for improvement and slide 20 highlighted several challenges being escalated to SOAC relating to data quality issues.

JK thanked ABT for the presentation and asked members if they had any queries.

PS advised that he was aware that many other systems were facing similar challenges to MSE with regard to MH service provision. There had already been a significant amount of investment into MH services to mitigate the severest areas of risk and it needed to be asked at what point could the system say the level of risk had actually reduced, although it was acknowledged further work was currently required. PS welcomed work being undertaken to consolidate services and to be clearer about services available, as it was vital partner organisations worked collaboratively to support people to stay well.

PS queried the national data relating to Talking Therapies and asked for this to be checked as he believed that performance was not that poor in South East Essex.

JK suggested it would be beneficial to analyse long term demand in more detail. PS agreed, particularly to understand potential future demand for children's MH services which would inevitably impact upon future demand for adult MH services.

PG advised there was a clear intent to align services with PCNs. Pilot work was undertaken in Basildon and Brentwood Alliance to see how the model of caseload management could be changed, how INTs were used, and how to improve housing which was critical to stabilising people's anxiety to enable them to thrive. In B&B, the population cohort exerting the most pressure on primary care was patients aged 15 – 45 years with a MH coding, who created significant levels of demand within primary care. Solving this could not occur via prescribing alone and required addressing the wider determinants of health, so it was necessary to align statutory services to support this. PG asked ABT if there was an opportunity to completely

redesign services on a much bigger footprint and if so, what was necessary, including support from wider teams, to do that.

ABT advised that PS invited him to an internal EPUT meeting regarding the MTP and Community First transformation work and subsequently agreed an approach to alignment with primary care. It was clear transformation must be clinically led, and those conversations had commenced. The LTP and delivery against it enabled organisations to look at the wider picture to deliver a reset of community transformation work to ensure it aligned to wider local needs via PCNs and INTs. PG offered the support of the ICB's primary care team and the GP Provider Collaborative (GPPC) to progress this work.

JK noted that as EPUT currently provided services across several ICBs there should be ample opportunity to learn what worked well from each area.

SG advised that it would be helpful if all MH metrics could be made available in one place. ABT confirmed that he and James Buschor (JB), Head of Assurance and Analytics had already worked on this. The data presented reflected Operational Plan requirements which JB reported on a monthly basis. SG asked ABT to ensure that the availability of metrics in one place had definitely been implemented.

In response to a query from SW, PS advised there had been no in-patient suicides on EPUT's Basildon site during the past few years, although there had been cases on the acute hospital site. Across the whole of EPUT, there had been no inpatient deaths for circa two-plus years and he was therefore confident that several investments made by the Trust had positively impacted on patient safety, although further work was required. PS also explained there was no clear evidence that suicides in the community were increasing, although there had been some volatility in some areas.

SW noted that ABT had outlined the current challenges to MH services and invited him to use this opportunity to highlight to those senior leaders present any further support that was required.

JK suggested that a focus on improving data was required, particularly as challenges in responding to Rule 9 requests for the Lampard Inquiry had been identified.

JK also noted the presentation highlighted significant workforce challenges and plans to establish a workforce sub-group, and suggested colleagues should consider if the sub-group should report to People Board and how Chief People Officers of partner organisations should be involved.

Resolved: The committee noted the Mental Health Services deep dive presentation.

- **Action 208:** ABT to check performance data relating to Talking Therapies, particularly in South East Essex, is accurate.

- **Action 209:** ABT to liaise with James Buschor to check that mental health performance metrics are available in one place.

7. MSEFT / EPUT – Care of Mental Health Patients in Hospital (presented by A Bandakpara-Taylor)

ABT advised he understood the request for an update and assurance to be provided to the committee related to the ongoing review of the psychiatric liaison provision in Basildon Hospital and whether it was Core 24 compliant, which he understood had been confirmed by NHSE, although meetings had occurred to review psychiatric liaison provision in totality. Subsequent

meetings would review the relevant action plan, and conversations had occurred between MSEFT, EPUT and the ICB to look at the wider commissioning of this service.

MH clarified that concerns had been raised regarding psychiatric liaison from all three acute hospital sites. MH asked ABT to share benchmarking information with committee members as he anticipated the experience of MSEFT staff was somewhat different to full compliance with Core 24.

Resolved: The committee noted the update on care of MH patients in Hospital.

- **Action 210:** ABT to share benchmarking information regarding psychiatric liaison provision with SOAC members.

8. This item has been minuted confidentially

9. Update on Elective / Cancer Recovery Plan (presented by F Ryan)

FR advised that a revised submission which would drive expectations regarding cancer and elective recovery expectations had been finalised. The final cancer submission was as per the original version, with additional activity committed for elective pathways that would see MSEFT deliver an additional 17,000 units of activity to enable it to address 65+ week waits by the end of Q1. FR provided a summary of other work undertaken to improve performance, including addressing the use of temporary staffing.

JK outlined work that was being undertaken to address non-recurrent funding and confirmed she and SG would have a clear focus during Q2 on demand management. In addition, SG had reached out to Trust colleagues regarding holding quarterly deep dives at the ICB's Finance & Performance Committee.

JK extended her thanks to everyone involved in finalising the submission.

Resolved: The committee noted the update on the Elective / Cancer Recovery Plan.

10. Update on Community Waiting Lists (Presented by L Wightman and J Wilson)

JW advised that in terms of the adults' community waits position, data showed this had been relatively stable over the past two years, with no extreme waits since 2022 and currently zero 52 week weeks, however, there were currently 7 waits over 40 weeks. JW provided an overview of performance within the report and confirmed that data had been cleansed resulting in greater confidence in performance metrics. Year on year referrals were increasing significantly and outstripped capacity. The biggest area of risk related to over 8,500 patients waiting over 52 weeks since their last follow-up review, which was circa 45% of patients not on the RTT caseload, which would be focussed upon. The current model was not sustainable and would need to move to a needs-based approach.

SW advised he would like to be clear on the timeline for the collaborative to come back with proposals as to how it would change the model and by when. Also, as one of the collaborative's key objectives was to reduce variation, SW was concerned that the projected waiting lists for children showed significant variation in waits across different areas, and asked how waiting lists could be balanced for the benefit of the overall population.

JW confirmed he was working with GT and Clare Angell, Deputy Director BCYP, SEND, Specialised Commissioning, in this regard.

LW advised that learning had been taken from North East London Foundation NHS Trust as to how they had managed to keep on top of children's waiting lists, although further work was required across the collaborative to change some practices.

SW requested a further update, including action to reduce variation across MSE in the short and longer term, was provided at the next meeting, and advised the ICB, working collaboratively with providers, should drive and insist on these changes.

Resolved: The committee noted the update on community waiting lists.

- **Action 211:** LW/JW to provide a further update report regarding community waiting lists, including action to reduce variation across MSE in the short and longer term, at the June SOAC meeting.

11. Committee Escalations to SOAC / Triangulation (presented by J Kearton)

7.1. ICB Main Committees

JK confirmed there were no escalations from ICB main committees to SOAC.

7.2 Other Committees/Forums

JK confirmed there were no escalations from other forums to SOAC.

Resolved: The committee noted that no escalations to SOAC had been received.

12. Escalations from SOAC (presented by J Kearton)

8.1 SOAC to ICB / provider Boards

No escalations to the ICB or provider Boards were identified.

8.2 Provider Board escalations to ICB Board

No escalations from provider Boards were received.

8.3 SOAC to Chief Executives' Forum (CEF)

No escalations from SOAC to the CEF were identified.

Resolved: The committee noted the position regarding escalations from SOAC to other forums.

13. Review of Committee Effectiveness 2024/25 – update on process (presented by J Kearton)

JK advised that SO had circulated the desktop review of the committee's effectiveness and a link to an online survey seeking members views on the committee, which would remain live until the end of the month. JK also mentioned that she intended providing some comments on the revised committee terms of reference.

Resolved: The committee noted the verbal update on the annual review of committee effectiveness 2024/25.

14. Review of Effectiveness of this Meeting (presented by J Kearton)

JK asked members for their views on the effectiveness of this meeting. No comments were received.

15. Any Other Business

No other business was discussed.

16. Date of Next Part I SOAC Meeting

Friday, 27 June 2025, 1.30 to 2.30 pm, via MS Teams.

Part I Board Meeting, 17 July 2025

Agenda Number: 13.6

Amendment to the ICB Constitution

Summary Report

1. Purpose of Report

NHS England has mandated clustering ICBs to make changes to section 3.5 (Chief Executive Officer) of their constitution.

The changes will mean the following addition to section 3.5.4 (in bold):

3.5.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

b) Subject to clause 3.5.3(a), they hold any other employment or executive role **other than chief executive of another Integrated Care Board (ICB).**

This paper is to update the Board that the mandated changes will be finalised and implemented following this meeting and the updated version uploaded to the ICB website.

As these changes are mandated by NHS England, they will not require formal approval and it is for the Board to note the changes.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nurse

3. Report Author

Tonino Cook, Executive Business Manager

4. Responsible Committees

N/A

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

N/A

7. Financial Implications

N/A

8. Details of patient or public engagement or consultation

N/A

9. Conflicts of Interest

None Identified

10. Recommendation/s

The Board are asked to NOTE the mandated changes to the ICB's Constitution by NHS England.

Part I ICB Board Meeting, 17 July 2025

Agenda Number: 13.7

Corporate Objectives and Risk Appetite

Summary Report

1. Purpose of Report

To present for ratification the proposed ICB Corporate Objectives and Risk Appetite Statement for 2025/26.

2. Executive Lead

Tom Abell, Chief Executive Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The ICB Board has responsibility for setting the organisations Corporate Objectives and Risk Appetite.

5. Impact Assessments / Financial Implications / Public Engagement

Not applicable to this report.

6. Conflicts of Interest

None identified.

7. Recommendation(s)

The Board is asked to approve the ICB Corporate Objectives and Risk Appetite Statement for 2025/26.

Corporate Objectives and Risk Appetite

1. Introduction

As an NHS organisation, the ICB is responsible for setting out how it intends to deliver the objectives set out within the Integrated Care Strategy (ICS) (established by the Integrated Care Partnership (ICP)) alongside its duties as set out within the Health and Social Care Act.

The ICB approved the refreshed Joint Forward Plan in 2025 that sets the strategic ambition of the ICB and details the work it intends to undertake over the next five years.

Each year the ICB will set its corporate objectives as the foundation of planning for the year ahead.

Upon establishing those objectives, the Board will consider its appetite for risk, in order to provide a framework to make informed planning and management decisions to ensure that the ICB is not exposed to risks that cannot be tolerated, or that they do not take an overly cautious approach which could stifle innovation.

Risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain, or take in pursuit of its corporate objectives. It represents risk optimisation - a balance between the potential benefits of innovation and the threats that change inevitably brings (recognising that most risks cannot be eliminated).

2. Main content of Report

Corporate Objectives

At the Board seminar on 15 May 2025, the Board considered its corporate objectives. It was noted that the objectives would cement the priorities of the Board and enable reporting on their achievement and any challenges. The Board acknowledged that they would be used to map organisational risks, framing the Board Assurance Framework and guiding the work of sub-committees and how the Executive reports to the Board.

The Board agreed that the objectives should reflect national priorities (the core purpose of an integrated care system), locally agreed plans (set out within the ICP strategy and Joint Forward Plan) and priorities for the year ahead, as well as being mindful of the significant changes ICBs are navigating. In principle the objectives should be succinct and specific, limited in number and easily recognisable to staff, partners, and stakeholders.

The proposed corporate objectives are set out below in section 3.

Risk Appetite Statement

The Board also considered its appetite for and tolerance levels for risk at the seminar on 15 May. Using the Good Governance Institute Risk Appetite Maturity Matrix the Board considered its appetite for financial, regulatory, quality, reputational and people risks; in the context of its appetite in the previous year and the circumstances for the ICB and wider NHS e.g. financial sustainability, pending organisational change and significant staff reductions.

Consequently, the proposed risk appetite statement of the ICB Board is set out below in section 3.

3. Findings/Conclusion

Corporate Objectives

The proposed corporate objectives for consideration and approval of the Board are:

1. Through strict budget management and good decision making, the ICB plans and purchases sustainable services for its population and manages any associated risks of doing so within the financial position agreed with NHS England.
2. Being assured that the healthcare services we strategically commission for our diverse populations are safe and effective, using robust data and insight, and by holding ourselves and partners accountable.
3. Achieve the objectives of year one of the ICB Medium Term (5 year) Plan to improve access to services and patient outcomes, by effectively working with partners as defined by the constitutional standards and operational planning guidance.
4. To strengthen our role as a strategic commissioner and system leader by using data and clinical insight to make decisions that improve patient outcomes, reduce health inequalities, and deliver joined-up care through meaningful collaboration with partners and communities.
5. Through compassionate and inclusive leadership, consistent engagement and following principles of good governance, deliver the organisational changes required, whilst ensuring staff are supported through the change process and maintaining business as usual services.

Risk Appetite

The proposed risk appetite statement for approval of the Board is:

Risk Type	ICB Risk Appetite Level
Financial How will we use our resources? Current: **3 (Open)** Ambition: **4 (Seek)**	The financial risk appetite reflects the position of the ICB as it will be required to lead on making several difficult decisions in the coming year to deliver the financial targets set for both the ICB and wider system health partners and to achieve the financial cost savings required of ICBs. The Board is prepared to accept some financial risk if appropriate controls are in place and acknowledges that the functions of the ICB will shift over the course of the year. The ICB has a holistic understanding of value for money (VFM) with price not being the overriding factor. However, where it is appropriate to do so, the Board will invest for the best possible return and accept the possibility of increased financial risk in line with its ambition for greater risk appetite.
Regulatory How will we be perceived by	The Board recognises the complex and sometimes conflicting requirements of different regulators, or different functions within a single regulator. While the ICB remains committed to full compliance,

Risk Type	ICB Risk Appetite Level
our regulator(s)? <u>Current:</u> **4 (Seek)**	our risk appetite has evolved from cautious to open, with an ambition to develop a seeking posture over time. The ICB will continue to engage early and transparently with regulators, especially when making decisions that may challenge conventional interpretations of regulatory expectations. The Board is prepared to accept a degree of regulatory challenge where there is a sound evidence base, alignment with national strategy, and demonstrable benefit to patients and the wider system. Where appropriate, we will learn from innovation and precedent across the NHS and beyond. As part of our strategic ambition, we aim to work with regulators not only to comply, but to influence, shape, and support the evolution of the regulatory environment to enable better outcomes, greater equity, and system-wide transformation.
Quality How will we deliver safe services? <u>Current:</u> **4 (Seek)**	The Board has a seeking appetite for quality risk, reflecting its commitment to deliver outstanding care, reduce inequalities, and lead innovation across the system. The Board is willing to accept higher levels of quality-related risk where this supports transformation, equity, and longer-term improvements in patient outcomes and experience. The Board recognises that increasing financial pressures present challenges to sustaining and improving quality. However, the Board will continue to support bold, evidence-based innovation—particularly where it offers both quality gains and better use of collective resources. We will prioritise high-impact opportunities that align with our duty to maintain financial stewardship, while remaining focused on improving care for our population. Our approach will be to lead transformation through collaborative design, evaluation, and learning—using innovation to enhance value, not just cost, and ensuring any trade-offs are carefully considered and transparently managed.
Reputational How will we be perceived by the public and our partners? <u>Current:</u> **4 (Seek)**	With the challenging environment the ICB operates in, it is understandable that it will be forced to take decisions that the public or partners may find challenging. However, the Board will always make those decisions having engaged with members of the public and having completed assessments to manage any potential impact to residents. The Board is willing to take decisions that are likely to bring about scrutiny of the organisation and will outwardly promote new ideas and innovations where potential benefits outweigh the risks, following rigorous assessment.
People	The Board has a seeking appetite for workforce risk and is committed to shaping a skilled, flexible, and future-ready workforce that can

Risk Type	ICB Risk Appetite Level
How will we be perceived by our staff? Current: **4 (Seek)** Tolerance: **5 (Significant)**	meet the changing needs of our population. While we recognise the difficult journey that our staff have experienced since the ICB's inception—and the profound impact of the current staff reduction programme—we remain resolute in our commitment to staff wellbeing, engagement, and development. The Board is prepared to take bold and proactive decisions that may carry significant short-term workforce risk, particularly where these are required to support long-term transformation, workforce sustainability, or improvements in recruitment, retention, and capability. Innovation and redesign are likely to bring disruption, but we believe that, when thoughtfully managed and co-produced, they also offer opportunity—for our staff to grow, for our teams to evolve, and for our organisation to become a workplace of choice. We will ensure risks are openly communicated, well-governed, and balanced with our duty of care as an employer and system leader.

4. Recommendation

The Board is asked to approve the ICB Corporate Objectives and Risk Appetite Statement for 2025/26.