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, 18 September 2025 at 2.00 pm – 3.30 pm

Committee Room 4a, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, Essex SS2 6ER

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	Approval of Minutes of previous Part I meeting held 17 July 2025.	Approve	Attached	Prof. M Thorne	7
5.	2.13 pm	Matters arising (not on agenda)	Note	Verbal	Prof. M Thorne	-
6.	2.14 pm	Review of Action Log	Note	Attached	Prof. M Thorne	19
		Items for Decision / Non-Standing Items				
7.	2.15 pm	Lampard Inquiry Update	Note	Atached	Dr M Sweeting	20
8.	2.20 pm	Winter 2025/26 Assurance Framework	Approve	Attached	S Goldberg	27
9.	2.40 pm	Quarterly Communications Performance Report	Note	Attached	T Abell C Hankey	136
		Standing Items				
10.	2.50 pm	Chief Executive's Report	Note	Attached	T Abell	156
11.	3.00 pm	Quality Report	Note	Attached	Dr G Thorpe	161
12.	3.10 pm	Finance & Performance Report	Note	Attached	J Kearton	166
13.	3.20 pm	Primary Care and Alliance Report.	Note	Attached	P Green D Doherty R Jarvis A Mecan	178

No	Time	Title	Action	Papers	Lead / Presenter	Page No
14.	3.25 pm	General Governance:				
		14.1 Board Assurance Framework	Note	Attached	T Abell	185
		14.2 Revised Constitution and Executive Committee Terms of Reference	Approve	Attached	Prof. M Thorne	200
		14.3 Review of Board effectiveness 2024/25	Note	Attached	Prof. M Thorne	253
		14.4 New and Revised Policies	Note	Attached	Prof. M Thorne	269
		14.5 Approved Committee minutes	Note	Attached	Prof. M Thorne	272
15.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
16.	3.30 pm	Date and time of next Part I Board meeting: **To be confirmed.**	Note	Verbal	Prof. M Thorne	-

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - September 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	Cera	x			Indirect	Son (Alfred) employed as Head of Revenue and Operations.	Jan 2023	Ongoing	No conflict of interest is anticipated, but declared for completeness and should Cera be considered within the system appropriate arrangements will be 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.

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - September 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
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								Nil
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
George	Wood	Non-Executive ICB Board Member	Nil								

AGENDA ITEM 2

Mid and South Essex Integrated Care Board - Register of Interests of Regular Attendees at Board meetings - September 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.
Joanne	Cripps	Executive Director of System Recovery	Thrive Health Hubs			x	Indirect	Family member employed by Thrive Health Hubs	July 2025	Ongoing	No conflict is anticipated. However, I will keep any related information confidential and will not be involved in any decision-making with regards to this organisation.
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.
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.

Mid and South Essex Integrated Care Board - Register of Interests of Regular Attendees at Board meetings - September 2025

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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.

Minutes of the Part I ICB Board Meeting

Held on Thursday, 17 July 2025 at 1.00pm – 4.00pm

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

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.
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Sarah Muckle (SMu), Partner Member, Essex County Council.
- Robert Persey (RP), Partner Member, Thurrock Council.
- Dr Anna Davey (AD), Partner Member, Primary Care Services.

Other attendees

- Dr Geoffrey Ocen (GO), 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.
- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- Emma Richardson (ER), Director of Commissioning, (representing Mark Harvey, Partner Member, Southend City Council).
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Helen Garvey (HG), Essex Neurological Rehabilitation Lead, MSE ICB.
- Kate Butcher (KB), Deputy Alliance Director (Mid Essex), MSE ICB.
- Anna Bokobza (AB), Director of Strategy, EPUT.
- James Sharp (JS), Specialist Communications Manager, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Barry Frostick (BF), Executive Chief Digital and Information Officer, MSE ICB.
- Siobhan Morrison (SMo), Interim Chief People Officer, MSE ICB.

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

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

MT apologised for technical issues experienced with the livestream of the last meeting, held on 15 May 2025, which were partly due to issues with the YouTube channel. Consequently, as well as being livestreamed, this meeting would also be recorded separately so the whole meeting would be publicly available if technical difficulties arose again.

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.

HG declared an interest in relation to Item 7, Neurological Services Update as a member of the Neurology Network.

Declarations of Interest were provided within the report for Item 3, Community Hospital Services, as detailed below:

MSEICB Board members:

- Paul Scott, Partner Member, Chief Executive of Essex Partnership University Foundation Trust (EPUT).
- Matthew Hopkins, Partner Member, Chief Executive of Mid and South Essex NHS Foundation Trust (MSEFT).

MSEICB Executive Team Members:

- Daniel Doherty, Alliance Director for Mid Essex Alliance.

No other declarations were made.

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

3. Community Hospital Services Decision Making Business Case (presented by T Abell, K Butcher and C Hankey)

The Board noted early engagement with Maldon residents regarding community hospital services, which informed future consultation processes. The Community Consultation Working Group (CCWG) was thanked for its contributions.

Three decisions were considered:

- The future location and configuration of community intermediate care (IMC) beds and the stroke rehabilitation beds in MSE.
- The future location of the freestanding midwife-led birthing services in MSE.
- The future of ambulatory care services provided at St Peters Hospital (SPH) in Maldon.

In October 2023, changes were made to community beds to improve safety and effectiveness during winter 2023/24. This included the closure of 16 stroke beds at SPH and their replacement with 25 beds at Brentwood Community Hospital. Six IMC beds at Cumberledge Intermediate Care Centre (CICC) in Rochford were repurposed for stroke rehabilitation. These changes were prompted by estate concerns at SPH, including lift safety and flooding risks.

A public consultation was held from January to April 2024, supported by a Pre-Consultation Business Case (PCBC) approved by NHS England (NHSE). Following feedback, the ICB Board paused the decision-making in September 2024 and established the CCWG. Final recommendations were informed by scoring, clinical and financial reviews, Equality and Health Inequality Impact Assessments (EHIIAs), Quality Impact Assessments (QIAs), and external reviews.

KB confirmed that the Decision Making Business Case (DMBC) was developed collaboratively and enabled evidence-based decisions. It included public consultation feedback analysis, CCWG recommendations, proposed options, impact assessments, and implementation plans.

KB summarised the proposals consulted on as detailed in the presentation. Evaluation was structured across four key domains, each with defined subdomains. These included demand and capacity, service provision to meet current and future patient needs; delivery of high-quality care aligned with local and national guidance in a safe environment with a sustainable workforce and a review of estate to ensure affordability and value for money.

CH advised that over 5,500 survey responses and 1,000 face-to-dace engagements were received including one hosted by Sir John Whittingdale, MP for Maldon. Feedback was independently analysed and presented to the Board in July 2024.

Five key themes emerged: strategy, clinical models, workforce, estate/travel; and access. The CCWG, independently chaired by James Halden, included representation from NHSE, Healthwatch, local councillors, and campaign groups.

Final recommendations presented to the ICB Board in May 2025 included:

- Retaining SPH for five years while seeking capital funding for a new facility.
- Acknowledging low viability of inpatient services in Maldon.

- Support Option B for stroke rehabilitation and IMC beds, preserving access for Southend.
- Retaining antenatal/post-natal care at SPH and relocating the midwife led birthing unit to William Julien Courtauld (WJC), Braintree.

The proposals passed NHS reconfiguration and financial sustainability tests, with mitigations in place for identified risks. A new community committee was proposed for oversight.

TA directed the Board to consider whether the proposals improved access and safety, the ICB duty to engage was met, risks were effectively mitigated and whether proposals were fair, equitable and aligned with NHSE strategic priorities.

KB outlined that option B was preferred for stroke and IMC beds due to safety, capacity, equity, and alignment with estate strategy. It included split stroke units at Brentwood and Rochford and 66 IMC beds across Mountnessing Court, Thurrock and Halstead. The stroke ward at SPH would close permanently. It was noted that while option A scored higher due to the financial impact; option B scored higher on quality and the strategic fit. The integrated impact assessment (IIA) was neutral, and mitigations were outlined in the DMBC where potential negative impacts were identified.

The freestanding midwife-led birthing unit would relocate unit to WJC, which offered safety, accessibility, and sufficient capacity. Antenatal and postnatal care would remain in Maldon. The IIA showed mainly positive or neutral impacts, with mitigations in place for any negative impacts.

Ambulatory care services would be retained at SPH for up to five years. Estate issues limited long-term viability, but short-term optimisation measures were planned, including essential maintenance led by MSEFT's Chief Executive to ensure continued safe service provision. A long-term plan for a new health hub was committed within five years.

Implementation would be monitored, with staff engagement and a new community group in Maldon overseeing service delivery.

The Board acknowledged the ageing population, declining birth rates, and increasing maternity care complexity. Assurance was given on regular site maintenance at SPH. Staff were encouraged to raise concerns regarding care quality and environment.

The Board discussed future development of a neighbourhood health hub in Maldon, aligned with the NHS 10-year plan. Opportunities to repurpose underutilised estate across MSE were noted.

Following questions from Board members and further discussion, the need for clearer communication and earlier planning was noted.

MS welcomed clarity for staff and residents and the shift toward out-of-hospital care and noted JFs suggestion for a pro-active approach for underutilised estate.

Resolved: The Board approved/agreed:

- **The implementation of Option B for the location and configuration of community intermediate care and stroke rehabilitation beds.**
- **The permanent relocation of the freestanding midwife-led birthing unit from St Peter's Hospital, Maldon to the William Julien Courtauld (WJC) Unit,**

Braintree.

- **To sustain the current ambulatory care services, listed in the Decision Making Business Case, for up to five years, whilst a long-term solution for a Maldon Health Hub/replacement for St Peter's Hospital was developed and delivered.**

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

MT noted questions had been submitted by members of the public, as set out below.

Caroline Donnison requested a list of the ambulatory care services facilitated at St Peter's Hospital (SPH) and the criteria applied to maintaining as such and those being considered for closure during the five-year period to published. In addition, how would residents across Maldon and the Dendie Peninsular be offered said local services when making bookings.

MT advised that the ambulatory care services list could be found in the DMBC document on Page 49 and the services would be accessed as they were currently.

Stephanie Ireland asked if residents of the Maldon district could be assured that the medical facilities, especially those at Westcombe Park, Heybridge, would come to fruition and that the extra medical facilities residents needed, hopefully at SPH, were in addition to the current and previously promised provision. Also, had strategic plans been updated to ensure that medical services would keep pace with future population growth.

MT advised that work was ongoing as earlier referred to in the Community Services item by TA.

Terry Brown enquired about the services at Thurrock Community Hospital now that the Community Diagnostic Centre had opened. TA advised that a briefing was being prepared, and a response would be sent to Mr Brown following the Board meeting.

Peter Blackman referred to an independent academic report regarding access to healthcare services in Maldon and the Dengie and South Woodham Ferrers area and asked how the ICB would enable appointments for healthcare services to be mutually convenient to clinicians, patients and carers, and be easily accessible by private vehicle or public transport.

DD advised that the ICB recognised and understood the importance of access to physical locations and healthcare services. Access for patients, relatives and carers was an important aspect when considering equity of healthcare service provision and formed a significant part of the impact assessments, which were completed when new services or changes to existing services were considered. The report noted that travel challenges could impact those living in deprived areas. Patients on low incomes could claim back travel costs for hospital appointments through the NHS healthcare travel cost scheme. The scheme ensured that cost was not a barrier to accessing necessary care. For those not eligible for patient transport, community transport options were available.

The MSE ICB would be working towards the three main shifts as published in the NHS Long Term Plan which were hospital to community, treatment to prevention and analogue to digital. The ICB awaited further detail to support the implementation of the plan, particularly in relation to neighbourhood health.

Paul Osman referenced cancer waiting times in the performance report and asked what additional actions the ICB Board was taking to rectify such poor cancer performance that meant patients cancer becoming worse while they wait for diagnosis and treatment.

SG advised that the ICB recognised the seriousness of this issue and acknowledged the variation from national standards, particularly in the faster diagnostic standard and the 62-day treatment performance. The ICB understood the risks associated with delays in diagnostics and treatment. Timely care was vital to improving outcomes and preventing progression to advanced cancer stages.

The system wide approach addressed pathway performance, reinforced clinical harm reviews for patients facing long waits, ensured lessons were captured and safety concerns addressed. Whilst performance remained below national targets, key improvements included an increase in the 31-day treatment performance to 79%, which was a 5.5% uplift in Quarter 1, backlog reductions through multidisciplinary team processes and revised governance oversight and additional diagnostic capacity mobilised in radiology and pathology at acute providers for faster results.

To support ongoing recovery, the ICB was pursuing continued oversight through cancer taskforces and system recovery groups and pathway redesign to increase direct-to-treatment models to reduce delays. The ICB remained committed to improving Faster Diagnosis and 62-day treatment performance in conjunction with acute colleagues, focusing on delivering meaningful change and protecting patient safety.

Paul Moorcraft asked who would be running the Thurrock NHS Talking Therapies service from 1 August 2025 onwards, and whether there was a plan in place to ensure continuity of care for both service users and staff.

TA advised that arrangements were being finalised to ensure continued delivery of the Thurrock Talking Therapies service from 1 August 2025. It was noted that this was part of a wider procurement currently in 'stand-still' stage and so unable to provide specific details which could prejudice any decision. MSE ICB priorities were to maintain continuity of care for all service users accessing Talking Therapies provision, with minimal disruption and to provide stability for staff, wherever possible. In the meantime, the ICB would continue to work with the current provider of the service and other stakeholders to ensure continued service delivery and any changes would be communicated. Assurance was provided that continuity of care and staff wellbeing remained central to the planning and decision making in relation to these services.

5. Minutes of the ICB Board Meeting held 15 May 2025 and matters arising (presented by Prof. M Thorne)

MT referred to the draft minutes of the ICB Board meeting held on 15 May 2025 and asked members if they had any comments or questions.

MT had been notified of the following minor changes.

- Page 19, Item 7, second paragraph: The sentence should be amended to '**MS advised that responding to a statutory inquiry was a legal requirement for an ICB and support would continue for the entirety of the inquiry**.'

- Page 19, Item 8, third paragraph should read '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 **advance** care planning (supported by a skilled workforce).'

There were no further comments or amendments.

Matters Arising.

There were no matters arising.

Resolved: The Board approved the minutes of the Part I ICB Board meeting held on 15 May 2025 as an accurate record, subject to the amendments noted above.

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

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

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

7. Neurological Services Update (presented by Dr M Sweeting and H Garvey)

The paper was presented in response to questions raised by the Essex Neurology Network on 11 May 2025. MS thanked the Network for its engagement and confirmed that all queries had been addressed.

It was noted that over 216,000 people in Mid and South Essex (MSE) were affected by long-term neurological conditions. The neuro navigation team supported the neuroscience strategies and contributed to regional work. The Medium-Term Plan (MTP) included senior responsible officers (SROs) for key programmes, with MS acting as the SRO for specialised commissioning. MS was involved in discussions on neurorehabilitation and future service improvements, to be presented via a joint commissioning collaborative.

HG confirmed that the neuro navigation service operated across Essex, with a small, clinically expert team informing pathways and commissioning decisions. The team worked closely with local authorities.

A patient case study was shared demonstrating the positive impact of the neuro navigation service on in patient neurorehabilitation outcomes. Early involvement often prevented hospital repatriation, which could negatively affect cognitively impaired patients. MT requested circulation of the case study slides.

JF queried how accurately the estimated 216,000 cases reflected local demand and how could this be tracked for planning purposes. JF also requested clarification on the numbers of out of area placements**.**

GT thanked HG and the team for their work in coordinating pathways across health and social care, highlighting it as an example of partnership working.

Resolved: The Board noted the Neurological Services Update as a response to the questions raised by the Essex Neurology Network.

Action: HG to circulate slides on the neurorehabilitation pathway to Board members.

8. MSE ICB Annual Report and Accounts 2024/25 (presented by Prof. M Thorne)

MT advised that approval of the MSE ICB Annual Report and Accounts 2024/25 was delegated to the Audit Committee and the Chair of the Audit Committee had confirmed approval.

No other comments or questions were raised.

Resolved: The Board ratified the final version of the ICB's Annual Report and Accounts 2024/25.

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

TA presented the Chief Executive's report highlighting key developments.

The NHS 10-year plan, published on 3 July 2025, outlined future expectations for ICBs, including a shift towards strategic commissioning and an expectation that funding would be shifted to prevention and community care. Commissioning support units would be phased out, with strengthened local commissioning capabilities. New frameworks would assess ICB maturity and effectiveness. Structural changes to governance and ICB Boards were anticipated, with further guidance awaited on delivery responsibilities, neighbourhood provider models, contracts and outcome-based commissioning.

Chief Executive and Chair appointments for the anticipated new ICB covering the Essex area launching on 1 April 2026, were in final approval stages. The executive team consultation had commenced, with further organisational changes expected throughout the year.

A summary of the National Oversight Framework was provided. Although ICBs would not be segmented this year, assessment measures had changed, and reporting was being updated.

JF requested clarification on 'year-of-care tariffs' and the relationship between the 2% annual productivity gain and the 50% cost reduction. JK explained that the tariff followed a patient's care episode, but further clarification was awaited. These tariffs were in use elsewhere, but not yet in MSE. TA confirmed the 50% reduction applied to ICB running costs, while the 2% efficiency related to funding allocation and would inform the refreshed MTP for Essex.

RP asked about government guidance on neighbourhood centres operating six days a week. TA explained that neighbourhood contracts were based on populations of approximately 50,000, typically aligned with Primary Care Networks (PCNs) and Integrated Neighbourhood Teams (INTs). Further work was needed to map current service footprints to neighbourhoods across Essex. Multi-neighbourhoods would cover populations over 250,000.

GO queried the ICB's commitment to prevention, community care and tackling health inequalities. TA acknowledged reduced ICB capacity but emphasised the role of strong community organisations and partnerships. Strategic engagement with the Voluntary, Charity, Faith and Social Enterprise sector was encouraged. The new data-led, outcomes-focused commissioning approach aimed to improve outcomes, ensure better use of public funds, and addressed inequalities.

Resolved: The Board noted the Chief Executives Report.

10. Quality Report (presented by Dr G Thorpe)

GT presented the quality report and highlighted key updates.

The report included an overview of regulatory activity across the system, with continued support provided by the ICB to MSEFT.

Key quality risks for June were noted. At the time of reporting no decision had been made regarding the ten trusts to be included in the national maternity and neonatal investigation.

Discussions were ongoing between the Chief Nursing Officer for England and the Secretary of State.

Recent cases of tuberculosis and rabies were addressed in collaboration with the UK Health Security Agency (UKHSA), with appropriate screening and monitoring measures implemented to protect public health. GT confirmed the rabies case involved an international traveller and was not UK-sourced.

Challenges were reported in managing children and young people presenting with emergency dysregulation in emergency departments. A safeguarding risk summit was commissioned by the Essex Children's Safeguarding Board, with task and finish groups established to focus on transitions to adult services and support for neurodivergent children.

In alignment with the NHS 10-year plan, Dr Penny Dash, Chair of NHSE, published recommendations on future quality oversight. These focussed on five key areas and included nine recommendations, which would be reviewed with national teams.

MT congratulated SM on the positive Care Quality Commission (CQC) inspection outcome for social care. RP reported that Essex City Council was rated 'Good', while Southend City Council and Thurrock Council had received draft reports pending publication by the CQC.

Resolved: The Board noted the Quality Report.

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

JK presented the joint Finance and Performance Report.

The system remained on track for a break-even position, supported by £106 million deficit cash funding from NHSE, subject to quarterly review and conditional adherence to plan. Early pay pressure were offset by non-pay and income adjustments, though concerns were raised about early use of mitigations and slow efficiency uptake. The Finance and Performance (F&P) Committee requested workforce efficiency reprofiling for earlier intervention.

Month 3 figures were progressing through governance. MHop reported staffing remained tight at MSEFT, with benefits expected in month 4 despite industrial action risks. Budget discipline was maintained.

JF flagged concerns about the underlying financial run rate.

SG reported strengthened governance in emergency care, cancer and elective services. Urgent and Emergency Care (UEC), and ambulance handover performance remained below national standards, though MSEFT's improvement plan was on track. Cancer Referral to Treatment (RTT) performance met the 31-day standard (79%), but 62-day and faster diagnosis standards declined. Outpatient RTT exceeded trajectory (55.7%) due to improved clinic planning.

Recovery efforts included outsourcing and commissioning community pathways to reduce acute demand. Orthopaedic recovery plans were supported by independent providers.

MT raised concerns about 65-week waiting list (882 patients). SG confirmed deep dives were underway and metrics would be included in the September report. MHop reported near zero 78-week waiters, with orthopaedic delays linked to expired stock and theatre closures at

Basildon.

JF recommended clearer narrative to support performance and forecasting.

Resolved: The Board noted the Finance and Performance Report.

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

PG reported national work to reduce variation in primary care, including self-declaration processes and dashboards development. The team focused on delivering value through the medium-term financial plan and advancing the neighbourhood health model.

Progress was noted in pharmacy, optometry and dentistry, including support for head and neck cancer pathways and community-based dental procedures. Estate improvements were funded via small capital allocations managed by the ICB, separate from Section 106 (S106) monies.

AD reported the first formal meeting of the MSE GP provider collaborative (GPPC), which connects practices via Primary Care Networks (PCN) clinical directors. The GPPC aimed to strengthen general practice and support neighbourhood care, with priorities including mental health and obesity services, supporting left shift to bring care closer to patients. Plans to expand to an Essex GPPC were underway.

RJ confirmed successful entry into the Coastal Navigators Network, focusing on healthy neighbourhoods and care technology. RJ also chaired a meeting with Lord Patel and partners to explore links between work and health, supporting the Connect to Work programme. A further expression of interest was submitted for employment support investment. Year two of health inequalities funding was launched, with Dr Jose Garcia leading the South East Essex GPPC arm**.**

MT emphasised the need for strategic estates planning. TA advised that unused S106 funds should support GP improvements and be integrated into planning for the new ICB covering the Essex.

GO welcomed collaboration with voluntary organisations and suggested funding grassroots groups. RJ confirmed the three-year health inequalities programme would devolve funding to local Councils for Voluntary Services (CVSs) with a focus on learning and collaboration. A strategic approach was needed to address non-recurrent funding challenges.

PS congratulated AD on the GPPC's formation and highlighted the importance of aligning primary care and secondary care processes as electronic patient records were deployed.

DD reported 24 INTs were in place, with 15 INTs adopting stewardship models. INTs would focus on end-of-life and frailty care. Savings targets were behind schedule but monitored via the Athena dashboard. Full coverage was expected to improve metrics such as non-elective admissions.

SM noted local authority resource constraints and stressed the importance of partnership working to reduce duplication.

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

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

13.1 Board Assurance Framework

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

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

13.2 Revised Committee Terms of Reference

MT referred members to the following revised Committee Terms of Reference which had been approved by the Committees themselves:

- 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.

There were no comments or questions raised.

Resolved: The Board approved the revised Terms of Reference for the Board sub-committees as listed above.

13.3 Committee Effectiveness Reviews 2024/25

MT referred members to the report of the committee effectiveness reviews 2024/25 which sub-committees were required to undertake annually. There were no comments or questions raised.

Resolved: The Board noted the committee effectiveness reviews for 2024/25.

13.4 New/Revised Policies

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

- 055 Patient Choice Policy
- 075 MSE Cross System Response Policy
- 086 Under and Overpayments Policy.

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

13.5 Approved Committee Minutes

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

- Clinical and Multi-Professional Congress, 26 March and 28 May 2025.
- Digital and Data Technology Board, 8 May 2025.
- Finance and Performance Committee, 1 April, 6 May and 3 June 2025.
- People Board, 1 May 2025.
- Primary Care Commissioning Committee, 9 April, 14 May and 11 June 2025.
- Quality Committee, 25 April 2025.
- System Oversight and Assurance Committee, 25 April 2025.

Resolved: The Board noted the latest approved committee minutes.

13.6 Updated Constitution

MT advised that an update to the Constitution was required as mandated by NHS England:

Section 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).

Resolved: The Board noted the changes mandated by NHS England to the ICB's constitution.

13.7 Corporate Objectives and Risk Appetite Statement

MT advised that the corporate objectives and risk appetite had been considered by the Board and updated following a workshop.

Resolved: The Board approved the ICB Corporate Objectives and Risk Appetite for 2025/26.

14. Any Other Business

There were no items of any other business.

MT thanked the members of the public for attending.

15. Date and Time of Next 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.

Mid and South Essex Integrated Care Board
Part I Board Action Log, September 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	An update regarding EDI High Impact Actions is included within the Chief Executives Report to Board, 18 September 2025. **Action closed.**	Completed
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	An update on this review is included within the Primary Care Report to Board, 18 September 2025. **Action closed.**	Completed
61	17/07/2025	7	**Neurological Services Update.** Circulate slides on the neurorehabilitation pathway to Board members.	H Garvey	18/09/2025	The presentation slides have been circulated to Board members.	Completed

Part I Board Meeting, 18 September 2025

Agenda Number: 7

Lampard Inquiry Update

- **There are no restrictions on the circulation of this document.**

Summary Report

1. Purpose of Report

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

2. Executive Lead

Dr Matthew Sweeting, Executive Medical Director

3. Report Author

Phil Read, Associate Director – Central PMO

4. Responsible Committees

ICB Board

Quality Committee.

5. Link to the ICB's Strategic Objectives

- 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.
- 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.

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

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

9. Conflicts of Interest

None identified.

10. Recommendation/s

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

Lampard Inquiry Update

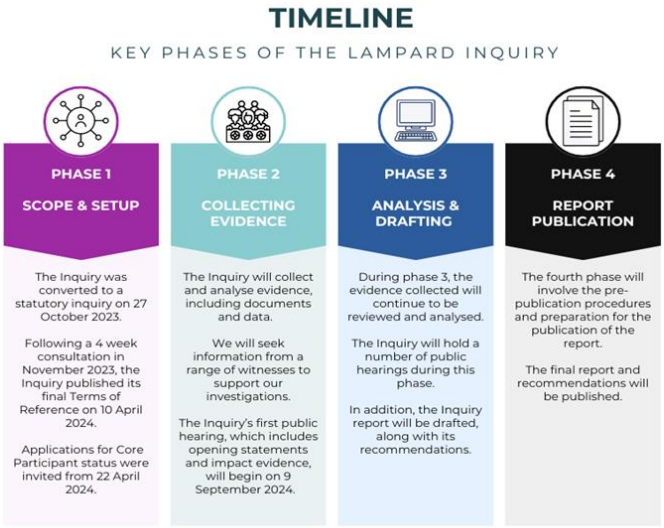
1. Introduction

1.1 The Lampard Inquiry

In June 2023 it was announced that the Essex Mental Health Independent Inquiry (established in 2021) would be granted statutory status (Public Inquiry) under the Inquiries Act 2005. In April 2024 final Terms of Reference were published, and the first public hearings began on 9 September 2024.

The purpose of the Inquiry is to investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex ("the Trust(s)") between 1 January 2000 and 31 December 2023.

The Inquiry will continue into 2026/27. A schematic of the phases of the Inquiry is shown below.



1.2 The ICBs' Approach

The three Essex Integrated Care Boards; Mid and South Essex (MSE), Hertfordshire and West Essex (HWE) and Suffolk and North East Essex (SNEE) continue to work collaboratively to be able to respond collectively and effectively to the requirements of the Inquiry.

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

A shared programme office has been established comprising:

- Programme Director (part time)
- Senior Project Manager (1 whole time equivalent (wte))
- Administrative Support (1 wte)

Mills & Reeve LLP have been appointed as Legal advisors and a King's Counsel (KC) appointed as legal representation to the Lampard Inquiry representing the three ICBs.

Programme and legal costs are being apportioned 1/7 to SNEE and Herts & West Essex ICBs, 5/7 Mid & South Essex ICB. Legal costs are monitored and reported through each of the ICBs and remain within budget.

The three Senior Responsible Officers (SROs) are;

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

They are supported by ICB Lampard leads;

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

This paper updates the Board following the report submitted in May 2025. It includes:

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

2. Main content of Report

2.1. Inquiry Updates

Scope of the Inquiry

In May 2025 the Board were informed the Inquiry's scope had been updated to clarify the Inquiry's definition of inpatient death, as well as inclusion of Learning Disability and Drug and Alcohol units. The scope on mental health assessments was also updated to clarify the Inquiry's focus on assessments in Accident and Emergency, assessments by gatekeeping teams, and Mental Health Act assessments.

There have been no further amendments to the Inquiry's scope although other cases may be included at the Chair's discretion.

Disclosure

The Lampard Inquiry publishes 'Disclosure Updates' confirming the number of requests for information under either Rule 9 of the Inquiry Rules 2006 (a formal request for submission/response) or Section 21 of the Inquiries Act 2005 (notices issued by the Chair on the Inquiry to compel the submission of evidence).

The latest published position is as reported to the Board in May 2025, based on March 2025 figures:

- 58 requests to organisations which are core participants.
- 72 requests to organisations which are not core participants.
- 162 requests to individuals and families.

The ICBs have received no further Rule 9 or Section 21 requests. Two Rule 9 requests have been received to-date (July 2024 and Feb 2025), both of which were responded to within the required time limits.

2.2 Public Hearings

Two public hearings have taken place in recent months.

Monday, 28 April to Thursday, 15 May 2025 - The Inquiry heard contextual evidence relating to the provision of mental health inpatient care in Essex, and evidence relating to some systemic issues around the provision of care. The ICBs submitted written evidence as part of this hearing (in response to the Rule 9 requests) but were not asked to give any evidence in person.

Monday, 7 July to Monday, 14 July 2025 – The Inquiry heard witness statements from bereaved family members. The ICBs were not asked to submit any information relating to this public hearing.

Future public hearing dates are below, agendas and supporting information will be confirmed in due course.

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

Hearing recordings are available online: The Lampard Inquiry - investigating mental health deaths in Essex

2.3 Inquiry Requests to the ICBs

There have been no further inquiry requests for information.

2.4 Joint Essex ICBs Programme

The ICBs commissioning, finance, quality and contracting teams remain in place to respond positively and promptly to any requests for information. Navigating the complexities of the commissioning landscape from 2000, retrieving historical data or information from former commissioning organisations across this period and reliance on corporate memory of individuals for pre-ICB processes remains the most challenging aspect of responding to the Inquiry.

The programme was formally established in autumn 2024 with the cross ICB Joint Project Working Group meeting monthly from December 2024. As reported to Board in May 2025 the programme is supported by several groups with targeted areas of work, which include:

Safeguarding – MSE ICB leads the Safeguarding process for the three Essex ICBs and has a Memorandum of Understanding (MoU) with the Inquiry. The ICBs have agreed a process for any Inquiry 'Safeguarding Alerts / Non-Alerts', including receiving responses from Essex Partnership University NHS Hospital Trust (EPUT), and have a weekly scheduled meeting to discuss anything outstanding.

The first ‘referral’, now referred to as an alert, was received in May 2024. Since then, we have received the following:

- Alerts Received: 24 (HWE: 1 / SNEE: 3 / MSE: 17 / Other: 3)
- Non-Alert Received: 4 (Issues outside the scope of the Inquiry)

Communications – Maintaining a dedicated Inquiry space on the respective ICB’s intranet, explaining further details about the Inquiry, where to find support, and who to contact; as well as relevant updates aligned with the Inquiry’s public hearings from 2024 until 2026. There is also information available on the ICS website.

Human Resources (HR) – The Project Team and HR group meet monthly to review support needed for staff affected by the Inquiry, specifically focusing on legal support (provided by Mills and Reeve), practical support (provided by the Project Team), and wellbeing support, available to all staff.

Information Governance (IG) and Historic Records – The Information Governance Team support with primary oversight of historic records, as well as IT service support and Cyber Security for any records from former organisations held within ICB servers and databases, and completion of the privacy impact assessment. We have developed and issued new procedures for records destruction to ensure the ICBs meet the additional requirements of the Inquiry e.g. further retention of documents beyond ordinary timescales. A ‘Stop’ notice is in force to prevent the destruction of any Inquiry related records or information.

Senior Responsible Officers (SROs)

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

2.5 Sample Case Review September Statement

The NHS commissioning cycle and associated processes is included within the scope of the Inquiry and has been identified as a future area of interest. In June 2025 meetings were held between key members of ICB staff and legal representatives to discuss current and historical commissioning, contracting and quality monitoring arrangements covering the 23-year period of this Inquiry. The ICB had previously identified a risk associated with NHS commissioning reorganisation and concerns raised and acknowledged through these meetings regarding the potential loss of organisational memory and key members of staff, that may be called upon, to respond to any future Rule 9 requests.

As a result, the ICBs in partnership with legal teams, have commenced a review of 6 cases spanning 2015 to 2023 (note: records prior to 2015 are not held by the ICBs and therefore excluded from this review). Sample cases were chosen in liaison with legal teams taking into consideration the circumstances of the patient’s death, the location, changes in the commissioning landscape and the scope of the Inquiry.

The intended output of this undertaking is to submit a statement to the Inquiry prior to the next hearing (October 2025) to provide a detailed evidence-based assessment of:

- the commissioning landscape at this time of these cases
- identification of contracts in place and how they were monitored
- the quality monitoring arrangements at the time of these incidents, and
- any specific sample case knowledge and/or actions taken by the ICB, relating to these cases.

Following discussion between ICB legal representatives and the Lampard Inquiry legal teams, this proactive ICB case review (may) become a formal Inquiry Rule 9 request for information, in accordance with the Inquiry's scope.

The three ICB SROs will oversee this case review.

3. Findings/Conclusion

The Essex ICBs continue to work together through a joint programme approach to the Inquiry and are ready to respond positively to any future Rule 9 and supplementary requests.

No further formal requests for information have been received to that which has already been reported to Board.

The sample case review is intended to provide the ICBs, ICB legal representatives and the Lampard Inquiry with sufficient detail regarding the commissioning and quality monitoring arrangements in place at key times of interest to the Inquiry. The review also seeks to address any loss of organisational memory and mitigate against organisational change risks.

4. Recommendation

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

Part I ICB Board Meeting, 18 September 2025

Agenda Number: 8

2025/26 Mid & South Essex Winter Plan

Summary Report

1. Purpose of Report

To present the Mid and South Essex Integrated Care System (MSE ICS) Winter Plan for 2025/26 (**Appendix A**), setting out the strategic and operational framework for managing seasonal pressures across the system. The plan outlines measures to ensure resilience in the face of increased demand and potential disruption, while maintaining safe, effective, and timely care delivery.

To seek Board approval for the implementation of the Winter Plan, which defines system-wide actions to support urgent, emergency, and elective care services, and to uphold performance, patient flow, and service continuity throughout the winter period.

2. Executive Lead

Samantha Goldberg, Executive Director Performance & Planning

3. Report Author

Samantha Goldberg, Executive Director Performance & Planning

4. Responsible Committees

- 2025/26 Winter Planning Strategic Group – 4 September 2025
- Urgent Emergency Care Oversight & Assurance Committee – 5 September 2025
- Integrated Care Board – 18 September 2025

5. Link to the ICB's Strategic Objectives

- 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.
- 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.
- 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.

- 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.

6. Impact Assessments

Quality / Equality and Health Inequalities Impact Assessment (EHIAA) (Appendix B).

7. Financial Implications

No financial implications.

8. Details of patient or public engagement or consultation

Designated Provider Leads have been appointed. Strategic Group representation commenced 17 July 2025 to oversee the development and delivery of the Mid & South Essex (MSE) Operational Winter Plan. System leaders and provider Boards retain overall accountability for ensuring winter plans are robust, responsive to demand and acuity, and deliverable within existing capacity and resources, supporting safe, urgent emergency, and elective care across MSE.

No patient or public engagement.

9. Conflicts of Interest

None Identified.

10. Recommendation/s

The Board is requested to:

- **Note** the strategic approach outlined within the 2025/26 Winter Plan (**Appendix A**), including the identification of associated risks and the proposed mitigation measures, and the associated Quality / Equality and Health Inequalities Impact Assessment (**Appendix B**).
- **Approve** the 2025/26 Winter Plan (**Appendix A**) and its implementation framework for deployment across the Mid and South Essex Integrated Care System.
- Endorse the submission of the Integrated Care Board NHS England (NHSE) Winter Board Assurance Statement (**Appendix D**), acknowledging that the respective Provider Board Assurance Statements have been formally signed off by each provider Board in support of their individual winter plans.

2025/26 Mid & South Essex Winter Plan

1. Introduction

This report outlines the strategic and operational approach for managing the 2025/26 winter season within the Mid & South Essex Integrated Care System (MSE ICS). The Winter Plan sets out a system-wide framework to ensure resilience in the face of increased seasonal demand and potential service disruption, while maintaining patient flow and delivering safe, timely, and effective care.

Executive leadership for winter planning and delivery will be provided by the Executive Director of Performance and Planning, supported by designated ICS Winter Leads and Provider Leads. These leaders are jointly responsible for the design, coordination, and implementation of the Winter Plan, informed by the 2024/25 Winter Debrief and evaluation. The MSE Winter Planning Group will convene weekly to monitor progress, share operational updates, and escalate risks through appropriate governance channels.

Operational oversight will be led by the System Coordination Centre (SCC), which operates seven days a week and is co-located with the Unscheduled Care Coordination Hub (UCCH) and the Integrated Care Transfer Hub (ICTH). This integrated model enables multidisciplinary collaboration and real-time management of patient flow across the system. The SCC uses the Operational Pressures Escalation Level (OPEL) framework and SHREWD Resilience platform to monitor system pressures, allocate actions during daily Situation Awareness meetings, and ensure timely escalation and intervention.

Out-of-hours leadership is jointly provided by the ICB and provider on-call teams, while the Emergency Preparedness, Resilience and Response (EPRR) team leads incident management to preserve SCC capacity for operational coordination. The EPRR Associate Director also oversees the system vaccination programme, working with partners to maximise uptake and inform targeted interventions.

This strategic and operational model ensures that winter plans are robust, responsive to fluctuations in demand, and deliverable within existing capacity, supporting the consistent provision of urgent, emergency, cancer and elective care across MSE ICS.

2. Main content of Report

2.1. Meeting National Requirements

MSE's Winter Plan for 2025/26 aims to support the system in providing the best possible care to residents through the winter period. The plan provides a framework to maximise capacity across the system and to provide maximum resilience and oversight during periods of increased pressure.

The plan will also help MSE deliver on the priorities set out in the Urgent and Emergency Care Plan 2025/26 (**Appendix C**) published in June 2025, which included:

- **Strengthening Vaccination Programmes:**
  Strengthen childhood flu vaccination and ensure Respiratory Syncytial Virus (RSV) vaccines are offered to all adults aged 75–79 by 31 August 2025. NHS Trusts are also required to provide accessible staff flu vaccination services.

- **Infection Prevention and Control (IPC) Preparedness**:
  Mitigate winter respiratory illness pressures, test IPC measures, including cohorting spaces, enabling direct flu patient admissions to community beds, and aligning with national IPC protocols to reduce transmission and maintain capacity.

- **Expanding Community and Home-Based Care:**
  Reduction in hospital attendances and expand urgent care access in community and home settings, optimising virtual wards, urgent community response teams, direct ambulance off-loading, and enhanced clinical triage of 999 calls. Adopt 'Call Before Convey' and strengthen overnight in-home care support.

- **Improving Patient Flow and Reducing Delays:**
  Target faster ambulance handovers, timely paediatric emergency care, and eliminate discharge delays over 48 hours.

- **Enhancing Mental Health Crisis Response:**
  Reduce out-of-area placements, shorten inpatient stays, and lower re-admission rates among high-intensity users. Fewer patients should wait over 24 hours for admission, supported by crisis assessment centres and assertive outreach teams.

- **Leveraging Digital Infrastructure and Data**:
  Leverage the NHS Federated Data Platform and Connected Care Records for real-time decision-making and forecasting.

2.2. Delivering Against National Requirements

The MSE Winter Plan demonstrates clear alignment with national urgent and emergency care priorities through a comprehensive, system-wide framework. It is designed to support the delivery of safe, effective care to residents throughout the winter period. The plan sets out coordinated actions across providers and partners to ensure resilience, manage seasonal pressures, and maintain continuity of care.

- **Strengthening Vaccination Programmes:**
  The plan includes targeted flu, COVID-19 and RSV vaccination campaigns for eligible cohorts, including children and adults aged 75–79. Staff vaccination is prioritised with a 5% uptake improvement target, supported by vouchers, peer vaccinators, and outreach initiatives across all providers.

- **Infection Prevention and Control (IPC) Preparedness**:
  IPC measures are embedded across settings, including cohorting spaces, respiratory zones, and direct flu admissions to community beds. IPC champions and refresher training support frontline teams, with outbreak protocols aligned to national guidance.

- **Expanding Community and Home-Based Care**:
  The system plans on optimising virtual wards, urgent community response teams, and integrated neighbourhood teams. 'Call Before Convey' is standardised and enhanced triage of 999 calls is in place. Overnight in-home care and direct ambulance off-loading are supported through UCCH and ICTH coordination.

- **Improving Patient Flow and Reducing Delays**:
  Acute trusts are targeting improved ambulance handover times and timely paediatric care. Internal discharge delays over 48 hours and long-stay patients (21+ days) are actively monitored and addressed via Red to Green processes, discharge planning Standard Operating Procedures (SOPs) and system-wide escalation protocols.

- **Enhancing Mental Health Crisis Response**:
  Crisis assessment centres and assertive outreach teams are being expanded. The plan includes reducing out-of-area placements, shortening inpatient stays, and improving admission timeliness. Children and Adolescent Mental Health Services (CAMHS) and adult mental health services have robust escalation and discharge pathways in place.

- **Leveraging Digital Infrastructure and Data**:
  SHREWD Resilience, TeleTracking, and Power BI are used for real-time monitoring, escalation, and flow management. The NHS Federated Data Platform and Connected Care Records support operational forecasting and clinical decision-making across services.

3. Findings/Conclusion

3.1 Risks & Mitigations

The system and provider winter plans have identified several delivery risks for the upcoming period. While mitigations have been developed and formally signed off by provider Boards through their Winter Plans and Board Assurance Statements. These risks will be actively monitored by the Winter Planning Strategic Group, which meets weekly. Any emerging or escalating risks will be promptly addressed through appropriate escalation channels to ensure system resilience and continuity of care:

System Risks	Mitigation Strategy
Increase in demand and surge management	• Real-Time System Monitoring via SHREWD and OPEL Framework: The SHREWD platform will be used to provide dynamic, real-time visibility of system pressures across health and social care settings. This will be complemented by the application of the OPEL escalation framework, enabling consistent assessment of operational pressure levels and structured escalation across the system. Together, these tools will facilitate timely, coordinated responses to emerging pressures, ensuring that appropriate actions are taken in line with predefined thresholds and escalation protocols. • Daily Operational Huddles: Multi-agency daily huddles convene to review system status, assess capacity and flow, and agree immediate operational actions, which will support rapid decision-making and ensure alignment across partners. • Activation of Full Capacity Protocols (FCP): Acute and community will implement FCP when OPEL thresholds are met, enabling safe and structured escalation of capacity measures, including the use of non-core bed base spaces and prioritisation of discharge pathways.

System Risks	Mitigation Strategy
	• Enhanced Discharge Coordination: Strengthened discharge planning and coordination, including deployment of discharge hubs and increased use of attendance avoidance and out of hospital capacity to support timely patient flow and reduce avoidable delays.
Workforce Shortages	• **Targeted Vaccination Campaigns:** Comprehensive flu vaccination programmes will be rolled out for all health and care staff, aimed at reducing sickness absence and maintaining workforce resilience. • **Flexible Staffing Models:** Implementation of flexible staffing arrangements, including bank and agency utilisation, cross-site deployment where appropriate, and mutual aid agreements across system partners, will support surge capacity and maintain safe staffing levels during periods of peak demand. • **Enhanced Infection Prevention and Control (IPC) Training:** Refreshed IPC training will be delivered to all frontline staff, ensuring adherence to best practice standards and minimising the risk of healthcare-associated infections that could further impact workforce availability. • **Workforce Wellbeing and Retention Initiatives:** Wellbeing support, including access to mental health resources, rest spaces, and flexible working options, will be prioritised to support retention and reduce burnout.
Discharge Delays	• **Activation of Integrated Community Transfer Hub (ICTH):** Continue to support timely discharge and continuity of care in the community. For winter 2025/26, the model will be strengthened with the inclusion of a mental health expert into the team to support patients with clinical and operational oversight to improve coordination, accountability, and responsiveness across health and social care partners, ensuring safe and effective discharge pathways. • **Implementation of Red to Green Days:** Consistent use of the Red to Green methodology across inpatient wards will drive proactive discharge planning, reduce delays, and progression toward discharge. • **Strengthened Care Home Coordination:** Improved coordination with care homes, including early identification of placement needs, streamlined communication pathways, and dedicated discharge liaison roles, will facilitate timely transfers and reduce bottlenecks. • **Use of Virtual Wards and Intermediate Care Beds:** Increased utilisation of virtual wards and step-down/intermediate care beds will provide safe alternatives to hospital-based care, supporting earlier discharge and reducing acute bed occupancy.

System Risks	Mitigation Strategy
	• **Real-Time Discharge Tracking and Escalation:** Integration of discharge data into SHREWD and OPEL reporting will enable real-time tracking of discharge delays, allowing for prompt escalation and deployment of targeted interventions.
Vaccination Uptake	• **Targeted Outreach Campaigns:** Tailored outreach initiatives will be delivered through community health teams, primary care networks, and trusted local partners to engage underserved groups and improve accessibility to vaccination services. • **Incentivisation through Vouchers and Engagement Activities:** The use of vouchers and other incentive schemes will be deployed to encourage uptake among frontline staff and priority cohorts, supported by local engagement events to raise awareness and address vaccine hesitancy. • **System Vaccination Oversight Group:** The Vaccination Group will provide strategic oversight and coordination of all vaccination activities, ensuring alignment across providers, monitoring uptake trends, and enabling rapid response to emerging gaps or challenges. • **Real-Time Data Monitoring and Reporting:** Vaccination uptake will be tracked, enabling targeted interventions in areas of low coverage and supporting data-driven decision-making across the system. • **Workforce Engagement and Leadership Advocacy:** Senior clinical and operational leaders will actively promote vaccination through internal communications, peer advocacy, and visible leadership, reinforcing the importance of vaccination for staff wellbeing and patient safety.

Specific Provider Risk	Mitigation Strategy
MSEFT Bed Model: Average -95 bed deficit. *Please note that the MSEFT Bed model is work in progress to reduce bed deficit.*	• **Length of Stay Reduction Programme:** A trust-wide initiative will be deployed across all hospital sites to reduce average length of stay. • **Front Door Streaming Model:** Implementation of a new front door model to redirect patients away from the Emergency Department where clinically appropriate, includes diversion to Pharmacy First services and streaming to alternative urgent care pathways within the hospital, particularly Same Day Emergency Care (SDEC) to reduce avoidable admissions. • **Early Discharge Planning:** Discharge planning will begin at the point of admission, supported by discharge teams and digital tracking tools, enabling timely discharge and reduce delays, especially for patients with complex needs. • **Activation of Full Capacity Protocols (FCP):** FCPs will be deployed during periods to offload ambulances and support real-time operational planning to maintain patient flow.

System Risks	Mitigation Strategy
	• **Integrated Transfer of Care Hub (ICTH):** The ICTH will centrally manage complex discharges, coordinating across health, social care, and voluntary sector partners to ensure timely access to out-of-hospital capacity, including virtual wards, intermediate care, and step-down beds.

3.2 MSE Winter Planning Tabletop Exercise

As part of the system-wide preparedness for the 2025/26 winter period, the MSE ICB will host a full-day Winter Planning Tabletop Exercise on Wednesday 24 September 2025 at Anglia Ruskin University. This event will serve as a critical opportunity to evaluate the robustness of the MSE System and Provider winter plans through a series of structured scenarios, including those developed by NHSE.

The exercise will focus on key operational domains such as surge management, infection prevention and control, infrastructure resilience, and integrated system working. It will be attended by provider representatives and subject matter experts, with NHSE Urgent Emergency Care and EPRR leaders present to provide national and regional oversight, ensuring alignment with broader strategic objectives and facilitating real-time feedback.

4. Recommendation(s)

- **Note** the strategic approach outlined within the 2025/26 Winter Plan (**Appendix A**), including the identification of associated risks and the proposed mitigation measures, and the associated Quality / Equality and Health Inequalities Impact Assessment (**Appendix B**).
- **Approve** the 2025/26 Winter Plan (**Appendix A**) and its implementation framework for deployment across the Mid and South Essex Integrated Care System.
- Endorse the submission of the Integrated Care Board NHS England (NHSE) Winter Board Assurance Statement (**Appendix D**), acknowledging that the respective Provider Board Assurance Statements have been formally signed off by each provider Board in support of their individual winter plans.

5. Appendices

Appendix A – Mid & South Essex System Winter Plan 2025/26.

Appendix B – Quality / Equality and Health Inequalities Impact Assessment.

Appendix C – Urgent and Emergency Care Plan 2025/26 – June 2025.

Appendix D – MSE ICB Winter Planning 2025/26 Board Assurance Statement.

Appendix A

Mid & South Essex System Winter Plan 2025/26

Contents

Strategic Co-ordination

The Executive Director of Performance and Planning will provide executive leadership for winter planning and delivery across Mid and South Essex (MSE), supported strategically by nominated Integrated Care System (ICS) Winter Leads.

Designated Provider Leads are responsible for overseeing the design, coordination, and implementation of the MSE Operational Winter Plan. This includes the integration of insights and recommendations derived from the comprehensive 2024/25 Winter Debrief and evaluation, along with the proactive identification of system-wide risks and the development of robust mitigation strategies. The MSE Winter Planning Group will convene on a weekly basis to monitor progress, exchange operational updates at the provider level, and escalate any critical risks or emerging pressures through the appropriate governance channels.

Overall accountability rests with system leaders and provider Boards to ensure that provider winter plans are robust and responsive to fluctuations in demand and patient acuity. Plans must be deliverable within existing provider capacity and resources to ensure the consistent provision of safe, high-quality urgent and emergency care (UEC), as well as elective services, for the population of MSE.

Furthermore, the system must continue to meet the performance commitments and activity trajectories outlined in the 2025/26 Operating Plan.

Operational Co-ordination

The System Coordination Centre (SCC) will lead the day-to-day oversight and coordination of winter pressures across the health and social care system. Operating seven days a week, the SCC serves as the central hub for integrated operational management, co-located with the Unscheduled Care Coordination Hub and the Integrated Care Transfer Hub. This co-location enables multidisciplinary collaboration to support patient flow and ensure seamless transitions across services.

A core function of the SCC is to coordinate patient demand and flow across the system in conjunction with system partners, leveraging SHREWD Resilience to monitor real-time demand and capacity. This digital platform provides a live operational view of system pressures, enabling timely, data-informed decision-making and proactive management of escalation and de-escalation processes.

The SCC maintains direct escalation to Samantha Goldberg, Executive Director for Performance and Planning, who also serves as the nominated Lead Director for Winter 2025. Out-of-hours leadership will be jointly provided by the Integrated Care Board on-call team and provider on-call teams, ensuring continuity of oversight and decision-making beyond core hours.

To safeguard the SCC's capacity for daily operational management, the Emergency Preparedness, Resilience and Response (EPRR) team will assume leadership for any incidents arising during the winter period. This clear delineation of roles ensures that incident response is managed distinctly, while enabling the SCC to maintain its focus on system-wide coordination, flow, and resilience.

In addition to incident management, the EPRR Associate Director holds the system vaccination portfolio and is responsible, in conjunction with system partners, for maximising uptake of vaccinations across the population. This includes leading efforts to improve access and engagement, as well as monitoring and reporting vaccination rates to inform system-wide planning and targeted interventions.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
09:00hrs	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle
09:00hrs	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical
12:00hrs	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle
12:30hrs	NHSE EoE UEC Tactical Meeting		NHSE EoE UEC Tactical Meeting		NHSE EoE UEC Tactical Meeting		
15:00hrs	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle	SCC, UCCH & ITCH Huddle
16:00hrs	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical	MSE Situation Awareness Meeting - Tactical
17:30hrs	MSEFT Night Plan Meeting	MSEFT Night Plan Meeting	MSEFT Night Plan Meeting	MSEFT Night Plan Meeting	MSEFT Night Plan Meeting	MSEFT Night Plan Meeting	MSEFT Night Plan Meeting

Figure 1: Weekly tactical and operational meeting schedule across MSE services, including huddles, situation awareness briefings, and night planning sessions.

Winter Priorities

1. Governance, Leadership & Accountability

- Appoint an accountable executive for winter oversight.
- Engage all system partners in plan development, testing, and stress-testing (September 2025).
- System control centre to enable real-time intelligence sharing, coordinated risk management, and continuous monitoring of operational pressures via the OPEL framework to support timely decision-making and escalation.
- Test and activate on-call arrangements for clinical leaders.

2. **Prevention, Vaccination & Community Care**

- Deliver comprehensive vaccination campaigns across priority groups: Flu, COVID-19, and RSV for eligible adults, including older adults and pregnant women, and childhood immunisations with enhanced outreach.
- Boost frontline staff vaccination uptake to exceed pre-pandemic levels (+5% target).
- Urgent care outside hospitals: Unscheduled Care Coordination Hub, Urgent Community Response teams, Virtual wards and Mental health crisis services.

3. **Urgent & Emergency Care Performance**[1]

- Reduce ambulance wait times for Category 2 patients (target: 30 minutes) and meet the 45-minute ambulance handover standard.
- Improve A&E performance:
  - 78% of patients admitted, transferred, or discharged within 4 hours.
  - Cut 12-hour waits to under 10%.
  - Increase timely care for children (within 4 hours).
  - Reduce 24-hour ED stays for mental health admissions.

4. **Mental Health Integration & Crisis Response**

- Invest in crisis assessment centres and expand inpatient capacity.
- Eliminate inappropriate out-of-area placements.
- Implement tailored crisis and relapse plans for high-risk individuals.
- Reduce Emergency Department waits for mental health patients.

5. **Discharge, Admission Avoidance & Flow**

- Model and plan for winter demand across all settings.
- Align discharge profiles with local authorities (P1 & P3 standards) and stretch targets for discharge pathways (P0–P3).
- Eliminate internal discharge delays >48 hours and tackle delays for patients staying 21+ days past discharge-ready date.
- Use Better Care Fund (BCF) to support surge capacity and step-up/down care.

[1] *NHSE Urgent and emergency care plan 2025/26 - June 2025:* *https://www.england.nhs.uk/publication/urgent-and-emergency-care-plan-2025-26/*

- deliver elective and cancer services in alignment with the operating plan trajectories.

6. **Digital & Data-Driven Improvement**
   - Expand Connected Care Records for paramedic and ambulance access.
   - Implement technology to reduce falls and support independent living.
7. **Workforce and Resource Management**
   - Ensure safe and resilient patient care through strategic workforce planning, including equitable rota design and proactive bank holiday scheduling.
   - Foster a positive working environment to prioritises staff wellbeing across physical, emotional, and psychological domains.

System Risks & Mitigation

Operational Pressures & Demand Surge	Rising demand for urgent and emergency care exceeding system capacity.	• SHREWD Resilience for real-time monitoring and escalation. • Daily system-wide huddles and Situation Awareness Meetings. • Activation of Full Capacity Protocols and prioritisation of SDEC services.
Workforce Shortages & Sickness	Staff absences due to illness, industrial action, or seasonal pressures.	• Flu and RSV vaccination campaigns with a 5% improvement in uptake target. • Flexible staffing models, mutual aid agreements, and bank staff pools. • IPC refresher training and wellbeing initiatives across all services.
Discharge Delays & Flow Blockages	Delays in discharge due to social care, transport, or documentation issues.	• Activation of Integrated Care Transfer Hub (ICTH) with 7-day coverage. • Red to Green processes, discharge planning standard operating procedures, and escalation protocols. • Coordination with local authorities and care homes for timely transitions.
Vaccination Uptake & Access	Low uptake among staff and vulnerable populations.	• ICS-level Vaccination Group oversight. • Flu voucher schemes for non-eligible staff. • Outreach via community, voluntary, and faith groups. • Communication strategies and tool kits for providers

Table 1: Overview of key system risks and mitigation strategies across urgent care, workforce, discharge, and vaccination challenges.

Provider Specific Risks & Mitigations

Subject	Risk	Mitigation
MSEFT (Mid & South Essex Foundation Trust)	Bed deficits of -95 on average from November to end of March 2026, and a peak in January with up -156 beds in January 2025. Corridor care, and offload delays.	• Activate Full Capacity Protocols to manage surges and reduce corridor care. • Protect SDEC services to support early flow and ambulance offloads. • Strengthen discharge planning to increase volumes and prioritise earlier discharges. • Pre-allocate escalation areas with clear plans for activation and de-escalation.
EEAST (Ambulance Service)	Handover delays, staff sickness, and system dependencies.	• Maximise Call Before Convey (CB4C) to reduce avoidable hospital admissions. • Engage Private Ambulance Support to increase frontline capacity during peak demand. • Activate Clinical Cell to coordinate system-wide flow and escalation response.
IC24 (NHS111)	Surge demand during holidays, staffing gaps.	• Use Real-Time Triggers to detect rising demand and activate surge protocols. • Implement Flexible Hybrid Rotas to support staffing during peak periods. • Run Vaccination Prize Draws to boost uptake and reduce staff sickness.
Primary Care	Unmet demand and repeat prescribing issues.	• Winter Access Scheme to increase proactive and reactive capacity during peak demand. • Pharmacy First Promotion to divert minor ailments from GP and ED services. • Self-Referral Pathways to reduce unnecessary GP appointments and streamline access.
CAMHS Crisis & Eating Disorder Teams	Delays in assessment, staffing gaps, medical deterioration.	• Maintain 24/7 Coverage to ensure continuous access and responsiveness. • Deploy Peer Vaccinators to improve staff vaccination uptake and reduce illness. • Utilise Virtual Beds to manage demand and support admission avoidance. • Conduct Regular MDT Reviews to streamline care planning and discharge.
EPUT Adult Mental Health	Non-commissioned weekend working, delayed discharges.	• Submitted proposal to Executive Board to secure funding for extended service coverage. • Implement Flexible Staffing Models to adapt to demand fluctuations. • Utilise Digital Tools (MaST, SMART) for predictive analytics and real-time bed management.
INTs, Virtual Wards, UCRT, Inpatient Beds	Capacity gaps, IPC challenges, transport delays.	• Activate mutual aid and escalation protocols to manage surges and maintain service continuity.

		• Deploy IPC champions to uphold infection control standards and support clinical teams. • Use SHREWD tracking to monitor pressures in real time and guide responsive actions.
Local Authorities (Essex, Southend, Thurrock)	Workforce shortages, resource constraints, care home closures.	• LAPEL framework implemented to coordinate local system responses. • Utilising the Better Care Fund to enhance community-based care and discharge pathways. • Expand Home First models to care homes to reduce reliance on inpatient care. • Targeted recruitment strategies underway to strengthen staffing levels.
Mortuary Services	Surge in winter deaths	• Additional storage capacity available to manage surges. • Use forecasting tools to anticipate demand and allocate resources proactively.

Table 2: Mitigation strategies for winter pressures across MSE system partners, addressing bed deficits, handover delays, surge demand, and workforce gaps.

New Interventions & Services Post 2024/25 Winter

System Coordination & Leadership

- Establishment of System Coordination Centre, Unscheduled Care Coordination Hub, and Integrated Care Transfer Hub
- Integration of Local Operations Coordinator into the System Coordination Centre for winter
- Appointment of Substantive Managing Directors at acute hospital sites
- Designated Executive Director Winter Leads at ICB and provider level

Attendance Avoidance and Discharge Co-ordination

- Integrated Care Transfer Hub Enhancements - fully evaluated and budgeted Integrated Care Transfer Hub
- Inclusion of Mental Health professionals, Leadership roles, and Subject Matter Experts:
  - Urgent Community Response Team,
  - Geriatricians to support Frailty Hotline integration
- Reduction in ambulance conveyances from care homes via the Unscheduled Care Coordination Hub

Urgent & Emergency Care Transformation

- Missed Opportunities Audits by NHSE UEC National Improvement Lead identifying improvements in front door redirection and streaming
- Implementation of New ED Redirection & Streaming Model:
  - Redirect to Pharmacy First
  - Stream directly from triage to urgent care services within the hospital
- Increase in ambulance vehicle numbers

Digital & Operational Enhancements

- IC24 NHS111 hosting the Unscheduled Care Coordination Hub:
- Supporting increased volumes through workforce resilience
- ITK link development for automated C5 call integration
- Enhanced case management and overnight holding
- Same Day Emergency Care (SDEC) Expansion
- Launch of Trauma & Orthopaedic SDEC Units at Broomfield, with rollout planned for Basildon and Southend
- Expansion of Surgical SDEC at Broomfield; review underway at Basildon and Southend
- Acute Medical Pathway Development
- Introduction of Acute Medical Referral Units (AMRU) at Basildon and Southend Hospitals
- IC24 NHS111 hosting the Unscheduled Care Coordination Hub:
- Supporting increased volumes through workforce resilience
- ITK link development for automated C5 call integration
- Enhanced case management and overnight holding

Same Day Emergency Care (SDEC) Expansion

- Launch of Trauma & Orthopaedic SDEC Units at Broomfield, with rollout planned for Basildon and Southend
- Expansion of Surgical SDEC at Broomfield; review underway at Basildon and Southend

Acute Medical Pathway Development

- Introduction of Acute Medical Referral Units (AMRU) at Basildon and Southend Hospitals

System Co-ordination & Emergency Preparedness Resilience & Response

System Co-ordination Centre

Operational Readiness:

- A has been appointed with overarching responsibility for leading the Mid and South Essex Integrated Care System (MSE ICS) response and the operational governance of the System Coordination Centre (SCC). With Strategic emphasis is being placed on fostering system-wide collaboration, promoting visible leadership, and reinforcing shared accountability among all partner organisations collocated at Phoenix within the SCC/UCCH and Discharge team.
- The system remains equipped to respond effectively to manage serious or major incidents impacting service delivery, including industrial action, cyber security threats, and communicable disease outbreaks. EPPR and SCC will split in response to an incident and BAU operations if required to manage them separately if appropriate. There is also the ability to oversee incidents as a joint team if more appropriate depending on the circumstances.
- Increased on site working from October for SCC and UCCH teams with a minimum of 3 days per week this will give us more support on the day if required.

System Integration:

- Daily Calls: Structured system calls at 09:00, 12:00, 15:00 (UCCH Huddle), 09:30 and 16:00 (system-wide), and 17:30 (MSEFT Site), with flexibility to increase frequency.
- Real-Time Monitoring: SCC oversees urgent and emergency care performance using SHREWD, EEAST TOC reports, and a developing live UCCH board. SHREWD Action enables automatic escalation to MSEFT, mental health, and community partners.
- Pressure Management: Early identification of operational pressures via OPEL thresholds supports timely escalation and intervention.
- Mutual Aid Coordination: Resources are allocated across acute and community services during surges, including support for diverts and agreed criteria.

- Escalation Governance: Structures are in place to respond to local, regional, and national escalation requirements.

Patient Flow & Discharge:

- The Urgent Care Co-ordination Hub (UCCH) and the Integrated Care Transfer Hub (ICTH) are co-located with the System Coordination Centre (SCC), with operational and flow huddles convened three times daily to ensure effective system oversight and patient throughput.
- We'll use live dashboards (SHREWD, OPEL and Power BI) to watch core IT systems, ambulance calls, A&E waits and staffing in real time. New Shrewd automated actions will let the right teams know when demand spikes or there are gaps in service provisions so partners can take the relevant actions to reduce demand or patient risks.
- A regional Winter Exercise/Tabletop is scheduled for 8 October 2025. The purpose of this exercise is to validate regional winter preparedness, stress-test system-wide plans, and assess responses against evolving Urgent and Emergency Care (UEC) and Emergency Preparedness, Resilience and Response (EPRR) scenarios.
- The Mid and South Essex (MSE) system-wide Winter Exercise/Tabletop is planned for 1 October 2025. This exercise will evaluate the system's capability to manage surges in demand, implement effective Infection Prevention and Control (IPC) measures, and maintain operational resilience during unforeseen incidents.
- The ICB is providing extra performance monitoring (beyond BAU) and plans to collaborate or co-locate with the EEAST Performance Cell within the SCC and UCCH for real-time oversight. The baseline for Hear & Treat is 16% and that will increase to 17 & 18% over the winter period.
- Plans are ongoing to expand and optimise the Single Point of Access by merging the frailty hotline, UCRT lines and current EEAST SPOA into a single number that routes callers directly into the UCCH's multidisciplinary team, reducing ambulance conveyances and ensuring patients are treated at home or in virtual hospitals.

Workforce:

- The East of England Ambulance Service Trust (EEAST) Local Operational Cell is to be co-located within the System Coordination Centre (SCC), facilitating improved communication, operational alignment, and responsiveness across urgent and emergency services.
- Leadership from Essex Partnership University NHS Foundation Trust (EPUT) Adult Mental Health is to be integrated within the Integrated Care Transfer Hub (ICTH).

This inclusion is intended to enhance oversight of adult mental health patient flows and mitigate delays in care transitions.

- A request has been submitted to position the patient transport provider within the SCC. This aims to address the existing service gap and strengthen coordination across transport and system-wide response functions.
- IC24, the NHS 111 service provider, continues to host the Urgent Care Coordination Hub (UCCH), offering direct access to General Practitioners and supporting timely triage and community-based patient care pathways.
- The ICB has committed to providing flu vaccination vouchers for staff who are not otherwise eligible, ensuring broader access across the workforce. This initiative will be promoted to staff as appropriate within the SCC locality and is aimed at both clinical and non-clinical personnel who engage in direct, face-to-face patient contact. The programme supports efforts to reduce the risk of flu transmission, particularly in light of evolving working environments.

Digital & Data:

- Shrewd action updated and implemented by October 2025 this will allow us to automatically escalate delays or OPEL escalation in real time to the nominated leads and require them to confirm their organisation response, this will also strengthen our resilience as will be an automated process and not rely on individuals. From a governance overview we will have accurate escalation and actions taken information for future learning if required.

Risks Identified & Mitigation:

- As part of wider NHS reform initiatives, fixed-term contracts have been extended until 13 March 2026 to safeguard staffing consistency within the SCC and maintain continuous operational oversight.
- The SCC is currently sustained by a small team delivering seven-day-a-week coverage. Any disruption to staffing, whether due to sickness, vacancies, or other capacity challenges, poses a risk to operational resilience and may negatively impact system coordination. The mitigation for this is we have a pool of SCC leads that could and if released by their departments could step in to support if required as well as our Tactical and Gold on calls.
- Demand for Urgent and Emergency Care continues to rise, often exceeding available resources across the system, leading to pressure on service delivery and patient outcomes.
- There is potential for further industrial action, possibly involving additional staff groups, which could exacerbate existing service vulnerabilities.

Emergency Preparedness Resilience & Response

Operational Readiness:

EPRR will support the ICB and ICS to prepare for winter-related incidents or incidents which may occur concurrently during winter.

We will do this by:

- Coordinating the systems Festive Holiday Assurance process and collating the systems Festive Holiday Plan (covering the period of Monday 15 December 2025 – Sunday, 11 January 2025).
- Co-designing and delivering MSE System winter readiness tabletop exercise to test provider 2025/26 winter plans against the nation scenarios. Event schedule for 24 September 2025.
- Leading the systems winter vaccination programme building on learning identified from winter 2024-25 – which included starting preparations earlier, revamping our local winter vaccination strategy and communications approach to address vaccine fatigue and mistrust

System Integration:

EPRR will maintain effective relationships and collaboration with system and multi-agency partners ahead of, during and after winter.

We will do this by:

- We will continue to maintain business-as-usual operations throughout winter while leading system-wide EPRR efforts. This includes chairing the monthly EPRR Forum with local NHS providers, engaging with the Essex Resilience Partnership, and leading the Essex Local Health Resilience Partnership. Ongoing horizon scanning will support short-term preparedness by identifying emerging risks and ensuring coordinated resilience across the region.
- Leading the systems winter debriefing process for winter 2025-26 to capture learning to inform preparations for winter 2026-27

Patient Flow & Discharge:

EPRR will ensure that patients and services that support patient flow and discharges are at the heart of EPRR arrangements ahead of winter.

We will do this by:

- Maintaining patient safety across the system remains a top priority, supported by the 7-day-a-week System Coordination Centre (SCC) as a critical service. This

includes the capability to initiate an EPRR-led incident response for both unforeseen and planned circumstances or events.

- Maintaining robust arrangements to support the timely notification, escalation and activation of incident management arrangements
- Through the annual EPRR Core Standards Assurance process obtain assurance that robust business continuity management is in place for services that contribute to patient flow and discharges
- Through the systems winter vaccination programme ensure focus is on vaccinating eligible staff would work across patient flow and discharge services which will be monitored via the System Winter Vaccination Group

Workforce:

It is vital to maintain the health, welling and resilience of our staff during winter.

We will do this by:

- Promoting the organisations existing staff health and wellbeing initiatives to reduce the risk of stress and fatigue: https://nhs.sharepoint.com/sites/99F_Connect/SitePages/ICB-Change-2025/Health-and-wellbeing-support.aspx
- Maintaining the organisations' ability to respond effectively to major incidents impacting service delivery, including industrial action, cyber security and communicable disease outbreaks, while continuing to resource the SCC and maintain continuous operational oversight
- Supporting our on-call staff ahead of winter by providing a briefing the systems winter plan and any implications from an on-call perspective including a refresher on common escalations during October 2025
- All System Partners are expected to appoint Executive level Winter Leads, this list will be included in the System Winter Plan

Digital & Data:

EPRR will utilising existing systems to support situation awareness and decision making this winter.

We will do this by:

- Refreshing the on-call section of MS Teams ahead of winter to make more user friendly and contains winter related documents and material.

Risks Identified & Mitigation:

Risk	Mitigation
Increase risk of winter related risks such as severe and adverse winter weather, infectious diseases and outbreaks requiring an EPRR response.	EPRR Horizon Scanning activity to provide early warning. EPRR Core Standards provide a level of assurance on EPRR arrangements, system winter readiness exercise.
Non-winter related EPRR risks occurring concurrently with winter pressures resulting in a significant burden on already stressed systems resulting in casualties and disruption.	EPRR Horizon Scanning activity to provide early warning. EPRR Core Standards provide a level of assurance on EPRR arrangements.
Industrial action, the BMA already have a mandate to strike until 6 Jan 2026 with many other trade unions likely to follow suit.	EPRR Horizon Scanning activity to provide early warning, robust and well testing industrial action preparations.

System Vaccination Programme

Operational Readiness:

EPRR will lead the coordination of the ICS Winter 2025–26 vaccination programme, encompassing Flu, COVID-19, and RSV, to strengthen system-wide vaccination uptake and resilience. Key priorities include:

- **Vaccination availability:** being increased across the system through targeted outreach and proactive delivery for eligible cohorts. Delivery models vary by provider and partner, including clinics, roaming teams, and incentive-based schemes such as vouchers.
- **Resilience of critical services:** Minimum 5% annual increase in frontline staff uptake, supported by a coordinated plan - occupational health, peer vaccinators, communications, incentives, and monitoring. The Vaccination Group provides strategic oversight.
- **Community Engagement:** Local communications and collaboration with voluntary, faith, and community sector partners are being strengthened to improve vaccine uptake and reach underserved groups. A data-driven approach is guiding targeted messaging and outreach, with health inequalities embedded in this year's vaccination planning.
- **Delivery Resilience** explore opportunities to enhance the robustness of vaccination infrastructure, including estates, workforce, digital systems, and supply chain, with clear escalation protocols to manage emerging pressures.

System Integration:

The winter vaccination programme will play a key role in effective collaboration across system and multi-agency partners before, during, and after the winter period. This will be achieved by:

- Maintaining the ICS-wide Infectious Diseases and Winter Vaccination Group to coordinate strategic oversight and delivery.
- Collaborative planning will be actively supported across NHS organisations, Local Authorities, Hospices, and the Voluntary and Community Sector to ensure aligned approaches and shared priorities.
- In addition, joint working with multi-agency partners through the Essex Resilience Forum will help promote vaccination uptake among eligible staff and amplify NHS messaging to the public.

Patient Flow & Discharge:

The winter vaccination programme is a key enabler of safe and effective patient flow and discharge across the system. To support this:

- Proactive and targeted approach will be taken to vaccinate the most vulnerable cohorts, helping to prevent outbreaks and reduce avoidable attendances at emergency departments.
- Vaccination uptake among frontline staff will be prioritised to maintain continuity of critical services and care pathways essential to flow and discharge processes.
- Vaccinations will be offered to patients being discharged into care homes, reducing transmission risk and supporting safer transitions of care.

Workforce:

Maintaining the health, wellbeing, and resilience of our workforce is essential to sustaining safe and effective service delivery throughout the winter period. To support this, the following measures will be implemented:

- **Vaccination Uptake:** Focused actions to increase uptake among frontline and eligible staff aim to reduce illness-related absences and support workforce resilience, with a target of a 5% improvement from the 2024/25 baseline. Progress is monitored by the ICS Vaccination Group.
- **Access Expansion:** Exploration of cross-provider access to vaccination sites and the establishment of an ICS-level vaccinator pool to improve uptake across the system.

- **Staff Education:** Distribution of educational materials to all staff highlighting the importance of vaccination in protecting themselves, colleagues, and patients.
- **Absence Monitoring:** Provider organisations will proactively monitor staff absences during winter to inform adjustments to local vaccination programmes and workforce planning.
- **Flu Voucher Scheme:** The ICB has committed to offering flu vaccination vouchers to staff not otherwise eligible, ensuring broader access across clinical and non-clinical roles. This initiative will be promoted within the SCC locality and is specifically aimed at personnel engaged in direct, face-to-face patient care. The programme supports efforts to reduce flu transmission, particularly in the context of evolving working environments.

Digital & Data:

To enhance situational awareness and support informed decision-making throughout the winter period, the vaccination programme will be underpinned by robust digital and data systems. Key actions include:

- **ICS-Level Dashboard Monitoring** An integrated dashboard will be maintained at the ICS level to track vaccination uptake across eligible cohorts and frontline staff, measured against pre-agreed trajectories. This will enable timely identification of gaps and inform targeted interventions.
- **Booking and Capacity Oversight** Real-time monitoring of vaccination bookings and site capacity will be conducted to ensure adequate availability and responsiveness. This will support operational planning and facilitate swift action where uptake or access issues are identified.

Risks Identified & Mitigation:

Risk	Mitigation
Reduced workforce resilience due to illness/low vaccination uptake.	Campaigns to improve vaccination rates among frontline/eligible staff supported by educational materials promoting importance of immunisation.
Limited access to vaccination services across the system.	Explore cross-provider access to vaccination sites and establish an ICS-level vaccinator pool to support broader uptake and operational flexibility.
Staff unaware of vaccination benefits or eligibility.	Disseminate clear, accessible educational resources to staff, reinforcing vaccination in protecting personal health and patient safety.
Inability to respond to emerging absence trends during winter.	Providers proactively monitor staff absences and use data to inform real-

Risk	Mitigation
	time adjustments to vaccination programmes and workforce planning.
Non-eligible staff unable to access flu vaccinations.	ICB provision of flu vaccination vouchers for staff not otherwise eligible, ensuring broader access for clinical and non-clinical staff.
Increased risk of flu transmission in evolving work environments.	Voucher scheme within SCC locality to support uptake among staff with face-to-face patient interactions, reducing transmission risk and supporting service continuity.

Provider Plans

Primary Care

Operational Readiness:

- The ICB intends to operate a Winter Access Scheme based on the same principles as has been in place over each of the previous four winters. This will enable proactive care for an identified cohort of the population as well as reactive capacity for supporting patients during peak periods of winter ailments.
- Primary Medical Services and Community Pharmacy Services are spearheading our flu, covid and RSV vaccination programmes for this winter. Planning is already in place to operationalise at the commencement of the programme. This includes promotion of the flu vaccine to eligible primary care staff.
- Providers have in place their own resilience/critical incident plans. This will support the maintenance of core provision should there be issues such as significant staff sickness, snow etc.
- The ICB will reaffirm contractual obligations of providers over holiday periods etc.

System Integration:

- Actively promoting Pharmacy First as an alternative to general practice for common winter ailments. This includes promotion in local Emergency Departments.
- The ICB has 12 self-referral pathways in operation. These will be promoted to patients to avoid the need to access unnecessary GP appointments during peak winter periods.
- Urgent Access to Dental Care is now fully integrated between IC24 (111) and our dental access providers. This enables direct booking of appointments which in turn will reduce patients presenting with dental issues to EDs or general practice.

Patient Flow & Discharge:

- Most practices are operating total triage models as part of their Modern General Practice implementation. This will result in improved addressing of patient need during the winter period with needs being assessed and sign posted to the most appropriate service.
- Practices and PCNs have well established process to support care homes including delivery of the Enhanced Health in Care Homes elements of the Network DES.
- System to promote admission avoidance pathways and services to primary care as part of the winter planning process.

Workforce:

- Flu vaccinations will be promoted to staff across primary care to improve coverage ahead of peak flu season. Whilst coverage is unknown previously (not centrally recorded), we aim to notionally increase coverage by 5% through the promotion of opportunities to be vaccinated (i.e. CPs and Primary Care sites), the sharing of promotional materials and increasing awareness through PCN discussions.
- ARRS recruitment and retention levels remain strong and resilient
- Winter Access Scheme will fund additional staffing sessions
- Recruitment of ARRS roles and resilience in wider workforce has significantly increased the number of consultations undertaken in MSE over the last five years.

Digital & Data:

- Online consultation systems are widely used across primary care, with "total triage" methodology expected to peak in winter 2025/26.
- NHS App usage is high, with over 15 million logins in Mid and South Essex over the past two years.
- Digital service utilisation, including health record access, patient messaging, online consultations, and prescription management is the highest in the East of England.
- Remote monitoring tools (e.g., blood pressure monitors, pulse oximeters) are well-utilised, enhancing primary care's ability to manage winter-related conditions.
- Cloud-based telephony will be in place across all practices this winter, improving patient access to services.

Risks Identified & Mitigation:

Risk	Mitigation
Increase in unmet demand/need associated with peak winter demands.	This will be partially mitigated through the commissioning of our winter access scheme. The Winter Access Scheme is a PCN level scheme commissioning proactive and reactive capacity. The proactive capacity will be targeted at INT priority cohorts; reactive capacity will operate during January to March 2026 during period of peak seasonal demand.
Patients presenting with repeat prescribing needs having not accounted for holiday periods.	This will be mitigated through both the ICB comms exercises and practices informing patients. This will be undertaken during November/December 2025.

Pharmacy

Operational Readiness:

- **Stock Resilience**

- Community pharmacies maintain appropriate stock levels of winter respiratory and mental health medications, aligned with historical usage and anticipated demand.

- **Pharmacy First Delivery**

- Majority of community pharmacies are signed up to deliver the Pharmacy First service, covering seven designated clinical pathways.

- **Hospital Discharge Medicines**

- Standard procedures for hospital pharmacy discharge medicines will continue to be followed to ensure continuity of care.

- **Holiday Opening**

- Only Christmas Day is formally commissioned; other bank holidays rely on voluntary opening, tracked by HWE.
- Christmas Day hours are limited (2–3 hours per pharmacy), staggered across the day.

- **End-of-Life (EoL) Medicines:**

- All pharmacies can order EoL medicines.

- Nine MSE ICB pharmacies are commissioned to stock a full range during normal hours.
- Boots voluntarily stock the national list, though with a slightly reduced range.

System Integration:

- Community pharmacies receive referrals to the Pharmacy First service from NHS 111, IC24, and general practice.
- The service remains accessible to patients presenting directly without a prior referral.
- General practices are encouraged to adopt formal referral mechanisms to Pharmacy First, rather than informal signposting, to alleviate pressure on GP appointments.
- Emergency Departments have an opportunity to direct appropriate patients to community pharmacies via signposting, pending the establishment of a formal referral pathway.
- Implementation of formal referral processes supports improved clinical governance by ensuring a documented and auditable record of referral receipt within community pharmacy settings.

Patient Flow & Discharge:

- TTA Supply Protocols: Standard procedures are in place for dispensing and supplying To Take Away (TTA) medicines within managed services.
- Contractual Guidance: Hospitals are not contractually required to supply medicines if patients already possess at least 14 days' worth of their prescribed medications.
- Patient Responsibility: Patients may have existing supplies at home or may arrange repeat prescriptions via their GP while admitted. Staff must confirm this with patients to prevent unnecessary delays in discharge.
- Contingency Planning: Use of hospital FP10s for discharge medicines may be considered during pharmacy staffing shortages. This must be pre-planned, as FP10 usage is tightly regulated by hospital pharmacy teams.

Workforce:

Pharmacy Staff Vaccination

- **NHS Eligibility:** Staff eligible for a free NHS flu vaccine should be encouraged to book appointments via their GP or local community pharmacy.

- **Managed Services:** In organisations such as MSEFT, Provide, EPUT, and NELFT, vaccines are procured for staff through occupational health or peer-to-peer arrangements.
- **Community Pharmacy Staff:** Those without formal occupational health schemes may access the NHS vaccine as frontline workers. However, vaccine costs and administration fees are not reimbursable under the Flu Vaccine Advanced Service. Vaccination uptake data for this group is currently not collected.
- **PCN/GP Pharmacy Staff:** These staff should receive flu vaccines through the GP process. Practices cannot claim reimbursement for vaccine or administration costs unless the staff qualify under NHS criteria or are GP locums, as outlined in the General Practice Seasonal Influenza Vaccination Programme Additional Guidance.
- The virtual pharmacy service supporting virtual wards operates under a formal service contract, which requires providers to ensure adequate cover for staff absences due to sickness or planned leave. In instances where internal cover is unavailable, community collaborative pharmacy teams may be called upon to provide support. Prescriptions within this service are issued using FP10 forms and dispensed by community pharmacies, ensuring continuity of care and access to necessary medications for patients under virtual ward management.

Digital & Data:

- **Prescribing Data:** FP10 prescribing data via ePACT is based on dispensing dates and lags by 2–3 months, making it unsuitable for timely monitoring.
- **Pharmacy First Activity:** Monthly data on consultations (minor ailments, urgent meds, clinical conditions) and outcomes is available but not yet integrated into Athena dashboards, despite requests. Access is currently via the homepage.

Risks Identified & Mitigation:

Risk	Mitigation
Pharmacy Operational Risk: Pharmacies are legally required to have a pharmacist on site to operate. On occasion, contractors face challenges securing locum cover or experience delays in pharmacist arrival, resulting in temporary closures.	Mitigation procedures are in place to manage such incidents and minimise disruption to service.
Hospital Pharmacy Staffing: Staffing shortages, particularly at Southend Hospital, are affecting the delivery of pharmacy services.	The Trust is actively addressing this issue through a dedicated task and finish group focused on recruitment and workforce planning.
Community Pharmacy Opening on Bank Holidays and Public Holidays: The	Consideration should extend beyond dispensing and supply functions to

Risk	Mitigation
commissioning arrangements for community pharmacy openings during bank and public holidays require review by the Primary Care team.	include provision of the Pharmacy First service to ensure continuity of care.
End of Life Medicines Availability: Pharmacies contracted to hold End of Life (EoL) medicines may not be commissioned to open on Christmas Day.	HWE currently relies on a volunteer-based model to determine holiday openings, typically resulting in two to three pharmacies being available. This process is reviewed annually to ensure adequate coverage.

Integrated Neighbourhood Teams

Operational Readiness:

- There are 24 Integrated Neighbourhood Teams (INTs) across Mid & South Essex, of these 15 have a partial or full focus on frailty or EOL and 9 have a focus on other areas, part of the INT programme is to support all 24 INTs to have a focus on frailty over the remainder of the 25/26 year.
- This focus on frailty supports the primary care action card requirement to focus on proactive frailty reviews, this will be undertaken via the system use of FrEDA to implement the core interventions to support adults with frailty, including CGA, Falls and medicines assessments and advanced care planning.
- The Frailty and EOL Case finding tool is being made available to wider teams (subject to IG sign up by the Caldicott Guardians in PCNs) and meets the requirement for PHM Risk Stratification. This roll out will start in July 2025 to wider INT teams and is expected to take around 2 months including training for the nominated INT coordinators to access and use the tool. This will support INTs to identify residents at risk of an admission in the next 6 months to focus on prevention

System Integration:

- The roll out of FrEDA is being supported across multiple layers of work including the wider EOL workstream with the hospice collaborative, with the MSECC in the community contract and in delivery with the MSEFT QI team to support a joined-up approach – with leadership from the Age Well Stewards, to support this multi-pronged approach.
- A support resource guide has been developed to support INT teams develop INTs in a systematic way aligned to frailty and EOL care.

Patient Flow & Discharge:

- The focus on frailty will support adults leaving hospital and, in the community, to have the relevant interventions (CGA, falls assessments, medication assessments, PEACE plans etc) that prevent avoidable admissions and readmissions, delivery via the use of FrEDA across acute, community and primary healthcare teams with interventions as per the frailty framework.

What is the expected impact:

- Reduction in Non-elective admissions from care homes to less than 8% across MSE – Baseline across MSE for 24/25 was 18%
- Reduction in >3 non-elective hospital admissions in last 90 days of life – Baseline for the over 65 population in 24/25 was 5.95%.aim to be below 5%
- Reduction % (and number) Emergency admissions due to falls in over 65s (age-standardised rate per 100,000) – Baseline in 24/25 was 2981 (13.6%) admissions for falls

Workforce:

- All staff within Integrated neighbourhood teams (INTs) networks are existing roles within teams who are working together, they are not a sperate team as such staffing support and oversight is via individual providers
- Providers are responsible for supporting the system wide flu campaign with staff aligned to INTs to support system resilience

Digital & Data:

- The INT cohort finder tool has been deployed this supports awareness of cohort sizes at ICB and Alliance level
- An INT case finder tool is due to start rolling out August onwards (timeframe TBC and requires PCN/Practice level sign up to Athena IG to access)
- Primary care and community providers are asked to use the FrEDA tool to record interventions and guidance to support this is within the resource guide for INTS circulated in July 2025.

Risks Identified & Mitigation:

Risk	Mitigation
INTs need to be signed up to Athena to access some tools to support the frailty cohort reviews.	Ongoing work with the IG teams
Staff in provider organisations could be pulled from INT focus on frailty and EOL	Ongoing engagement with INTs re benefits to organisations within the INT

Risk	Mitigation
to support BAU activities or surge work reducing effectiveness of the INT work programme.	
That the remaining 9 INTs are slow to adopt the Frailty and EOL model that the delivery of key interventions will not be undertaken and risk delivery of the metrics.	Alliance teams are working with INTs not yet focusing on frailty to support the roll out.

IC24 – NHS111, CAS, UCCH, OOH

Operational Readiness:

UCCH Clinical Review

- UCCH clinically reviews all EEAST Category 3–5 ambulance calls.
- Focus areas include:
- Here and Treat interventions
- Alternative care pathways
- Community and mental health support
- Transfers to Virtual Wards (VW)
- Occupational health assessments

System Impact

- Here and Treat rates continue to rise month-on-month.
- Ambulance dispatch remains 2.6% below 2019/20 levels, despite increased 999 demand.
- 12% reduction in hospital conveyance, with 2,134 fewer ambulances attending hospital sites.

IC24 Clinical Validation

- IC24 aims to validate all NHS 111, Ambulance, and ED dispositions within 60 minutes.
- Supports safe non-conveyance through Here and Treat or alternative care options.

System Integration:

System Engagement and Operational Coordination

- Active participation in Mid and South Essex (MSE) system calls and huddles, with Silver/Gold-level attendance as required.
- Daily internal huddles incorporate feedback from system calls and communications with system partners.
- Submission of daily situation reports (SitReps), including updates on OPEL status, call abandonment rates, and response times.

Service Development and Integration

- Early discussions underway to explore Primary Care utilisation of UCCH for admission avoidance, enabling a multidisciplinary team (MDT) approach.

Patient Flow & Discharge:

Hospital Avoidance Initiatives

UCCH Clinical Review

- All EEAST Category 3–5 ambulance calls are reviewed for *Here and Treat*, alternative care, community support, Virtual Ward (VW) transfer, mental health, occupational health, and other community services.

Proactive Care Home Support

- IC24 conducts virtual ward rounds with selected care homes to provide early clinical support and reduce reliance on NHS 111.

Pathway Validation

- IC24 aims to validate all NHS 111 Pathways, Ambulance, and ED dispositions within 60 minutes, ensuring safe *Here and Treat* or alternative care options.

Hospice Collaborative Support

- IC24 provides out-of-hours clinical advice to hospices, primarily around prescribing, to enhance patient experience and avoid unnecessary hospital admissions.

Disposition Monitoring and Quality Assurance

- IC24 monitors NHS 111 dispositions, including Primary Care, rejected referrals, self-care, and Pharmacy First/Plus.

- Data insights are used to identify training needs and Directory of Services (DoS) issues, which are addressed accordingly.

Workforce:

Christmas Bank Holiday Staffing and Planning

- Increased staffing across NHS 111, Clinical Assessment Service (CAS), Unscheduled Care Co-ordination Hub (UCCH), and Out-of-Hours (OOH) services during the Christmas Bank Holiday period.
- Workforce planning teams align staffing to demand, with monthly trend reviews and weekly adjustments approaching Bank Holidays.
- Additional clinical hours made available across all services during the festive period.
- Real-time triggers and escalation protocols in place for activating pre-agreed additional staffing.
- Ongoing recruitment supports consistent clinical and non-clinical rota coverage.

Staff Wellbeing

- Free flu vaccination vouchers provided, allowing staff to access vaccinations at their convenience.
- Confirmed vaccination entries qualify for a free prize draw, encouraging uptake and engagement.

Digital & Data:

- Ongoing development of UCCH data to monitor performance, demonstrate outcomes, and inform future demand planning.
- Social media campaign launched to align with and support the national initiative.

Risks Identified & Mitigation:

Risk	Mitigation
Plan Review and Updates	Winter plans reviewed monthly and updated weekly in the lead-up to Christmas Bank Holidays. Adjustments based on emerging trends and system pressures.
Business Continuity: Robust Plan covering	• Incident response • Continuity of essential services • Recovery and return to normal operations
Escalation and Surge Response	• Additional escalation processes in place for winter and Bank Holiday pressures.

Risk	Mitigation
	• Flexible planning informed by rolling four-week trend data (e.g. flu/COVID outbreaks).
Service-Level Triggers: Pre-agreed triggers and support for IC24 services, including staffing and extended hours	• NHS 111 • Clinical queues (NHS 111 and CAS) • Face-to-face and home visiting • UCCH
System-Level Coordination: Defined triggers and support parameters for system partners	• Acute Trusts • EEAST • Community services • Includes staffing support for hospital triage and increased UCCH/OOH capacity.

East England Ambulance Service Trust

Operational Readiness:

Strategic Planning and Leadership

- Winter Plan developed by the Trust Board and CEO, with executive-level representation in ICB winter planning.
- Regional stress-testing exercise scheduled for September 2025 (awaiting revised date).

Service Delivery and Performance

- Targeted actions to meet Category 2 ambulance response times (within 30 minutes).
- Expanded overnight support for 999 call handlers to manage peak demand.
- Standardisation of the CB4C model to reduce unnecessary conveyance.

Coordination and Oversight

- Activation of Local Operational Oversight Cells (LOOC) for daily performance management, with full coverage from November 2025 to March 2026.
- Clinical Safety Plan and Safety Cell in place for escalation and risk oversight.
- Fleet Management supported by a dedicated logistics cell to ensure vehicle availability.

System Integration:

- Executive Director assigned to the ICB to lead system-wide winter planning, supported by Executive and Business Partnership Leads to strengthen collaborative working.
- Improving Patient Flow: Active management of hospital handover delays to meet the 45-minute standard, with enhanced coordination between ambulance and acute providers.
- Strengthen ambulance access to SDECs through trusted accessor plans.
- Expand use of alternative care pathways, including neighbourhood multidisciplinary teams.
- Improve integration with mental health to support timely access and continuity of care.
- Co-location of EEAST clinical staff with community provider teams to enable shared decision-making and pooled resources.

Patient Flow & Discharge:

Optimising Patient Flow

- Support the elimination of corridor care through improved access to alternative pathways, including neighbourhood multidisciplinary teams.
- Mandate the “Call Before Conveyance” (CB4C) model for patients aged 75+ to reduce avoidable hospital admissions.
- Direct less urgent cases to Same Day Emergency Care (SDEC) and maximise utilisation of Urgent Treatment Centres (UTCs).

Improving Clinical Consistency

- Reduce variation in “Hear and Treat” and “See and Treat” rates to ensure equitable and effective care delivery.

Enhancing Operational Efficiency

- Actively manage “Handover to Clear” processes to meet the 45-minute handover target.
- Implement productivity measures to reduce out-of-service time and improve triage outcomes.

Workforce:

- **Staff Vaccination Strategy:** Implementation of targeted vaccination initiatives to enhance staff participation and overall uptake.
- **Optimisation of Patient-Facing Staff Availability:** Deployment of measures including strategic leave adjustments, authorised overtime, and integration of private ambulance services to maximise frontline coverage.
- **Operational Performance and Workforce Commitments:** Sustained focus on achieving productivity benchmarks while ensuring adherence to contracted staff hours.
- **Seasonal Leave Management:** Temporary reduction of annual leave allowances during the Christmas period to support service continuity and patient care demands.

Digital & Data:

- **Enhanced Access to Patient Information:** Ensure timely access to Summary Care Records and federated data platforms to support clinical decision-making and continuity of care.
- **Standardisation of NHS 111 Provider Performance:** Implement region-wide consistency in NHS 111 service delivery across Integrated Care System (ICS) areas to improve patient experience and reduce variation.
- **Integrated Call Routing and Triage:** Enable automatic routing of Category 5 calls to NHS 111, supported by seamless integration of triage systems to enhance efficiency and reduce unnecessary ambulance dispatch.

Risks Identified & Mitigation:

Risk	Mitigation
• **Operational Pressures**: Increased service demand and hospital handover delays, with a need to meet the standard of no handovers exceeding 45 minutes. • **Workforce Challenges**: Higher levels of staff sickness and absence due to seasonal illnesses, compounded by adverse weather conditions affecting staffing and infrastructure.	• **Workforce Resilience**: - Improve vaccination uptake across staff. - Implement a 50% reduction in annual leave over the festive period. - Reduce training temporarily to increase frontline service hours. - Activate overtime and incentive schemes.

Risk	Mitigation
• **System Dependencies**: Strain on system partners impacting EEAST operations, alongside interoperability issues with NHS 111 and the Interoperability Toolkit.	- Apply robust sickness management protocols. - Engage Private Ambulance Services to supplement staffing. • **Operational Coordination**: - Activate Clinical Cell for clinical oversight. - Deploy Local Operational Oversight Cell for tactical response. - Mobilise Fleet Cell to ensure vehicle readiness and availability.

HTG UK – Non-Emergency Patient Transport

Operational Readiness:

- A seven-day workforce model is in place to support both planned journeys and patient discharge transport, ensuring continuity of service throughout the week.
- HTG UK has submitted proposals to the ICB outlining adjustments to daily operations and resource configuration. These plans are designed to support all patient cohorts through winter and beyond, while remaining within existing contractual resource parameters.
- The proposals prioritise pre-planned discharges, introducing measures to optimise vehicle utilisation and establish a dedicated pool of resources for unplanned, same-day demand. This approach safeguards scheduled patient journeys and enhances visibility of available capacity.
- Effective collaboration with acute sites is essential to agree discharge priorities, aligning hospital flow with transport logistics and maximising vehicle deployment efficiency.

System Integration:

- SHREWD Resilience has been enhanced to reflect the current capacity of transport services, ensuring that scheduled demand is aligned with available resources.
- Direct electronic and telephone booking of patient transport from acute and community hospitals.

- Consistent weekday coordination touchpoints are established with acute care teams, enabling collaborative prioritisation and early identification of daily operational risks.

Patient Flow & Discharge:

- HTG has proposed allocating a limited number of daily resources specifically to respond to On the Day transport demand. These resources have been strategically mapped in terms of operational hours and geographic coverage to reflect current demand patterns.
- Enhanced early discharge planning, including transport coordination, is critical to maintaining flow and avoiding delays.
- Particular attention is required for Pathway 2 and Pathway 3 discharges from both acute and community settings. Timely alignment of transport with package of care arrangements and cut-off times is essential to ensure safe and efficient discharge.

Workforce:

- Following agreement on the revised resource configuration, HTG UK will undertake a rota review with all staff. This aims to ensure optimal resource availability during peak journey times, supporting all patient cohorts effectively.
- To maintain contracted workforce levels throughout the winter period, HTG has partnered with a new national agency provider, enhancing staffing resilience across regions.
- HTG continues to prioritise staff wellbeing through its annual flu and vaccination programme, supported by reimbursement schemes to encourage uptake.
- The organisation also offers a comprehensive Employee Assistance Programme (EAP), providing welfare and resilience support to all staff members.

Digital & Data:

- SHREWD Resilience is updated to accurately reflect the capacity of transport services, and scheduled demand now aligns with current resource availability
- PTS Online is accessible across all sites, enabling efficient management of transport bookings and real-time tracking.

Risks Identified & Mitigation:

Risk	Mitigation
Overdemand on NEPTS driven by renal dialysis growth	HTG has submitted a proposal to the ICB to increase resources. Timely review and approval are essential to ensure service continuity.

Risk	Mitigation
Inability to expand evening and weekend NEPTS coverage	Resource uplift is contingent on ICB approval. Interim scheduling adjustments and prioritisation of critical journeys may be required.
Potential shortfall in NEPTS capacity if system adopts full 7-day discharge model.	Scenario planning and phased implementation of 7-day discharge, aligned with transport capacity reviews, will help manage risk.
Surge in demand during predictable peaks (e.g. pre-Festive period)	Early forecasting and temporary resource scaling, including agency support and flexible rota planning, will ensure readiness.

Mid & South Essex Foundation Trust

Operational Readiness:

- Bed modelling forecasts a sustained deficit averaging -95 beds per month from November to March 2026, peaking at -156 beds in January at a 95% occupancy rate. To address this, plans underway to: Reduce length of stay, Optimise SDEC models, and Strengthen ED front door triage and streaming pathways. These interventions will improve internal efficiency, reduce avoidable admissions, and support safe, patient flow.
- Standardised, consultant-led triage will launch at Broomfield and Southend from September. Streaming pathways to include Pharmacy First and SDEC, with direct EEAST into SDEC.
- Maintain 12-hour, 7-day access for Medical, Surgical, & Frailty SDEC services. T&O SDEC pilot begins in Q3 2025/26. The services will reduce ED breaches and avoiding admissions.
- HO45 and trolley capacity will be protected. Escalation beds require executive approval due to financial pressures. Acute frailty services will be protected to ensure rapid assessment and discharge.
- Full Capacity Protocols and prioritise SDEC to reduce corridor care and 12-hour waits. Delivery supported by the internal professional standards.
- On track to meet UEC targets while balancing urgent care and elective recovery.

System Integration:

- Implement safe redirection of patients presenting at the Emergency Department to Pharmacy First services where clinically appropriate, supporting demand

management and ED pressure, and patients receive timely care in the most suitable setting.

- Attendance at the daily MSE Situation Awareness Meeting providing an overview of hospital status, including demand, capacity and plans to support urgent care flow, maintain elective and cancer service delivery and performance against the operating plan.
- The Integrated Transfer Care Hub will be the operational bridge between acute services and system partners, facilitating and supporting the management of complex discharges and delays. This will enhance discharge efficiency, reduce length of stay, and improve coordination across care settings during winter pressures.

Patient Flow & Discharge:

- **Protect SDEC Services from Escalation Pressures:** Maintain medical, surgical, and frailty SDEC services as business-as-usual, ensuring they are protected from escalation bed pressures to maximise external referrals and reduce avoidable admissions. Risks remain due to site-specific bed deficits and staffing constraints.
- **Shift Discharge Profile to "Home for Lunch":** Continue quality improvement initiatives to extend the "home for lunch" discharge model, supporting earlier discharge and improved bed availability.
- **Embed Pre-Emptive Discharge Planning:** Strengthen daily board rounds and discharge planning, including weekly reviews for patients on the neuro pathway with Neuro Navigators. Continue embedding CCD and Red to Green processes to support timely discharge.
- **Activate Transfer of Care Hub (ICTH):** Ensure full activation of the ICTH with 7-day system partner coverage. The service is fully recruited and provides six-day central coordination, with named leads available across all seven days to support complex discharge planning and flow.
- **Eliminate Internal Discharge Delays (>48 Hours):** Embed system-supported Red to Green processes via ICTH, with a commitment to timely Estimated Date of Discharge (EDD), Clinical Criteria for Discharge (CCD), discharge letters, TTAs, and transport coordination to prevent delays.
- **Protect Elective Inpatient Capacity:** Maintain site-specific ring-fencing of elective beds to deliver cancer and elective operating plan trajectories. Flexibility between UEC and elective demand will be overseen by the COO and CMO.

Workforce:

- **Senior Clinical Decision-Makers:** Maintain a 7-day roster of senior clinical decision-makers to support timely patient flow and escalation management. While this is a business-as-usual function, a review of skill mix will be undertaken during the winter period to ensure resilience.
- **On-Call and Site Leadership:** Ensure robust on-call rotas are in place across all three hospital sites, covering operational, strategic, and tactical levels. The "Matron of the Day" model will continue to operate daily to support patient flow. During OPEL Level 3 and 4 escalations at weekends, on-call teams will be present to facilitate flow. Medical and nursing leadership will be strengthened through designated controller arrangements, with rotas compiled 12 weeks in advance to ensure appropriate skill mix during peak pressure periods.
- **Elective and Cancer Service Protection:** Safeguard elective and cancer capacity through dedicated staffing and operational oversight. A balanced approach will be maintained between urgent and emergency care (UEC) and elective/cancer activity, with flexibility overseen by the Chief Operating Officer and Chief Medical Officer to respond to demand fluctuations.
- **Staff Vaccination Programme:** Deliver the Flu and RSV vaccination programme for all staff. Under the leadership of the newly appointed Occupational Health Lead, vaccination plans will commence from Summer 2025, including roving vaccinators and Vaccine Champions embedded across Divisions.

Digital & Data:

- Embed SHREWD Resilience into daily Emergency Department and site meetings to support proactive demand management, improve situational awareness, and enable timely decision-making.
- Fully utilise TeleTracking across acute sites to optimise patient flow, embed red-to-green processes, and strengthen discharge tracking through real-time bed visibility.
- Automate data feeds into SHREWD to enhance system-wide visibility of demand and capacity, supporting coordinated mutual aid when required.
- Ensure timely and accurate upload of required datasets to national situation reports to maintain oversight of operational pressures and support regional and national coordination.

Risks Identified & Mitigation:

Risk	Mitigation
Bed deficits across sites may necessitate corridor care and escalation space	Escalation space and staffing above run-rate will require Divisional & Executive

Risk	Mitigation
usage. Staffing escalation beds above run-rate presents operational and financial challenges. From November to March 2025 the average bed deficit at MSEFT is -95 beds, with January peaking at -156.	sign-off. Planning is underway to reduce reliance on corridor care and safe deployment of resources. Further length of stay reduction, and mobilisation of T&O SDECs and ED front Door model will reduce the bed deficit.
High ambulance demand, particularly at Southend, may exceed offload capacity.	Temporary corridor offload space enacted to maintain flow and prevent delays.
Limited availability of HO45 and trolley capacity may hinder surge response and patient throughput.	Capacity is being pre-allocated and made readily accessible to support winter pressures.
Escalation pressures may impact medical, surgical, and frailty SDEC services, reducing admission avoidance opportunities.	Core services will be protected from escalation capacity enable direct referrals.

Integrated Care Transfer Hub

Operational Readiness:

- **Community Readiness**: The ICTH is fully staffed and operational, delivering seven-day services with regular staffing reviews and mitigation plans to support system flow.
- **Discharge Performance**:
  - Target to reduce medically optimised patients and discharge delays to 140 (MO: 95 / Delays: 45).
  - All assessments completed within one day.
  - Maintain 30 Hospital@Home slots per site.
- **Oversight and Escalation**:
  - Strategic Lead conducts daily reviews of delays across acute and community beds.
  - Proactive monitoring of discharge barriers with timely escalation to providers.
  - Escalation planning underway with local authorities to address system delays.
- **System Governance and Integration**:
  - **Care Home Task and Finish Group**: Focused on reducing acute demand, ambulance conveyances, and ensuring care is delivered in the right setting.

- **D2A Oversight Group**: Provides leadership and support for timely discharge.
- Improved integration with mental health services delay resolution meetings.

System Integration:

- Continue to capture and disseminate live data across the system to support operational transparency and timely decision-making.
- Ongoing review of areas for improved data collection to strengthen demand and capacity planning and inform pathway development and escalation triggers.
- TeleTracking to automate and monitor patient flow, bed availability, and discharge processes across acute/community settings, enabling faster response and coordination.

Patient Flow & Discharge:

Service Provision & Admission Avoidance

- Maintain 6-day service (including Saturdays) to support flow
- Strengthen integration with UCCH and review all repatriation requests to prevent unnecessary acute bed use
- Monitor care home admissions into MSEFT daily; allocate resources to support timely return and refer to out-of-hospital services
- Track Emergency Department notifications for care home residents; deploy resources to support admission avoidance in collaboration with community teams

Pathway Oversight & Development

- Weekly Neuro pathway reviews with Neuro Navigators
- Support Orthopaedic LOS reduction pilot at Southend; planned rollout to Broomfield and Basildon
- Collaborate with Virtual Wards to optimise capacity
- Identify new H@H pathways: AKI pathway live; Zoledronic acid IV pathway in development with SOP for winter

Performance Monitoring & Escalation

- Maintain stretch KPI: ≤120 medically optimised and delayed patients across MSEFT
- Daily Red to Green reviews and weekly long LOS meetings; proactive discharge planning for patients with LOS >21 days
- Increase IDT staffing across NELFT community beds, including stroke units

- Weekly community collaboration meetings to support flow

Workforce:

- **Staffing Model**: The Integrated Community Team Hub (ICTH) is now fully established, operating under a flexible workforce model designed to respond dynamically to system-wide pressures.
- **Bank Staff Utilisation**: Bank staff will be deployed to manage fluctuations in demand and patient flow across services within the ICTH portfolio, including Discharge to Assess (D2A) pathways.
- **Leadership Oversight**: Leadership structures are in place, with an operational group responsible for reviewing staffing levels in line with the approved business case.
- **Vaccination Programme**: All ICTH staff are actively encouraged to participate in the Trust's winter vaccination initiative to support workforce resilience.
- **Staff Wellbeing and Support**: Routine debriefs, and support mechanisms remain standard practice, with enhanced proactive wellbeing measures implemented during periods of increased winter pressure. All staff have access to the Trust's wellbeing resources.
- **Mental Health Integration**: A business approved on 27 August 2025 to embed dedicated mental health support within ICTH, aimed at reducing delays and improving access to specialist input across the system.

Digital & Data:

- **Real-Time Data Sharing**: ICTH continues to capture and share real-time data with system partners to support operational decision-making and improve responsiveness.
- **Demand and Capacity Monitoring**: Ongoing review of data capture opportunities to enhance visibility of system pressures and inform pathway development and escalation planning.
- **TeleTracking Implementation**: TeleTracking is actively used to monitor patient movement, bed availability, and discharge processes across hospitals and care facilities, supporting automation and real-time operational oversight.

Risks Identified & Mitigation:

Risk	Mitigation
Service Transition	Regular review of demand and capacity, supported by escalation processes and ongoing engagement with ECC.

Risk	Mitigation
ECC H2A service transition with new providers going live in November 2025; MSEFT bridging service will cease.	
Local Authority Staffing Lack of Sunday social worker coverage in Thurrock, causing assessment delays during peak demand.	Thurrock is exploring revised winter staffing models using Better Care Fund resources.
Equipment Services Delays in meeting equipment demand and timely delivery.	Monitor delays and escalate to the responsible lead for intervention as needed.
Care Home Capacity Care home closures may impact discharge pathways.	Monitoring with assurance around outbreak management plans to support safe admissions.
Discharge Failures Failed discharges due to process issues (e.g., cut-off times, TTAs, documentation delays).	Early notification and escalation when discharge plans are not progressing.

Community Collaborative: Minor Injuries Unit

Operational Readiness:

- A fully staffed seven-day service will be maintained, with rotas covered to meet patient care and urgent care requirements consistently across the week.
- Effective leadership will be in place to provide supervision, manage escalation pathways, and ensure safe, responsive care
- During periods of heightened operational demand, a review of all non-essential scheduled activities—including training sessions, study leave, and internal meetings—will be undertaken to optimise workforce availability and support service delivery.
- Daily flow huddles will continue to be conducted and updated regularly to support real-time decision-making and promote effective communication across teams.

- Ensure the Directory of Services (DoS) is consistently maintained and updated to reflect the current status of live, accessible services. This will support accurate service navigation and enable timely referrals across the system.

System Integration:

- Ensure consistent participation in the daily MSE Situation Awareness Meetings, maintaining seven-day coverage. These meetings provide a critical platform for real-time operational oversight, enabling proactive management of system pressures, patient flow, and service delivery across Mid and South Essex
- Ongoing liaison will be maintained with acute and primary care partners to ensure alignment of service provision and to facilitate coordinated responses to system pressures.

Patient Flow & Discharge:

- All patients attending the Minor Injuries Unit are screened upon arrival to ensure appropriate care pathways. Daily pre-opening handovers are conducted to support planned activity and manage anticipated demand.
- Throughout the day, the nurse in charge will proactively stream patients to the most suitable services, ensuring efficient use of resources and timely care delivery.

Workforce:

- Service coverage will be maintained across a seven-day working model, supported by rosters that ensure appropriate skill mix and operational resilience. Festive period rotas have been planned and will be shared system-wide to support coordinated delivery. Business Continuity Plans (BCPs) are in place to mitigate the impact of extreme sickness levels, with staff actively encouraged to receive flu and COVID-19 vaccinations. Daily flow huddles will continue to be updated to support real-time operational oversight and responsiveness.
- To support staff wellbeing and resilience during winter pressures and outbreak management, refresher training will be provided on key infection prevention and control (IPC) practices, including PPE donning and doffing, hand hygiene, and respiratory etiquette. IPC champions will be rostered across wards and emergency departments to reinforce best practice and provide on-the-ground support. In addition, staff wellbeing will be prioritised through proactive leadership, access to supervision, and escalation pathways to ensure teams feel supported and safe throughout periods of increased demand.
- Annual leave will be managed effectively, including over the festive period, to ensure service continuity.

- Implement a comprehensive on-site flu and RSV vaccination programme for all staff, patients, and volunteers, with the objective of achieving uptake at least 5% higher than the 2024/25 baseline. Supported by targeted outreach initiatives, enhanced awareness campaigns, and improved service accessibility. Progress monitored through weekly uptake reporting enabling timely evaluation and responsive adjustments.

Digital & Data:

None identified.

Risks Identified & Mitigation:

Risk	Mitigation
Demand consistently exceeds available capacity, resulting in service delays and increased operational pressure.	Caseloads are regularly reviewed to prioritise care and optimise resource use, with flexible staffing and escalation protocols in place to manage surges in demand.
X-ray service operational hours do not align with those of the Minor Injuries Unit (MIU), potentially impacting timely diagnostics and patient flow.	The issue has been formally escalated to Mid and South Essex NHS Foundation Trust (MSEFT), the provider of X-ray services, for resolution and alignment of service hours.

Community Collaborative: Urgent Community Response Team

Operational Readiness:

- A fully staffed seven-day service will be maintained, with rotas covered to meet patient care and discharge requirements consistently across the week.
- Strong Leadership and Escalation Support will be in place to provide supervision, manage escalation pathways, and ensure safe, responsive discharge planning.
- Staff pooling and resource sharing are in place across the community collaborative, supported by a 'mutual aid' Memorandum of Understanding (MOU) where required. A flexible staffing model enables staff to adjust working hours or take on additional shifts during peak winter demand.
- All caseloads will be systematically reviewed, with each patient undergoing a risk assessment to determine prioritisation based on clinical need and urgency.
- The Urgent Community Response Team prioritise patients currently on the ward, while balancing this with patients awaiting admission to the frailty virtual ward via UCRT.

- UCRT response times will be staggered in accordance with individual risk assessments, with agreed timelines communicated to the referring clinician or service.

System Integration:

- Participation in the daily MSE Situation Awareness Meetings, maintaining seven-day coverage. These meetings provide a critical platform for real-time operational oversight, enabling proactive management of system pressures, patient flow, and service delivery across Mid and South Essex.
- Daily flow huddles will be conducted to review action plans, with any necessary escalations directed to the Integrated Care Transfer Hub (ICTH) for system-wide coordination.

Patient Flow & Discharge:

- Review of patients on caseloads to identify those that could be discharged to create additional capacity
- Community teams working effectively together to share workload and flexing capacity based on demand in particular areas
  Additional touchpoints between the Urgent Community Response Team (UCRT) and Frailty Virtual Ward (FVW) will be established throughout the day to support improved patient flow and reduce avoidable Emergency Department attendances.
- The Urgent Community Response Team (UCRT) will work closely with NHS 111 to enable direct referrals, ensuring timely mobilisation of community-based care and reducing unnecessary hospital conveyance.
- The Urgent Community Response Team (UCRT) will work closely with primary care services to enable direct referrals, ensuring timely mobilisation of community-based care and reducing unnecessary hospital admissions.

Workforce:

- **Staff Wellbeing & Resilience:** To support staff wellbeing and resilience during winter pressures and outbreak management, refresher training will be provided on key infection prevention and control (IPC) practices, including PPE donning and doffing, hand hygiene, and respiratory etiquette. IPC champions will be rostered across wards and emergency departments to reinforce best practice and provide on-the-ground support. In addition, staff wellbeing will be prioritised through proactive leadership, access to supervision, and escalation pathways to ensure teams feel supported and safe throughout periods of increased demand.
- **Annual Leave Management:** Annual leave will be managed effectively, including over the festive period, to ensure service continuity.

- **Vaccination strategy:** Implement a comprehensive on-site flu and RSV vaccination programme for all staff, patients, and volunteers, with the objective of achieving uptake at least 5% higher than the 2024/25 baseline. Supported by targeted outreach initiatives, enhanced awareness campaigns, and improved service accessibility. Progress monitored through weekly uptake reporting enabling timely evaluation and responsive adjustments.

Digital & Data:

- Capacity and flow data are shared with ICB and acute partners up to three times daily through huddles, using the SHREWD Resilience platform to support real-time system coordination and response.

Risks Identified & Mitigation:

- Operational leadership 5 day a week full rota in place. On call paper due to go through governance to explore 7 day a week robust cover.

Community Collaborative: Virtual Wards

Operational Readiness:

- A fully staffed seven-day service will be maintained, with rotas covered to meet patient care and discharge requirements consistently across the week.
- Effective leadership will be in place to provide supervision, manage escalation pathways, and ensure safe, responsive discharge planning.
- Daily board rounds and twice-weekly multidisciplinary team (MDT) meetings are conducted to support patient flow and discharge planning. Board rounds will increase during capacity surges to help reduce length of stay.

System Integration:

- Ensure consistent participation in the daily MSE Situation Awareness Meetings, maintaining seven-day coverage. These meetings provide a critical platform for real-time operational oversight, enabling proactive management of system pressures, patient flow, and service delivery across Mid and South Essex.
- Daily flow huddles will be conducted to review action plans, with any necessary escalations directed to the Integrated Care Transfer Hub (ICTH) for system-wide coordination.

Patient Flow & Discharge:

- Review of patients on caseloads to identify those that could be discharged to create additional capacity

- Community teams working effectively together to share workload and flexing capacity based on demand in particular areas
- All caseloads will be systematically reviewed, with each patient undergoing a risk assessment to determine prioritisation based on clinical need and urgency.
- The Virtual Ward will prioritise patients currently on the ward, while balancing this with patients awaiting admission to the virtual ward via UCRT.
- Within the virtual ward prioritisation will be given to 'step-up' patients over 'step-down' cases to ensure timely escalation of care where clinically indicated.
- Additional touchpoints between the Urgent Community Response Team and Virtual Ward are maintained throughout the day to prevent Emergency Department attendance and improve flow.
- Staff are deployed across the three acute hospital sites to support discharge processes and facilitate timely transitions of care.

Workforce:

- A fully staffed seven-day service will be maintained, with rotas covered with the correct skill mix to meet patient care and discharge requirements consistently across the week.
- Strong Leadership and Escalation Support will be in place to manage escalation pathways, and ensure safe, responsive discharge planning.
- Staff pooling and resource sharing are in place across the community collaborative, supported by a 'mutual aid' Memorandum of Understanding (MOU) where required. Flexible staffing model to enables adjustable working hours or take on additional shifts during peak winter demand.
- To support staff wellbeing and resilience during winter pressures and outbreak management, refresher training will be provided on infection prevention and control practices, including PPE donning and doffing, hand hygiene, and respiratory etiquette. IPC champions will be rostered across wards and emergency departments to reinforce best practice and provide on-the-ground support. In addition, staff wellbeing will be prioritised, access to supervision and escalation pathways to ensure teams feel supported and safe throughout periods of increased demand.
- Annual leave will be managed effectively, including over the festive period, to ensure service continuity.
- Implement a comprehensive on-site flu and RSV vaccination programme for all staff, patients, and volunteers, with the objective of achieving uptake at least 5%

higher than the 2024/25 baseline. Supported by targeted outreach initiatives, enhanced awareness campaigns, and improved service accessibility. Progress monitored through weekly uptake reporting enabling timely evaluation and responsive adjustments.

Digital & Data:

- Participation in the daily MSE Situation Awareness Meetings, maintaining seven-day coverage. These meetings provide a critical platform for real-time operational oversight, enabling proactive management of system pressures, patient flow, and service delivery across Mid and South Essex
- Capacity and flow data are shared with ICB and acute partners up to three times daily through huddles, using the SHREWD Resilience platform to support real-time system coordination and response.

Risks Identified & Mitigation:

- Operational leadership 5 day a week full rota in place. On call paper due to go through governance to explore 7 day a week robust cover.

Community Collaborative: Inpatient Beds

Operational Readiness:

- A fully staffed seven-day service will be maintained, with rotas structured to ensure consistent delivery of patient care and discharge planning throughout the week.
- Strong leadership will oversee supervision, escalation management, and safe, responsive discharge coordination.
- To support system capacity, staff will be flexibly redeployed across teams, with additional bank/agency support utilised in line with local vacancy protocols for safe staffing levels.
- Business Continuity Plans are in place to mitigate the impact of high sickness levels and ensure service resilience.
- Community Matrons will triage referrals to facilitate timely discharge and prevent unnecessary admissions, supported by weekly caseload reviews to ensure care is delivered in the most appropriate setting.
- Integrated working with Neighbourhood Teams, Transfer of Care Hubs, and Urgent Community Response services will streamline discharge processes and activate community support.

- Home First approach will be prioritised, supported by reablement services with active management of delays +48 hours for discharge-ready patients to maintain patient flow.

System Integration:

- Participation in the daily MSE Situation Awareness Meetings will be maintained across seven days, providing real-time operational oversight and proactive management of system pressures, patient flow, and service delivery across Mid and South Essex.
- Collaborative working with the Integrated Transfer of Care Hub and Local Authority teams will support the resolution of complex discharges from Intermediate Care and stroke rehabilitation units, ensuring safe and timely transitions.
- Multi-Agency Discharge Events (MADE) in place to review referrals, assess caseload duration, evaluate self-administration of medication, and identify voluntary sector services to support patients, thereby enhancing caseload management and discharge efficiency.

Patient Flow & Discharge:

- The Full Capacity Protocol SOP has been finalised, with OPEL 4 actions now including use of day rooms in exceptional circumstances and flexible admission criteria to maximise bed utilisation during system pressure.
- Escalation beds and intermediate care units are fully staffed and prepared for surge activity, supported by seven-day therapy and diagnostic services to maintain discharge flow.
- Care plans are regularly reviewed to align with current patient needs and discharge pathways. An action plan is underway to implement the Xyla checklist across services for consistent assessment and planning.
- A Standard Operating Procedure for direct ambulance admissions via the Urgent Community Care Hub is under development.
- Early Supported Discharge and stroke services are being strengthened through caseload reviews with acute teams, risk-based discharge planning, increased MDT frequency, and prioritised step-downs from Bayman and CICC.
- Non-urgent services may be temporarily paused to release capacity for urgent care and discharge support during peak demand.
- Infection prevention and control (IPC) protocols for respiratory viruses and norovirus are robust, including zoning, cohorting, and designated respiratory zones

for direct flu admissions. Escalation protocols are in place for suspected outbreaks, with coordination through Health Protection Teams and rapid testing.

- Within community hospital settings, bays and side rooms are flexed to support cohorting and isolation in line with IPC guidelines.
- A vaccination protocol is in place for eligible patients being discharged to care homes, offering vaccination prior to transfer where accepted.

Workforce:

- The Full Capacity Protocol SOP has been finalised, with OPEL 4 actions now including use of day rooms in exceptional circumstances and flexible admission criteria to maximise bed utilisation during system pressure.
- Escalation beds and intermediate care units are fully staffed and prepared for surge activity, supported by seven-day therapy and diagnostic services to maintain discharge flow.
- Care plans are regularly reviewed to align with current patient needs and discharge pathways. An action plan is underway to implement the Xyla checklist across services for consistent assessment and planning.
- A Standard Operating Procedure for direct ambulance admissions via the Urgent Community Care Hub is under development.
- Early Supported Discharge and stroke services are being strengthened through caseload reviews with acute teams, risk-based discharge planning, increased MDT frequency, and prioritised step-downs from Bayman and CICC.
- Non-urgent services may be temporarily paused to release capacity for urgent care and discharge support during peak demand.
- Infection prevention and control (IPC) protocols for respiratory viruses and norovirus are robust, including zoning, cohorting, and designated respiratory zones for direct flu admissions. Escalation protocols are in place for suspected outbreaks, with coordination through Health Protection Teams and rapid testing.
- Within community hospital settings, bays and side rooms are flexed to support cohorting and isolation in line with IPC guidelines.
- A vaccination protocol is in place for eligible patients being discharged to care homes, offering vaccination prior to transfer where accepted.

Digital & Data:

- Teletracking will be used to enable real-time discharge tracking, beginning with the discharge order and nursing documentation. This integration ensures continuous visibility of patient status, supporting efficient coordination and timely discharge across the system.
- Capacity and flow data are shared with ICB and acute partners up to three times daily through huddles, using the SHREWD Resilience platform to support real-time system coordination and response.

Risks Identified & Mitigation:

Risk	Mitigation
Operational leadership 5 day a week full rota in place.	On call paper due to go through governance to explore 7 day a week robust cover.
HTG is unlikely to provide transport for community patients before 12 midday.	Formal escalation of transport issues to the ICB via contractual routes; issue logged on the corporate risk register.
Community nursing teams are absorbing unplanned activity due to other services reaching capacity.	Regular caseload reviews to manage demand and prioritise care effectively.
Demand consistently exceeds available capacity within community teams, particularly affecting the EPUT Collaborative Care Team.	Business Continuity Plans (BCPs) in place to address staffing challenges.
Increased delays in service delivery during winter months.	Staff encouraged to receive flu and COVID-19 vaccinations to reduce sickness-related absences.

Hospices – Farleigh, Havens and St Lukes

Operational Readiness:

- **Clinical Workforce & Bed Capacity:** All clinical teams operating at full establishment, ensuring adequate staffing to meet service demands. Plans underway to expand Hospice Rapid Access bed capacity, with proposals for two additional beds at Farleigh Hospice and one at St Luke's Hospice to support timely discharges and community-based care.
- **Daily Operational Management:** The Hospice Escalation in Activity Tool (HEAT), modelled on the OPEL framework, is used daily to assess service pressure levels and guide resource allocation, and proactive management of capacity against demand.

- **Cross-Provider Coordination:** Daily safety huddles and multidisciplinary team meetings are held across providers for cohesive care planning, rapid escalation response, and shared situational awareness.
- **System-Wide Collaboration:** Daily review meetings with NHS provider organisations support discharge planning, escalation management, and continuity of care. Shared flow trackers are actively used in partnership with Mid and South Essex Foundation Trust to enhance visibility, coordination, and real-time decision-making.
- **4/7 Access to Specialist Palliative Care:** Access to SPC is maintained across the region

System Integration:

- A designated Executive Lead will represent the Health and Care Partnership (HCP) at the Integrated Care Board (ICB) Winter System Pressures Group.
- Expand access to Hospice Community Services to increase the number of patients receiving end-of-life care in community settings.
- Provide strategic and operational support to additional virtual ward pathways, specifically those focused on frailty and respiratory conditions.
- Integrated Digital Tools and Communication Utilise shared Microsoft Teams sites and flow trackers in collaboration with Mid and South Essex Foundation Trust (MSEFT) to enhance coordination, visibility, and responsiveness across services.

Patient Flow & Discharge:

- Hospice Rapid Access Services All hospices operate a Hospice Rapid Access service in accordance with a defined Standard Operating Procedure (SOP), enabling timely discharge or initiation of community-based care for eligible patients. Same-day assessments are available Monday to Friday to support rapid response.
- Emergency End-of-Life Discharges Implement processes to facilitate emergency end-of-life discharges from acute hospitals during weekends, ensuring appropriate transition to hospice care or home settings, thereby reducing length of stay.
- Palliative Care In-Reach to Emergency and Urgent Care Settings Explore opportunities to embed specialist palliative care input within Emergency Departments (ED) and/or Urgent Community Care Hubs (UCCH), including participation in "call before convey" pathways to support appropriate care decisions.
- Community-Based Specialist Palliative Care Availability Deliver specialist palliative care advice and support in the community to prevent avoidable hospital

admissions. Services are available:24/7 for St Luke's Hospice8am to 8pm, seven days a week for Farleigh Hospice and Havens Hospice

- Community Crisis Response Maintain robust community crisis support mechanisms to manage urgent palliative care needs outside of hospital settings.
- Multidisciplinary Team (MDT) Community Visiting Deploy Specialist Palliative Care MDTs for proactive community visits aimed at preventing hospital admissions and supporting complex care needs.

Workforce:

- **Staff Vaccination & Data Reporting** Continued increase in staff vaccination uptake, with timely submission of immunisation data to the Winter Pressures Group to support system-wide resilience planning.
- **PEoLC Clinical Advice Availability** A dedicated Palliative and End-of-Life Care (PEoLC) Clinical Nurse Specialist (CNS) advice line is operational seven days a week, ensuring consistent access to expert guidance for patients, carers, and professionals.
- **Consultant On-Call Coverage** PEoLC Consultant support is available seven days a week across the system, providing senior clinical input for complex case management and escalation.
- **Flexible Workforce Solutions** Utilisation of an internal staff bank alongside access to a pool of experienced and trained agency professionals ensures continuity of care and rapid workforce deployment during periods of increased demand.

Digital & Data:

- Access to the Summary Care Record (SCR) across relevant clinical teams to support informed decision-making and continuity of care.
- Drive an increase in referrals to the Enhanced Palliative and End-of-Life Care Coordination Service (EPAACs) to improve timely access to specialist support.
- Promote paed pathways within EPAACs to address needs of children & young people requiring palliative care.
- Expand the use of AccurRx for virtual consultations to enhance accessibility and remote clinical engagement.
- Integrate the BRIGID digital platform within Community Services to streamline care coordination, improve data sharing, and support multidisciplinary working.

Risks Identified & Mitigation:

Risk	Mitigation
Financial Sustainability	All hospices are currently managing charitable income shortfalls and financial deficits. Recovery plans are in place and under monthly review. These pressures may necessitate future reductions in clinical service provision if not addressed.
Workforce Resilience	Staff absence is being actively managed through established absence policies, ensuring continuity of care and minimising disruption to service delivery.
Inpatient Bed Capacity	Farleigh Hospice operates with a limited inpatient bed base of 10 beds, which constrains flexibility during periods of high demand and impacts discharge planning from acute settings.

CAMHS – Set CAMHS Crisis

Operational Readiness:

The SET-CAMHS Crisis Team is part of the Southend, Essex and Thurrock Child and Adolescent Mental Health Services (SET CAMHS), run by the NELFT NHS Foundation Trust:

- The SET-CAMHS Crisis Team operates as a 24-hour service and will remain fully functional throughout the winter period. A robust staffing rota has been established to ensure safe staffing levels are consistently maintained, with appropriate mitigations in place to address and resolve any emerging concerns.
- The crisis team across all areas meet twice daily as an MDT which includes seniors and Psychiatry Mon-Fri to ensure oversight of all cases.
- On Call Psychiatry rota remains in place for out of hours consultation support.
- NELFT weekend on call management huddle to ensure oversight of CYP at Emergency Departments.

System Integration:

- Liaison with the Provider Collaborative will be undertaken to ensure that bed flow management teams are fully informed of current service pressures and can identify inpatient beds as efficiently as possible. In parallel, collaboration with social care services will be initiated to confirm safe and appropriate discharge arrangements.

Additionally, ongoing engagement with Acute Hospital Mental Health Liaison Nurses will support the coordination of multidisciplinary meetings and provide oversight of patient care pathways.

Patient Flow & Discharge:

Mental Health Crisis Pathway for Individuals Under 18 Attending A&E:

- When a child or young person (CYP) under 18 presents to A&E in a mental health crisis, a referral to the SET-CAMHS Crisis Team may be made once they are medically cleared.
- The Crisis Team will attend the A&E or ward to conduct an assessment, which must occur within four hours of the CYP being deemed medically fit. This assessment determines whether the young person can be safely discharged.
- If discharge is appropriate, necessary steps will be taken. If the discharge location poses safeguarding concerns, the team will liaise with social care to identify a suitable alternative.
- Should the CYP's mental health or risk level prevent safe discharge, the team will work with acute staff to arrange continued hospital care until a CAMHS bed is available.
- Discharge planning meetings will be held as needed to ensure safe and coordinated transitions.

Workforce:

The SET-CAMHS Crisis Team operates on a 24-hour rota system to ensure continuous coverage. Team members are equipped through internal training focused on acute hospital procedures, enabling effective response and coordination within these settings.

SET-CAMHS Crisis Team – Escalation Process

Weekdays (Mon–Fri, 09:00–17:00)

- **Senior Practitioners (Band 7):** For hospital escalations: **0800 953 0222, (**Option 1 → then Option)
- **Team Manager:** Abbie O'Sullivan, Abbie.osullivan@nelft.nhs.uk, 07970 154629
- **Clinical Lead:** Lisa Parker, Lisa.parker@nelft.nhs.uk

Out-of-Hours (Evenings, Weekends)

- **Weekend Cover (Sat–Sun, 08:30–16:30):** Senior Practitioner via **0800 995 1000**

- **On-Call NELFT Manager (All other out-of-hours):** Contact via **0800 995 1000**
- The Winter Flu Vaccination programme 25/26 is delivered across NELFT to all staff. Peer vaccinators from each service are trained to improve access for staff, increase compliance rates and aid staff and patient safety by reducing the risk and burden of winter viruses.

Digital & Data:

- SHREWD data will be completed and submitted to the Mid and South Essex (MSE) system to provide oversight of all CYP CAMHS cases remaining in A&E or ward settings, and to report any staffing-related concerns.

Risks Identified & Mitigation:

- In the event of a potential increase in winter-related sickness, NELFT will take proactive measures to maintain service continuity. This includes securing appropriate cover through bank staff and coordinating with other CAMHS Crisis locality teams to ensure adequate coverage within acute hospital settings.

CAMHS – Eating Disorder

Operational Readiness:

- The SET-CAMHS Eating Disorders Service comprises three key components: the Core Eating Disorders Pathway, Enhanced Treatment Pathway, and Day Programme. The service remains fully operational throughout the winter period.
- Operating Monday to Friday, 09:00–17:00, the team ensures safe staffing levels are maintained, with proactive planning to accommodate staff leave and illness during seasonal pressures.

System Integration:

- **Provider Collaborative:** Ongoing liaison ensures bed flow management is aware of service pressures and can identify inpatient beds efficiently when required.
- **Social Care Collaboration:** Joint working with social care teams enables additional home support alongside the day programme, helping to prevent unnecessary admissions.

Patient Flow & Discharge:

Referrals & Triage

- Referrals via Single Point of Access and triaged by Clinician of the Day.
- Classification follows MEED guidelines - Urgent referrals: seen within 5 working days, and routine referrals: seen within 28 calendar days

- COD instructs admin staff to arrange assessments with parents/carers or healthcare professionals (HCPs).
- **Assessment Locations:** Assessments are conducted at: Chelmsford, Clacton, Colchester, Basildon, and Harlow. Hospital-based assessments are available for inpatients.
- **Post-Assessment & MDT Review:** Following assessment, the young person is discussed in a Post Assessment Discussion (PAD). The multidisciplinary team (MDT) confirms diagnosis and treatment eligibility.

Treatment Pathways

- Eligible patients are offered treatment under: Core Team, Intensive Support Pathway (ISP) and Day Hospital
- ARFID diagnoses are excluded from these pathways.

Medical Risk Management

- YPs at risk of re-feeding syndrome are placed on a re-feeding plan. If physically compromised they are referred to ED; if admitted, ISP provide daily reviews and support.
- Patients at risk of admission are referred to the Day Hospital, requiring completion of NHSE Form 1 and screening by the Provider Collaborative.
- The Day Hospital also offers one virtual bed.
- Therapeutic Interventions
- Core pathway patients receive therapy once or twice weekly based on risk level.
- Interventions include Family-Based Treatment (FBT), Cognitive Behavioural Therapy (CBT), Meal support and Dietetic and psychiatric input.

Workforce:

- The service operates during core hours: Monday to Friday, 08:00–18:00. Outside these times, young people are supported by additional NELFT services, including the SET-CAMHS Crisis Team.
- Teams are fully established with both administrative and clinical staff, including posts specifically allocated to support winter pressures and service continuity. The Winter Flu Vaccination programme 25/26 is delivered across NELFT to all staff. Peer vaccinators from each service are trained to improve access for staff, increase compliance rates and aid staff and patient safety by reducing the risk and burden of winter viruses.

Digital & Data:

- All clinical records are maintained on SystemOne, with an expectation that entries are completed within 24 hours of contact. This ensures continuity of care and safeguards against disruptions should a team member become unexpectedly unavailable.

Risks Identified & Mitigation:

Risk	Mitigation
During winter, patients with low weight-for-height are at increased risk of medical deterioration. Those identified as high risk under MEED receive regular reviews and close medical monitoring. If physical health concerns arise, appropriate medical intervention is sought, including referral to A&E when necessary.	- Robust continuity processes to ensure COD follow-up if staff are absent - Planned leave schedules to maintain safe staffing levels - Access to the Close Monitoring Clinic (CMC) for short-term risk management when allocation is affected In addition to core clinical care, the team can offer virtual appointments, supported by physical health monitoring at GPs or urgent care centres when needed.

EPUT – Adult Mental Health

Operational Readiness:

- **Crisis & Urgent Care Readiness:** Surge readiness of 24/7 crisis response and assessment services with bank staff support, with extended weekend working for Specialist Mental Health Teams to manage high-intensity demand. Dedicated task and finish group is optimising the urgent care pathway and a review of step-up/step-down protocols between Crisis Resolution Teams and Integrated Primary Care.
- **Emergency Department (ED) Flow & Diversion:** Expand access to assessment centres through the ED diversion capital project and interim plans, with a focus on reducing ED stays under 24 hours via targeted work on length of stay and discharge delays. Portfolio review is being considered to support targeted inpatient roll-out of Therapeutic Time Care.
- **System Flow, Capacity & Oversight:** Management delegated to locality teams with twice-daily oversight, weekly Adult system delay meetings and Older Adults in development. Locality meetings provide oversight of inpatient admissions and community demand.

- **Pathway Development & Governance**: Strengthen community capacity and pathways through the Community First Model, while streamlining referrals via an enhanced Single Point of Access with TFY and ECC Wellbeing Team. Local resolution of Quality Assurance Framework issues will support more responsive decision-making.

System Integration:

- **Alcohol Liaison Support:** OPEN Road Alcohol Liaison Workers are in post to provide follow-up support in the community following ED presentations.
- **High Intensity User Group (HIUG) Management:** System-wide approach to managing the top 20 HIUG cases through coordinated strategy meetings involving clinical teams, police, and out-of-hours AMHP service, focusing on positive risk-taking and safety planning.
- **Crisis Concordat Collaboration:** Strengthened PAN Essex Crisis Concordat with a focus on winter mental health planning, including working with police and AMHP/EDS services to reduce Section 136 detentions and prevent unnecessary use of the Mental Health Act.
- **Weekend System MDTs:** MDTs operating at weekends to support coordinated care and decision-making across the system.

Patient Flow & Discharge:

- **Reduce Inpatient LOS**: Target a 7% reduction in average length of stay across inpatient units, supported by the Time to Care programme and trust-wide tracking tools.
- **Clinical Review & Readmission Analysis**: Conduct medical reviews for all patients with stays over 60 days, including those under Section 3. Analyse readmissions within 60 days of discharge (Jan–July 2025) by diagnosis, frequency, and locality.
- **Operating Model Implementation**: Continue embedding the Operating Model principles—purposeful admission, proactive discharge, and Time to Care—to reduce LOS and out-of-area placements.
- **Ward-Level Improvements**: Ensure 'Red to Green' processes are embedded across all wards and hold monthly MADE events to drive discharge planning.
- **Discharge Prioritisation & Housing Support**: Prioritise discharge of long-stay High Intensity Users and out-of-area placements. Scope funding to enable in-hours emergency housing access and develop a consistent pathway and training for community teams to support accommodation needs.

Workforce:

- **Vaccination Programme**: Deliver flu and RSV vaccination programme for all staff, targeting a minimum 5% increase from 2024/25 uptake. Four clinics will operate across Essex sites, supported by People Asset Management and estate scoping.
- **Seven-Day Clinical Cover**: Roster senior clinicians across seven days, including matron and flow team coverage, and 7-day consultant presence on the Assessment Unit.
- **Discharge Support**: Provide additional temporary hours to expedite discharge paperwork from inpatient units.
- **Weekend Working & Cost Pressures**: Submit costing proposal to EPUT Executive Board to address uncommission weekend working for Community and Specialist Mental Health Teams.
- **Staffing Review & Flexibility**: Conduct a staffing review across CRS, HTT, MHLT, and UCD services. Implement flexible staffing between UCD and MHLT and increase administrative capacity at UCD to support night-time liaison with local authorities and VCSE partners, enabling clinicians to focus on patient care.

Digital & Data:

- **System Visibility & Leadership**: Submit capacity and demand data into SHREWD Resilience to support real-time system oversight and escalation management. Leadership presence at MSE Situation Awareness meetings to provide updates on capacity, flow, and escalation needs.
- **Digital Tools for Intelligence & Flow**:
  - Use MaST for crisis prediction and early intervention.
  - Apply SMART for real-time bed management.
  - Leverage Power BI for inpatient flow and demand analytics.
  - Roll out FOUNDARY tool with training to support demand and capacity modelling.

Risks Identified & Mitigation:

Risk	Mitigation
Lack of funding for uncommissioned weekend working may lead to reduced service availability, delayed care, and increased weekday pressures.	Submit a detailed proposal to the EPUT Executive Board, supported by data on service impact. Explore interim staffing solutions and engage system partners for potential co-commissioning.

Essex County Council – Adult Social Care

Operational Readiness:

- Management oversight and escalation protocols will continue to inform the setting of the LAPEL level, which directs the deployment or de-escalation of infrastructure to address system pressures. This includes determining the frequency of system calls and the cadence of reporting.
- Senior Leadership meets weekly at the Priority Review Meeting (PRM) to establish the LAPEL level, review the Situational Report (SITREP), and provide strategic position statements from each locality. This forum plays a central role in coordinating the Emergency Control Centre's (ECC) winter response.

System Integration:

Countywide Delivery

- **Support for Carers**: Centralised contact point, proactive carer identification, and targeted wellbeing interventions
- **System Schemes**: Dementia Community Support, ARC/ECL reablement capacity, and flexible surge response.
- **Pathway Support**: TOCH team spot purchasing to manage winter pressure

Locality-Level Actions

- **Falls Prevention**: Slipper swaps, exercise guidance, and social care links
- **Discharge Support**: VCS-led resettlement support following hospital discharge
- **Therapy Integration**: Therapy staff supporting reablement effectiveness

Patient Flow & Discharge:

Intermediate Care Programme Overview

Implementing a system-wide approach to strengthen the intermediate care offer through collaboration with providers/partners. The model will increase:

- Support for individuals to remain at home
- Use of care technology
- Reduction in demand for long-term care

The programme also aims to:

- Improve operational flow and efficiency
- Prioritise outcome-based support

- Integrate services under a unified specification
- Maintain protected capacity for admission avoidance
- Drive continuous improvement across care pathways

Operational Delivery

- Primary reablement contracts recommissioned with updated objectives
- Bridging services are transitioning to improve patient flow and support Home First model. The current contract ends on 31 October, with reduced Better Care Fund resources prompting a gradual scale-down of service slots. New service launches on 1 November, prioritising care pathways based on individual need. A joint mobilisation plan in place to ensure smooth transition.
- Referrals into reablement will be prioritised to reduce delays/spot purchasing
- Providers will coordinate and flex capacity based on demand, enabling faster discharge and reduced handoffs

Programme Development Actions

- Review of decision points and intermediate care pathways to establish shared roles and criteria, including CHC eligibility.
- Launch of the Home to Assess service to optimise reablement capacity
- Procurement schedules aligned with winter preparedness (H2a and RtH)
- Contracts structured to enable surge capacity activation when required

Workforce:

- **Management oversight and escalation:** Continue set a LAPEL level which guides us in standing up/down infrastructure for pressure response, including frequency of system calls and reporting. Senior Leaders convene at the weekly Priority Review Meeting (PRM) to set this level and review our SITREP report as well as give position statements from each locality area. This forum is key in coordinating the ECC response around winter.

Digital & Data:

- Development of an Intermediate Care Dashboard to monitor service utilisation, capacity, length of stay, spot purchasing, inpatient activity, and outcome metrics (e.g. failed starts, restarts, readmissions, ongoing care needs).
- Care Technology Expansion: The Care Technology programme aims to increase support to individuals, as it is designed to promote independence, enhance quality of life, and reduce demand on health and social care services. Care technology

offers a preventative approach and, in some cases, serves as an alternative to directly commissioned services by enabling individuals to manage their needs more autonomously.

Risks Identified & Mitigation:

- **Management Oversight and Escalation:** Continue to implement a LAPEL level framework to guide the activation and deactivation of infrastructure in response to system pressures. This includes determining the frequency of system-wide calls and reporting requirements. Senior Leaders convene weekly at the Priority Review Meeting (PRM) to establish the current LAPEL level, review the Situation Report (SITREP), and provide position statements from each locality. This forum plays a critical role in coordinating Essex County Council's (ECC) operational response, particularly during the winter period.

Southend-on-Sea City Council – Adult Social Care

Operational Readiness:

- Recovery Team supports patient flow through SEDS and reablement by assessing needs and attending MDT meetings to deliver person-centred care.
- Fortnightly partner meetings ensure processes remain relevant and capacity is aligned to demand.
- Contingency planning with providers helps scale services during peak periods (e.g., winter pressures, flu outbreaks) to maintain timely hospital discharges.
- Real-time capacity monitoring in SEDS and Reablement enables rapid decision-making and prevents discharge delays.
- Fall prevention initiatives continue year-round, with a focus during winter months, in collaboration with partners and providers.
- Community engagement with user groups and care providers ensures access to innovative support solutions.
- Strong relationships with local care providers are maintained, supported by regular Quality Team visits to uphold infection prevention and control standards, particular.

System Integration:

- To manage seasonal pressures, leveraging the Better Care Fund to support initiatives that prevent admissions, reduce readmissions, and enable timely discharges, strengthening patient flow and system resilience.
- We remain committed to close collaboration across the health and care system, ensuring individuals, carers, and frontline staff are supported throughout winter.

- Alongside targeted interventions, working with the Alliance on falls prevention programmes and promoting social connection through local groups. We're also partnering with the Voluntary and Community Sector to deliver Pathway 0 discharge support, helping people return home safely and confidently.

Patient Flow & Discharge:

- Through strong collaboration across the health and care system, we continue to advance a person-centred, home-first approach that leverages care technology to support safe discharge and independent living. Preventative care remains central to improving outcomes and easing pressure on urgent care services. Enhanced system integration with partners now enables real-time data sharing, improving care coordination and supporting more informed decision-making.
- Ensuring seamless transitions and operational efficiency across Southend's services remains a core priority. We are focused on preventing avoidable hospital admissions, delivering personalised outcomes, and championing a "home first" approach. Integrated services—such as SEDs—are instrumental in placing individuals on the most appropriate care pathway from the outset.
- Earlier this year, we enhanced the Supported Early Discharge (SED) service to improve discharge pathways and system flow ahead of winter pressures. A key change was shifting from fixed care "slots" to a flexible, hour-based commissioning model. Delivered by a single provider, the service now supports more individuals without exceeding commissioned hours or compromising quality. These improvements have already led to faster hospital discharges and fewer delays, and we expect continued benefits throughout the winter period.
- The SEDs service is a delivered 7 days a week including weekends. We have a clear timeline for hospital discharge through SEDs of 48 hours, with people in this service for no more than 14 days.
- Better Care Funding to support local care providers and workforce capacity, informed by lessons from previous winters. By continuing successful schemes and adapting contract capacity where needed, we ensure individuals are quickly placed on the right care pathway.

Workforce:

- To manage system pressures effectively, we continue to use a LAPEL level framework that helps guide when to activate or scale down operational infrastructure. This includes determining the frequency of system-wide calls and reporting requirements.
- Daily intelligence reports provide senior leaders with real-time insights into service pressures across the city. These updates are vital for year-round monitoring, but

especially critical during the winter months, enabling us to respond swiftly and proactively to emerging challenges.

- In collaboration with the Health Protection Operations Manager and Strategic Commissioning Officer, committed to ensuring that the vaccination programme, covering both flu and RSV vaccinations, is accessible to all eligible staff and residents across the city. Commissioning staff will also work closely with local providers to monitor vaccination uptake among their staff and service users, while actively encouraging increased participation.

Digital & Data:

- Work closely with local SEDs and Reablement providers, who deliver daily operational reports and live dashboard updates. This allows us to monitor system flow in real time and manage performance across services effectively.
- Share real-time bed availability and discharge data with NHS partners via the SHREWD Resilience platforms to support patient flow and resource allocation across Adult Social Care and hospital settings. Updated daily, SHREWD Resilience supports proactive planning, reduces delays, and improves outcomes by providing a system-wide view of capacity and demand.

Risks Identified & Mitigation:

- To manage system pressures effectively, we continue to use a LAPEL level framework that helps guide when to activate or scale down operational infrastructure. This includes determining the frequency of system-wide calls and reporting requirements.
- Daily intelligence reports provide senior leaders with real-time insights into service pressures across the city. These updates are vital for year-round monitoring, but especially critical during the winter months, enabling us to respond swiftly and proactively to emerging challenges.

Thurrock Council – Adult Social Care

Operational Readiness:

- Management oversight and escalation protocols will continue to inform the setting of the LAPEL level, which directs resource prioritisation.
- SPUR meetings – Weekly meetings consisting of senior management, ASC Functions (hospital team, brokerage, HR etc), community health partners (EPUT and NELFT). Please note meeting frequency is determined at AD level or above and changes in responses to situation/LAPEL level e.g. can move to twice weekly or daily. SPUR meetings establish the LAPEL level, review demand and capacity

(including PoLR workforce), resolves issues in the system, co-ordinates the system response and prioritises and directs resources.

- Established services and activities to manage seasonal pressures, such as reablement and interim beds, falls prevention and IPC support.

System Integration:

Delivering services for patient-centred care to improve outcomes with home first principles:

- **Sharing Information:** The SPUR acts as the main point to share information and co-ordinate an appropriate response.
- **Planning jointly:** Attendance at the MSE Winter Strategic Group, development and sharing of contingency plans etc, system wide planning and prioritisation of resources occurs at BCF Delivery group and ICB level.
- **Working collaboratively:** A number of services/functions are integrated or aligned in Thurrock. Joint health and social care appointments at director level to ensure collaboration. Integrated locality teams (ILT's) at neighbourhood level providing joined up, person centred and preventative services.

Patient Flow & Discharge:

Operational Delivery: following information does not include existing initiatives that are part of our BAU such as our intermediate care offer, unpaid carer support, home care etc.

- Re-procurement of home care contracts have occurred to ensure sufficient capacity in the market (discharge support)
- In-house Reablement service has been redesigned. This has currently created 100% additional capacity and improved outcomes/pathway for individuals. (discharge support)
- Significant underutilisation of bridging capacity/contract. If this trend continues there should be sufficient capacity to support hospital discharge, should we experience a surge in demand. (discharge support)
- Negotiations with Older People care home market on fee levels underway. This should ensure supply and potentially increase capacity (discharge support).
- Home from hospital voluntary sector resettlement and follow up service. Funding and capacity (moved to 7 day a week working and all age) was increased for 2025/26 (discharge support). Additional test and learn in A&E to see if the service can support with non-clinical issues and signposting to reduce demand (admission avoidance).

- In addition to our core unpaid carer services, a crisis response offer is being tested (admission avoidance).
- Falls prevention test and learn operating in ILT 4 to support with a reduction in admissions (admission avoidance)
- Respiratory test and learn operating in ILT 3 (including enhanced training for home care workers in advance of winter) to support with a reduction in admissions (admission avoidance).
- Enhanced payment to care workers to ensure cover over the festive period (discharge support).

Workforce:

- **Management oversight and escalation -** SPUR sets the LAPEL level including system response and use of resources. Representatives at this meeting include senior leaders, core ASC functions and partner/system organisations. This forum is key in coordinating Thurrock's response to winter pressures.
- **International Recruitment -** There is an emerging risk around International Recruitment and the impact of the change to immigration legislation affecting the care workforce. There are transitional arrangements in place which should mitigate some risk. However, Thurrock is reviewing our reliance/exposure to IR within our external care workforce and will be supporting the sector to increase domestic recruitment to minimise the risk of IR's choosing to leave the UK for other opportunities.
- **Vaccines and IPC –** It is Important to vaccinate health and social care workers to protect them and reduce the risk of them spreading flu to their patients, service users, colleagues and family members. Those eligible are frontline workers in social care settings without an employer led occupational health scheme. Employers are responsible for commissioning or implementing a service to vaccinate frontline staff and encouraging vaccination. Vaccination of eligible groups in the population including care home residents and those over 65 years is commissioned from General practice by NHS England and to school age CYP by Hertfordshire community trust (HCT).

Digital & Data:

- Monitors capacity in the care home market three times per week. Bed availability is shared and discussed at SPUR and action taken as appropriate during the period to secure supply (purchasing outside of Thurrock, block booking beds etc).
- Share real-time bed availability and discharge data with NHS partners via the SHREWD Resilience platform to support patient flow and resource allocation across Adult Social Care and hospital settings. Updated daily, SHREWD Resilience

supports proactive planning, reduces delays, and improves outcomes by providing a system-wide view of capacity and demand.

Risks Identified & Mitigation:

Risk	Mitigation
Workforce - We have identified workforce as our main risk within ASC (in general and for the purposes of winter planning). Adult social care as a sector has a significant number of vacancies and the recruitment and retention issues facing the sector have been mitigated by the use of IR's nationally (although please note that Thurrock is not as exposed as some councils). In response to the workforce risks, we have developed an Integrated Workforce Strategy and are recruiting an officer to lead on its implementation. This will include support to increase both domestic recruitment and improve retention. On an operational level, an outbreak of winter illness would impact significantly on our ability to provide services.	Mitigation is linked to the vaccination plans for the health and social care workforce.
Resources - As stated previously we have wider Care Act responsibility than hospital admissions/discharge and limited resources in which to deliver our statutory duties. We have committed to the activities detailed within the Patient Flow section but can only deliver services within our financial envelope.	No mitigation identified.
Significant changes within health - The efficiencies being sought by the health system may impact on the social care system and the quality of provision in the external market. This may result in increased hospital admissions.	No mitigation identified.

Mortuary Service Provision

Operational Readiness:

Mortuary capacity is crucial in supporting operational resilience over winter, as health systems face increased pressure from seasonal illness, adverse weather and higher mortality rates.

- Broomfield Hospital
  - Capacity: 144 adults, 25 paediatrics
  - Equipment: 17 standard freezers, 5 bariatric units
- Basildon Hospital
  - Capacity: 105 normal fridges, 5 narrow, 24 paediatrics
- Southend Hospital Current: 63 adults in temporary basement mortuary
  - Future: New mortuary with 195 fridges/freezers – September 2025
  - Contingency: Additional 63 spaces retained in basement post-build
- Adam & Greenwood
  - 120 spaces with capacity to uplift as required

System Integration:

- The Mortuary section within the MSE SHREWD Resilience platform will be updated daily and actively utilised to monitor system capacity, inform operational discussions, and support effective planning to maintain flow across the wider health and care system.
- In addition, mortuary capacity pressures will be escalated to the MSE ICB SCC in a timely manner to support coordination across the system and/or Essex Resilience as required.

Patient Flow & Discharge:

- Essex County Council capacity will be monitored through daily reporting, any requirement to flex will be reviewed and accommodated accordingly between each mortuary and ECC directly.

Workforce:

Ensure continuity of service and staff wellbeing during periods of increased seasonal pressure, mortuary services will adopt a proactive and flexible workforce strategy:

- Forecasting seasonal demand using historical trends to identify staffing gaps and initiate early recruitment
- Prioritising internal bank and permanent staff to minimise reliance on agency workers and maintain continuity of care
- Promoting staff wellbeing initiatives, including mental health support and flexible working arrangements

- Collaborating with Local Resilience Forum partners to develop contingency plans for surge capacity and ensure coordinated response

Digital & Data:

Robust digital infrastructure and data-driven insights are essential during winter, when seasonal illness and increased mortality place heightened pressure on mortuary services. To support operational resilience:

- Utilise SHREWD Resilience dedicated mortuary capacity dashboard, updated daily to reflect real-time availability across acute and community settings
- Leverage data analytics to forecast demand, monitor occupancy trends, and inform contingency surge planning
- Integrate with wider NHS reporting platforms to ensure mortuary operations are aligned with patient flow metrics and discharge performance indicators

Risks Identified & Mitigation:

Risk	Mitigation
Increased deaths from winter-related illnesses such as flu and cold which could overwhelm mortuary capacity.	Contingency storage such as mobile units or regional overflow arrangements) and utilising predictive analytics to forecast demand and prepare accordingly.
Over-reliance on digital tracking and case management systems may lead to system failures.	Implement back-up systems and offline access to critical data.
Increased workload and unfamiliarity with winter protocols or digital systems.	Provide winter-specific training on digital tools, infection control and surge protocols.

Appendix B

Mid and South Essex Winter Plan 2025/26

Quality / Equality and Health Inequalities Impact Assessment

1. Executive Lead

Samantha Goldberg, Executive Director of Performance & Planning

2. Policy/Plan

Mid & South Essex Winter Plan 2025/26

3. Purpose of the Policy/Plan

To ensure system-wide operational readiness and resilience across Mid & South Essex during the winter period 2025/26. The plan aims to maintain high-quality urgent, emergency, and elective care services while safeguarding vulnerable populations and promoting equitable access. It supports the delivery of national performance standards and enables proactive management of seasonal pressures through integrated, collaborative approaches.

4. Who is Effected by the Policy/Plan?

The Winter Plan impacts a wide range of stakeholders across the health and care system, including:

- Patients, particularly those with protected characteristics and complex needs
- NHS and social care staff, including permanent, bank, and agency workers
- Carers and families, who play a vital role in supporting care delivery
- Local authorities and voluntary sector partners, essential for community-based support and outreach
- Providers across acute, community, mental health, and primary care, who are central to delivering coordinated and responsive services

5. Equality & Health Inequality Considerations

Protected Characteristic / Group	Potential Impact	Mitigation / Positive Action
Age	Older adults are more vulnerable to winter illnesses and hospitalisation. Children may face delays in urgent care.	Prioritised flu/RSV/COVID vaccinations; enhanced frailty pathways; paediatric ED targets; virtual wards and UCRT support.
Disability	Risk of delayed discharge or access to services for those with physical or learning disabilities.	Use of SHREWD, TeleTracking, and ICTH to streamline discharge; accessible transport planning; digital inclusion efforts.

Protected Characteristic / Group	Potential Impact	Mitigation / Positive Action
Race/Ethnicity	Potential for lower vaccination uptake and access barriers.	Targeted outreach via community and faith groups; culturally appropriate comms; data-driven equity monitoring.
Sex	No direct negative impact identified.	Gender-neutral service delivery; workforce planning considers gender balance.
Pregnancy & Maternity	Increased risk from flu/RSV/COVID; access to maternity services during surges.	Prioritised vaccination for pregnant women; protected maternity pathways.
Religion/Belief	Potential conflict with service delivery during religious observances.	Flexible service models; culturally sensitive care planning.
Sexual Orientation / Gender Reassignment	Risk of discrimination or lack of inclusive care.	Staff training; inclusive language and policies; safeguarding protocols.
Carers	Increased pressure during winter; risk of burnout.	Carer support pathways; flexible discharge planning; voluntary sector engagement.
Deprived Communities	Higher risk of poor outcomes and lower access to care.	Enhanced community care, Pharmacy First, self-referral pathways, and digital access support.

6. Health Inequalities Focus

- Vaccination Equity: Deliver targeted outreach and engagement campaigns tailored to underserved and high-risk populations, leveraging community leaders and trusted voices to improve uptake and reduce barriers.
- Digital Inclusion: Expand access to digital health tools such as SHREWD, the NHS App, and remote monitoring platforms by providing training, support, and alternative access routes for digitally excluded individuals.
- Workforce Wellbeing: Strengthen inclusive wellbeing initiatives for all staff groups, including bank and agency workers, with access to mental health support, flexible working options, and recognition schemes.
- Access to Care: Enhance timely access to urgent and emergency care through the continued rollout of urgent community response teams, virtual wards, and 24/7 mental health crisis services, with a focus on equity of provision across geographies and demographics.

7. Impact on Quality Care

- Real-time coordination through SHREWD Resilience and daily huddles, enabling rapid response to system pressures.

- Protected Same Day Emergency Care (SDEC) services to reduce Emergency Department breaches, support early assessment, and improve patient flow.
- Integrated discharge pathways via the Integrated Care Transfer Hub and Unscheduled Care Co-ordination Hub , streamlining transitions and reducing avoidable admissions.
- Digital automation and dashboards for escalation, performance tracking, and governance oversight.
- Targeted vaccination programmes for staff and vulnerable groups, reducing illness-related disruption and safeguarding service continuity.

8. Monitor and Evaluation

- Real-Time Dashboards: Utilise SHREWD Resilience and Power BI dashboards to monitor system performance, including access, flow, and patient outcomes, enabling rapid response to emerging pressures.
- Vaccination Uptake: Track vaccination rates through the System Vaccination Group, with disaggregated data to identify and address disparities.
- Equity Audits: Conduct regular reviews of discharge delays, emergency department breaches, and service access, segmented by age, ethnicity, deprivation, and other key demographics.
- Feedback Loops: Strengthen feedback mechanisms via patient experience teams, Healthwatch, and community partners to ensure lived experience informs service improvement and equity planning.

9. Conclusion and Evaluation

The Mid & South Essex Winter Plan 2025/26 reflects a robust and inclusive approach to managing seasonal pressures. By embedding equity at the heart of service delivery, investing in the utilisation of digital and workforce resilience, and maintaining rigorous monitoring and evaluation, the system is well-positioned to mitigate health inequalities and safeguard vulnerable populations. The plan exemplifies collaborative leadership and proactive planning across the system, ensuring that no one is left behind during the most challenging months of the year.

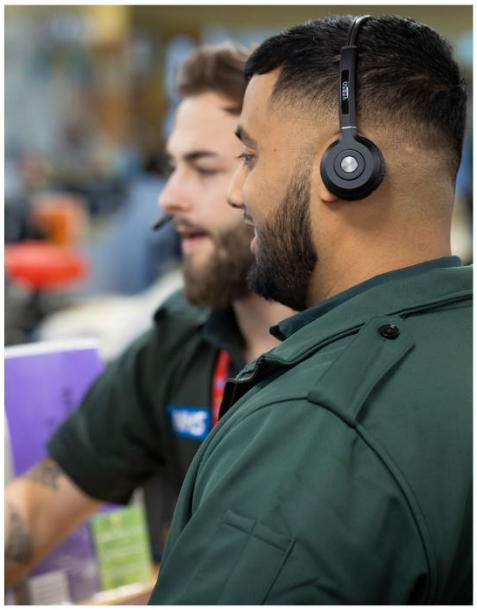
Department of Health & Social Care

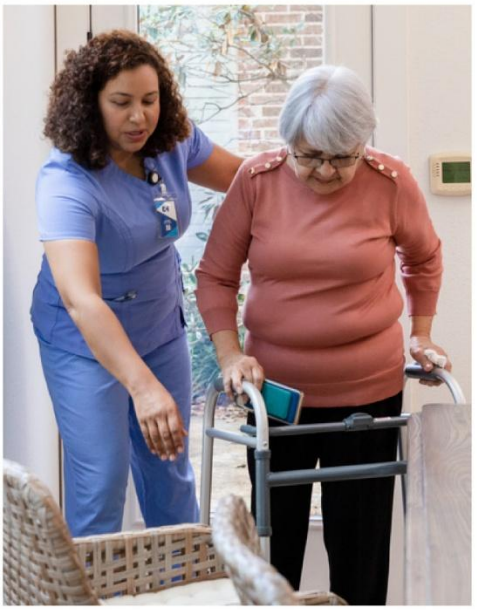
NHS England

Appendix C

Urgent and emergency care plan 2025/26

June 2025





Contents

Summary of priority actions and their impact

Actions	Impact for patients and carers
Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter	By the year-end, with improvement over winter, we expect to: • reduce ambulance wait times for Category 2 patients – such as those with a stroke, heart attack, sepsis or major trauma – by over 14% (from 35 to 30 minutes) • eradicate last winter's lengthy ambulance handover delays by meeting the maximum 45-minute ambulance handover time standard, helping get 550,000 more ambulances back on the road for patients • ensure a minimum of 78% of patients who attend A&E (up from the current 75%) are admitted, transferred or discharged within 4 hours, meaning over 800,000 people a year will receive more timely care • reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time. This will improve patient safety for the 1.7 million attendances a year that currently exceed this timeframe • reduce the number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month • tackle the delays in patients waiting to be discharged – starting with the nearly 30,000 patients a year staying 21 days over their discharge-ready-date, saving up to half a million bed days annually • increase the number of children seen within 4 hours, resulting in thousands of children every month receiving more timely care than in 2024/25
Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter	• improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19. This means that in 2025/26, we aim to improve uptake by at least 5 percentage points • increase the number of patients receiving urgent care in primary, community and mental health settings, including the number of people seen by Urgent Community Response teams and cared for in virtual wards

	• meet the maximum 45-minute ambulance handover time standard • improve flow through hospitals, with a particular focus on reducing patients waiting over 12 hours and making progress on eliminating corridor care • set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings • reduce length of stay for patients who need an overnight emergency admission. This is currently nearly a day longer than in 2019 (0.9 days) and needs to be reduced by at least 0.4 days
National improvement resource and additional capital investment is simplified and aligned to supporting systems where it can make the biggest difference	Allocating over £370 million of capital investment to support: • around 40 new same day emergency care centres and urgent treatment centres • mental health crisis assessment centres and additional mental health inpatient capacity to reduce the number of mental health patients having to seek treatment in emergency departments • expansion of the Connected Care Records for ambulance services, giving paramedics access to the patient summary (including recent treatment history) from different NHS services, enabling better patient care and avoiding unnecessary admissions

Introduction

1. This summer will mark a turning point for the NHS: the 10 Year Health Plan will set the most transformative agenda we have seen in over 2 generations.

2. But we cannot wait for the publication of the plan to fix those things we can change now.

3. Working across whole systems to improve urgent and emergency care (UEC) won't just deliver a better winter for our patients and staff, it will start to free up leadership headroom. Improving this important UEC pathway will help financially challenged systems become more productive and cost-effective.

4. But most of all, this plan is about being accountable to our communities. It's about committing to working around the clock this summer to prepare for winter 2025/26. Ultimately, this is about improving patient outcomes.

The imperative for change

5. The current performance of UEC services does not meet the standards our patients need or our frontline staff want to deliver.

6. It has been over 5 years since the 18-minute response to Category 2 ambulance calls standard was met, and over a decade since the service delivered the standard for 95% of patients waiting 4 hours or less in A&E.

7. The public continue to feel the impact of poor UEC delivery. The British Social Attitudes Survey into the NHS and social care, published in April this year, showed that satisfaction with the NHS and, in particular, A&E services – already at a record low last year – has deteriorated even further and is declining at a faster rate than before.

8. In short, we've normalised asking our staff to deliver sub-optimal care, and our patients have all but given up hope of expecting a reliable service in urgent care.

9. The burnout our frontline staff feel – particularly in the acute sector who feel the brunt of the consequence of poor system-wide urgent care delivery – has been clear in the conversations we've had with staff as part of the Change NHS process. The stories our patients have told us through the same process – sometimes heartbreaking descriptions of truly terrible experiences – underpin the urgency we now expect NHS leaders to have to meet essential constitutional standards.

10. We must do everything we can to significantly improve UEC services this winter compared to what our patients and staff have experienced in recent years, and this plan sets out clear expectations about what each part of the NHS needs to do – starting from today – to make this happen.

11. Every day, over 140,000 people access UEC services across the country, including more than 11,000 who are so unwell they need to be admitted to hospital for a day or more, and 20,700 people who are seen by the ambulance service. Since 2010/11, the number accessing UEC services has risen by 90%, and the number seen by the ambulance service has risen by 61%.

12. This huge increase in reliance on UEC services has only in part been fuelled by an ageing population and an increase in multiple long-term conditions and mental health needs. In truth, it is largely a consequence of services being organised in a confusing and

disparate way by multiple providers. We do not always work together to deliver services in a way our communities would expect and NHS staff would like.

13. Our inability – and, in some exceptional circumstances, unwillingness – to work more coherently across different service providers in the NHS and social care has led to a deterioration in performance that would have been unimaginable a decade ago.

14. When patients feel they have no choice but to go to emergency departments or call an ambulance just to access care, the system has failed them.

15. There are some exceptionally effective UEC services – however, this isn't consistently the case, with wide variation across the country. A significant and tangible step change is needed from all boards and chief executives to fully optimise all available services to improve UEC. Successful systems have reformed their approach to improving UEC; they have a shared focus on maximising the use of primary care and community diagnostics, as well as working closely with acute providers to improve internal flow.

16. While the 10 Year Health Plan will set a new course for how we deliver health and care services in the future, there are things we can and must do now to ensure our patients receive a better service this coming winter.

17. To make that commitment more than just a set of words in another publication, there are 3 things we need to change at different levels of the health and care system.

18. First, we all need to focus as a whole system on the 7 priorities that will have the biggest impact on UEC improvement this coming winter. As a minimum, these are:

- patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes
- eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes
- a minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
- reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time
- reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month

- tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date
- seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25

19. Second, leaders will need to commit to developing and testing collective winter plans, which will be signed off by every board and chief executive within each system by summer 2025. Regions will work with systems and providers on an exercise to stress-test and refine their plans in September 2025 and will continue to oversee improvement support to the most challenged organisations in the run up to and throughout this winter. As a minimum, each plan should show how, by this winter, systems will:

- improve vaccination rates
- increase the number of patients receiving care in primary, community and mental health settings
- meet the maximum 45-minute ambulance handover time standard
- improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care
- set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings

20. Each part of the system has responsibility for improving UEC performance. However, blame shunting has become a feature in some poorly performing systems and can no longer be tolerated. Each part of the system has responsibility for improving UEC performance, so systems' winter plans should evidence how:

- **integrated care boards (ICBs) and primary care** are demonstrably improving access to primary and community care and driving stretching system-wide improvement to prevent avoidable admissions and discharge rates
- **community providers** are quantifying demonstrable improvement in admission avoidance, making more effective use of community beds and care home facilities, and using technology to support people to stay well at home
- **trusts** are using all available tools to improve patient flow, including: optimising triage and appointment systems to direct less urgent cases to same day emergency care (SDEC); optimising the use of urgent treatment centres (UTCs) and Hot Clinics; ensuring medical directors and chief nurses are applying clinical operational standards to ensure all specialties – not just UEC – lead UEC improvement; and training and empowering medical staff to use the clock to drive performance improvements

- **ambulance trusts** are rapidly adapting best practice to maximise improvement opportunities this winter and nominating an executive director to work with every ICB to develop the system winter plan

21. To support providers and systems to accelerate improvement, we will significantly increase the amount of data available to the NHS and the public. We will undertake an urgent review of UEC data by the end of June 2025 (Q1), with improvements rapidly implemented as part of the NHS Federated Data Platform Operational Dashboard work. We will also explore how to improve the transparency of individual site-level improvement plans, enabling patients to understand the actions being taken to improve services and address their concerns.

22. Finally, we will simplify and align the numerous national improvement resources and additional capital investment to support the systems where those resources can make the biggest difference. There are currently multiple resources, teams and funding sources aligned with various elements of UEC improvement, all of which add value but are confusing. We have started work to bring together these resources and deliver them through a one-team approach to support local leaders, trusts and systems in driving UEC improvement faster this year than ever before. This will be achieved through a redesigned improvement function to ensure we target resources to those systems that need them most.

23. Leadership is the single most crucial factor that will determine our success this winter**.** Every leader must ensure that both within their organisation and across their system everything possible is being done to improve care. Where this was most effective last winter, chief executives, chief nursing officers and medical directors regularly worked from the emergency department to support staff on the frontline. This now needs to be the norm.

Delivering the asks for 2025/26

From treatment to prevention: taking steps now to reduce demand for urgent care later this year

24. To protect the most vulnerable and keep vital health and care services running when respiratory viruses surge, there is more we can do to reduce the effects of the flu.

25. Last winter, we heard your feedback that the restrictions on the National Booking Service and the lack of information on clinic times were suboptimal. That is why, this year, we will commit to:

- expanding the use of the National Booking Service for flu vaccination to make more appointments available, including keeping it open until the end of the flu campaign in March
- developing the “flu walk-in finder” so that, from October 2025, patients can easily look up when they can walk into a community pharmacy to get a vaccination

26. Regions will work with ICBs to develop a plan by the end of Q1 on how they will strengthen the childhood vaccination offer. Increasing vaccine uptake among children is one of the most impactful interventions, with every thousand childhood vaccinations saving around 4 hospital admissions. As a minimum, these plans should set out how:

- GPs and school-aged immunisation providers will increase vaccination rates, working with local directors of public health
- local campaigns will target those in clinical risk groups

27. To support this, we will ask some systems to test the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children. These systems will test the feasibility and value for money of different approaches and provide evidence to inform national roll-out from 2026/27.

28. Plans should also set out the delivery approach to the year-round RSV vaccination programme for older adults and pregnant women (for infant protection), ensuring all those in the older adult catch-up cohort (aged 75 to 79) have been offered a vaccination by 31 August 2025. The aim is to achieve 70% for the catch-up cohorts and 60% in the routine cohort during 2025/26. RSV vaccination provides multi-year protection, so those vaccinated now will have protection this coming winter. The UK Health Security Agency continues to analyse and evaluate these new programmes, with early assessment of the RSV vaccination programme in older adults showing it led to a 30% reduction in the confirmed RSV hospital admission rate among eligible 75 to 79-year-olds.

29. While some trusts have a strong offer, we know that many staff still find it difficult to access a flu vaccination. We will therefore ask all trusts to have an accessible occupational health vaccination offer to staff throughout the entire flu campaign, including onsite bookable and walk-in appointments. All trusts will be asked to have a fully developed plan for improving flu vaccine uptake for NHS staff by the end of Q1, incorporating a stretching target percentage increase on last year’s uptake. This plan should include:

- improved communications and engagement with staff to increase their vaccination rates and to support the promotion of vaccination to eligible patients, better highlighting the link with winter pressures

- work with sector partners to proactively promote available vaccination offers to those who provide and draw on care
- a requirement for NHS hospitals to offer vaccination on discharge to any patients going into a care home

30. We will work with NHS communication teams to share details of the most effective staff vaccination programmes from 2024/25. We will support this with national materials where this is deemed effective. We will also work with professional bodies, patient representative groups and charities to support consistent clinical advice about the benefits of flu jabs for patients in clinically vulnerable groups.

31. In 2024/25, there were patients ready to be admitted but, in some cases, trusts did not have an actionable infection prevention and control (IPC) strategy. Therefore, all systems should test their winter virus resilience plans against the IPC mechanisms available both in and out of hospital. This includes making sure they have identified cohorting spaces ready to be actioned, explored the direct admission of flu patients into community bedded capacity and followed appropriate policies and procedures.

From hospital to community: increasing the number of patients receiving care in community settings

32. At least 1 in 5 people who attend the emergency department don't need urgent or emergency care. An even larger number of attendees could be more efficiently managed by growing community capacity.

33. The Neighbourhood health guidelines published in January 2025 set out the 6 core components of neighbourhood health that all local health and care systems will start to implement systematically this year. This will help people stay independent for as long as possible, reduce avoidable exacerbations of ill health and minimise the time people need to spend in hospital or in long-term residential or nursing home care. This includes neighbourhood multidisciplinary teams (MDTs) co-ordinating proactive care for population cohorts with complex health and social care needs, integrated intermediate care with a "Home First" approach, and scaled and standardised urgent neighbourhood services for people with an escalating or acute health need.

34. We can see the benefit of this approach in examples across the country. In Washwood Heath in Birmingham, social care, primary care, mental health, community nursing teams and secondary care respiratory services are all working together to improve discharge, reduce admissions and provide SDEC for respiratory and cardiovascular disease patients. Over the last year, they have seen A&E attendances fall by over 30% among targeted patients, length of stay in hospital fall by over 14% and Category 3 ambulances are now conveyancing patients to the health centre instead of the emergency department.

35. Similarly for patients living with frailty or complex needs, neighbourhood multidisciplinary teams have been shown to reduce demand on hospital-based unplanned care. In Northamptonshire, local integrated teams involving a range of health and care providers are delivering responsive interventions, such as extended GP reviews, peer support groups, clinical-supported decision-making and remote monitoring. In the 18 months to March 2023, this approach resulted in a 9% reduction in hospital attendances for over 65s and a 20% reduction in falls-related acute attendance due to improved rapid response.

36. Achieving this shift is everyone's responsibility and requires everyone's full participation. As part of their system winter plan submission, ICBs will need to evidence how NHS providers and local authorities (through health and wellbeing boards) will improve discharge and admissions avoidance. System winter plans should build on the Better Care Fund (BCF) plans agreed between ICBs and local authorities in March 2025, which include local goals for performance on emergency admissions for over 65s and timely discharge. Where ICBs and local authorities are facing challenges in achieving these goals, the newly formed Discharge and Admissions Group will agree improvement plans with them, as set out in paragraph 76 below.

37. System winter plans should clearly set out how local partners – NHS acute trusts and primary care – are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for them. They should also detail how they plan to expand access to SDEC and enable direct ambulance off-loading at specialty facilities, such as SDECs.

38. Plans should set out how systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. This includes understanding the actual volume and optimising the use of urgent community response and virtual ward capacity in each integrated care system (ICS) as well as planning with the ambulance service and 111 how to use this capacity most effectively.

39. This will mean more 999 callers receive timely, clinically appropriate care without requiring hospital conveyance. Currently, half of ambulance incidents convey patients to an emergency department – a reduction on previous years, but there is still significant regional variation (45 to 54%). This new approach will enable ambulance services to prioritise the most critical cases while providing alternative pathways for those with less urgent needs. To achieve this, we will:

    - undertake and implement the findings of an evidence-based clinical review of categorisation, increasing clinical triage of 999 calls to identify patients who can be safely assessed and managed remotely, directing them to appropriate urgent care pathways such as virtual wards or urgent community response teams

- enhance paramedic-led care in the community to ensure more patients receive effective treatment at the scene or in their own homes, reducing avoidable hospital conveyance. This will be delivered through ambulance crews operating a call before convey principle and enabling “see and treat”, supported by additional clinicians in emergency operating centres (EOCs) and single points of access (SPoAs)
- expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day
- reduce the variation in rates of hear and treat (currently 8.1% to 20.7%) and see and treat (currently 25.6% to 36.7%), building on the progress we have already made. Progress will be reviewed monthly and research undertaken to understand what types of community capacity are most effective in preventing an avoidable conveyance

40. This model is already demonstrating success. For example, Hampshire’s call before convey initiative reduced emergency department attendances or admissions for 32 to 38% of cases, with 24% avoiding hospital entirely. This saved up to 87 hours over 3 weeks. Similarly, urgent community response services in Dorset and Kirklees have successfully managed approximately 80% of eligible patients without hospital attendance.

41. To support these initiatives, we have published ambulance commissioning guidance for systems – including ambulance trusts, acute trusts, and community providers – to enhance capacity and capability across urgent and emergency care pathways. Priorities in the guidance include:

- increasing the number of multidisciplinary clinicians in EOCs and enhancing their skills to improve patient management
- building on the EOC capacity by developing SPoA that accept calls directly from care homes and GPs, avoiding the need for clinicians to ring 999
- expanding capacity in the community sector, broadening access criteria and extending service availability beyond core hours
- strengthening ambulance trust access to SDEC and UTCs, supported by trusted assessor principles

42. The guidance also reinforces the “call before convey” principle, ensuring paramedics can access senior multidisciplinary decision-making support at the scene. This will help identify safe and appropriate alternatives to emergency department conveyance when this is not the most suitable option. By prioritising the right care in the right setting, we can optimise emergency resources for those with the greatest need.

43. We will publish and implement the recommendations from the 111 review to make the service quicker and simpler to navigate. This includes using natural language processing technology to improve call streaming from October 2025. We will also work with GPs and other healthcare providers to improve the patient referral process to primary care. Additionally, we will work with stakeholders to develop new measures that reflect the quality of care provided by 111 (including disposition outcomes) not just how quickly calls are answered, with the aim of implementing these in April 2026.

High-quality emergency care: meeting the maximum 45-minute ambulance handover

44. Putting a greater leadership focus on increasing and improving UEC services outside hospital will help colleagues to be more ambitious about improving ambulance handovers. The only way we are going to consign 8 and 12-hour ambulance handover times to history is by ripping the plaster off and ambulance services and trusts collectively signing up to a stretching but deliverable standard.

45. Most trusts are already implementing the Release to Rescue standard, and it should now be delivered without exception, including in the winter months.

46. This will be triggered once a handover reaches 30 minutes, meaning that all ambulances will complete their handover and leave the hospital site at 45 minutes. This allows ambulances to be cleared and available for the next call. To achieve this, ambulance services will do everything they can to avoid conveyance, and no 111 dispositions should occur without going through validation, even if that means holding risk out-of-hours and overnight. All acute trusts will be required to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target. This will significantly reduce ambulance response times across the country, with evidence from 2024/25 demonstrating that Release to Rescue implementation across London reduced the average length of ambulance handovers by 11%. The benefits of this approach can be seen in increased capacity to respond to those in need within the community, improved 4-hour performance, and reduced congestion in emergency departments.

Improving flow through hospitals

47. We will provide clear pathways and the right waiting environment when people do need to come to a hospital site with an urgent need. We will take a significant step to separate urgent from emergency care, so that people are treated in the most appropriate setting.

48. The evidence shows that co-located UTCs reduce both the number of people who spend time in emergency departments and overcrowding. Without this separation, everyone can often wait much longer. In UTCs, over 95% of people are treated and discharged within 4 hours.

49. For people who require treatment that can be completed within a day, we are expanding SDEC services across the country. The evidence shows that patients treated in an SDEC wait less on average for a clinical review, spend less time in an emergency department and in hospital overall, and are more likely to go home to their usual place of residence.

50. We know co-located UTCs and SDECs improve the patient experience and hospital flow, which is why we want to accelerate their implementation across England. We are allocating £250 million of capital budget to continue this expansion, the equivalent of 40 new SDECs or UTCs. We will prioritise supporting those systems that can best evidence how early investment will impact service improvement this winter.

51. Every patient living with frailty should be identified early in their journey and a comprehensive geriatric assessment initiated or amended. This assessment and early involvement of a frailty team is proven to reduce admissions and length of stay and improve the patient's chance of maintaining independent living.

52. We should be seeing more children within 4 hours based on the occupancy levels of most of the country; Lord Darzi's independent investigation identified more than 10,000 infants, some of the most vulnerable members of our society, have been left waiting for over 6 hours in A&E departments. We need to use UTCs effectively, as well as children and young people's specific services, and standards need to be refined. ICBs should also consider commissioning means of local advice and guidance (such as Healthier Together) so parents can navigate their local systems and care provisions more effectively.

Ending 12-hour waits in corridors for a bed

53. Last year, we saw too many patients cared for in corridors, waiting over 12 hours for a bed. This should never happen. We're asking our patients to accept care that falls below the standards they deserve while also asking our staff to do things we've no right to ask them. This is why this spring we have committed to publish the collected data on the prevalence of corridor care for the first time. In 2025/26, we will seek to publish site-level performance data on total attendances, admitted attendances and long waits.

54. We also know that when some patients arrive at an emergency department they require immediate treatment to avoid unnecessary deterioration. In some cases this is obvious, while for others, this may be more subtle. According to the UK Sepsis Trust, 245,000 people are affected each year by sepsis, with 48,000 deaths every year determined as sepsis-related. We know that early identification and accurate diagnosis, allowing appropriate management, can save lives. Everyone should be using the National Early Warning Score (NEWS2) to help identify symptoms early, and we will continue to work

with the Royal Colleges and Societies on updating and sharing sepsis guidance and learning from best practice.

55. As soon as possible, and set out in the system winter plans, we need to ensure that people see the right clinician and don't stay longer in the emergency department than necessary.

56. System winter plans need to set out how their clinical model will be configured and adapted to make sure the most appropriate clinician is consistently available to provide continuity of care, proactively identify deteriorating conditions, support rapid assessments into the most appropriate pathways, and join up more effectively with primary and community teams. While safety is always the priority, we also need to work to time-bound standards. This will speed up the decision-making process, with rapid specialty opinions and diagnosis and with only the patients who genuinely meet the "criteria to admit" standards (as published on FutureNHS – password required) being admitted.

57. We will work with the Royal Colleges and Societies to consult, publish and audit trusts against new clinical operational standards for the first 72 hours of care. These will set the minimum expectations in areas such as time to review following referral, availability for advice, and what happens to patients when multiple specialist teams need to input into care. We will publish these standards by late summer 2025, allowing them to be implemented by winter.

Mental health teams leading from the front

58. Mental health provision is critical to improving UEC services, and mental health trust chief executives and boards need to play a full and active role in the development of their system winter plan.

59. An emergency department is seldom the most appropriate setting for people experiencing a mental health crisis, yet too often, service users find themselves with no local alternative. As a result, too many patients wait for 24 hours or more in emergency departments. This is not acceptable. Those systems that invested in crisis assessment centres or specialist alternatives to emergency departments are able to evidence both a positive impact for service users in crisis and a broader impact on improving UEC provision in their areas. Those systems that haven't yet been able to invest in crisis assessment centres have seen benefits from ensuring community assertive outreach and crisis intervention teams are working with acute providers to support patients who attend an emergency department with mental health-related issues.

60. We will provide an additional £26 million of capital to support those systems that can demonstrate they can invest in crisis assessment centres in-year, ahead of this winter. They should be able to demonstrate they can offer rapid assessment and short-term

support in a therapeutic environment to ensure people in mental health crisis have timely access to specialist support and are directed to the right care pathway. All areas will have an opportunity to apply for this funding.

61. Too many mental health patients are still admitted to mental health hospitals far away from their home and family. We know this risks higher rates of suicide, depression and anxiety for patients following discharge due to being far away from their normal support network. This is why we are providing £75 million to eliminate inappropriate out-of-area placements by delivering additional capacity to improve local mental health inpatient provision. The new capacity will be available by the end of this financial year. We expect this to lead to a reduction of around 150 to 160 patients in inappropriate out-of-area placements at any one time.

62. System winter plans will need to demonstrate how local mental health providers can evidence that mental health inpatient stays will be as short as possible. Plans should set out:

- how the number of patients in out-of-area placements (OAPs) will be reduced as part of a broader commitment to eliminate all ICB commissioned OAPs by March 2027
- how mental health providers will proactively identify and reduce the re-admissions of high intensity users of crisis pathways. They will also be required to produce their own percentage reduction target of re-admissions for their highest intensity users
- how they will ensure fewer patients who need a mental health admission wait over 24 hours. This will include the consistent and systematic use of the mental health UEC Action Cards in all relevant settings (acutes) and delivery of the 10 high-impact actions for mental health discharges to support flow through all mental health (including child and adolescent mental health) and learning disability and autism pathways

A whole-system approach to improving patient discharge

63. In some trusts, 1 in 4 bed days are lost due to delayed discharges. This is unacceptable.

64. Acute trusts need to set stretching local performance targets for daily pathway 0 discharges and profile them through the week to ensure they are met, so we don't create problems we can't solve at the weekend. Acute trusts and local authorities should set local performance targets for pathway 1, 2 and 3 patients, ensuring patients are discharged as soon as possible to appropriate rehabilitation, reablement or recovery support, based on the "Home First" principle. ICBs should work with local authorities to ensure that BCF capacity plans include appropriate capacity for surges over winter, both for step-up and step-down care, making effective use of the 3.9% increase in the NHS

minimum contribution to adult social care announced in the 2025/26 BCF policy framework. As part of local plans, acute trusts, local authorities and ICBs should progressively eliminate the longest and most unacceptable discharge delays, starting with the 0.7% of patients who wait more than 21 days beyond their discharge ready date. All settings should eliminate any internal delays to discharge of more than 48 hours. These actions must combine to ensure that ICBs and local authorities achieve their local goals for reducing discharge delays, 1 of the 3 goals in the new BCF policy framework.

65. System winter plans must demonstrate effective use of capacity across the full system. The discharge rates of people who are ready to leave community beds are markedly low, with 1 in 5 beds occupied by people with no criteria to reside in the service. Reviewing bed usage and returning people to home-based care where possible will reduce long stays and increase capacity for those who need it. As well as providing surge capacity, additional beds have the potential to support acute admissions avoidance for respiratory and flu cases, alongside IPC cohorting where it is effective and appropriate to do so.

66. Focusing community bedded capacity on higher levels of dependency can have a profound impact. In Leicester, Leicestershire and Rutland, a joint health and care initiative relocated 25 beds in over 3 locations to a single 15-bed high dependency unit. Patients who do not meet the criteria to reside within the high dependency unit are managed within home-based services. The service is provided in 3 wings of an independent care home, with an onsite therapy and nursing MDT and in-reach mental health and other more specialised services as required. Funding is provided via the BCF and is not significantly higher than previous costs. 6 months in, the system has already seen a reduction in acute delays from 12 days to 1.45 days, saving 777 bed days (equating to around £0.5 million within the system) and a 50% reduction in one-to-one care on discharge.

67. We are seeing the impact of where trusts, local authorities and ICBs are collaborating to drive down discharge delays through early discharge planning, efficient in-hospital processes, streamlining complex discharge processes and matching intermediate care capacity to people’s needs. The key to improvement in these systems is actively using data about discharge-ready dates and proactively reviewing the reasons for delays to tackle variations in performance.

68. Systems that are struggling to improve discharge can use the additional guidance and best practice we have produced, including:

- care transfer hubs best practice, which sets out the 9 essential features of effective discharge arrangements for people with more complex needs
- Community rehabilitation and reablement model, which sets out best practice for commissioners and providers of intermediate care

- Neighbourhood health guidelines 2025/26, which support acute and community trusts, ICBs and local authorities to determine how neighbourhood MDTs will work with hospital wards and care transfer hubs, helping people with more complex needs return home with the right community support for their ongoing recovery

From analogue to digital: using data and digital investment to improve flow

69. 2025/26 is about getting the digital basics right for urgent and emergency care. We will use technology to speed up and improve patient care, allowing clinicians to view records and make referrals more efficiently – and to reduce the administrative burden on staff.

70. We have already seen the impact this can have, which is why we are providing an additional investment of £20 million in the Connected Care Records programme for all systems. This will establish the interoperability necessary for paramedics to see the patient summary from all different NHS services, including the patient's most recent treatment. All ambulance trusts will have sight of the summary by the end of 2025/26, up from 50% who currently have access. This in turn will enable them to provide better care to patients and avoid unnecessary admissions. For example, One London Shared Care Record provides a single, secure view of patient information, helping to speed up communication between care professionals across London.

71. We will continue to drive adoption of the NHS Federated Data Platform (FDP). The FDP will have been rolled out to 85% of acute trusts by the end of March 2026, with 77% of acute trusts having access by the end of Q2 this year, allowing for adoption ahead of winter. By expanding the use of the FDP, systems and trusts can consolidate multiple frontline operational systems into a single view, facilitating more effective and efficient clinical and operational decisions.

72. Rolling out the FDP is one thing: ensuring it is used effectively is another. System winter plans will need to evidence how teams will use FDP real-time data and forecasting tools to better manage demand, for example, by detailing how:

- the A&E Forecasting Tool is providing intelligence to support local operational decision-makers with resource and capacity management
- the Timely Care Hub is providing task tracking, monitoring and reporting of key metrics for quality
- the Optimised Patient Tracking and Intelligent Choices Application (OPTICA) system is providing clear visibility of all tasks required within the discharge process, supporting patients to return home or into step-down care

73. Finally, falls place a significant burden on UEC services, costing the NHS more than £2.3 billion a year. Falls in social care, home and community settings make up around 75% of this cost. Care technology in these settings can support people to live independently and avoid falling; for example, remote monitoring technology in care homes has been found to halve falls and prevent “long lies”, strongly associated with hospital admissions. To increase providers' confidence to adopt suitable, safe and future-proof technologies, we will set new national standards for initial priority care technologies by March 2026 and publish guidance to support providers to implement technology effectively.

Giving urgent care improvement the system-wide focus it deserves

74. None of the expectations set out in this plan will happen by accident: they require every leader in health and care to be purposeful and focused on getting the best out of their own teams and organisation and working across systems to create the most stretching ambitions for winter improvement we have seen in recent years. At its heart, this challenge is all about leadership.

75. We are combining the various elements of improvement support that have been developed – sometimes in silos – and using these resources to create a meaningful offer to systems to support them to realise their ambitions. We will also use the new NHS Performance Assessment Framework, which incorporates a range of metrics across all sectors, including primary care, hospitals, and ambulance, community and mental health trusts. This will drive the required focus and subsequent improvement that will support UEC recovery. We will also commit to publishing league tables on performance to drive improved transparency and public accountability and also to encourage less effective systems to work more closely with high performing systems to accelerate improvement.

76. Every system can access:

- **the model health system data** – available for all systems and providers to support UEC improvement. It includes a range of benchmarking data designed to help trusts review their practices and reduce unwarranted variation, which in turn delivers improvements, efficiencies and unlocks savings
- **UEC operational data dashboard** – this will be updated daily to provide a single version of the truth on key UEC performance metrics
- **improvement guides** – available to provide guidance on best practice in the areas that will drive maximum impact against the data points identified in their benchmarking data
- **learning and improvement networks** – led by a high-performing chief executive in each region with the responsibility to focus on reducing variation through the

application of best practice. The Learning and Improvement Networks will bring together clinical and operational leaders to identify opportunities for improvement and explore ways to deliver the improvement and share best practice. They will focus on the reduction of the percentage of patients in hospital over 7 days, supporting flow and reducing corridor care

- **training for on the ground clinical and operational leaders** – covering the fundamentals of operational management, leadership and improvement, including how to use improvement tools like LEAN. We have resourced this to ensure it can be accessed by 25,000 NHS staff this year and will be available from June 2025

77. **For those systems requiring additional support,** regional teams will provide this, including reviewing benchmarking data, improvement plans and associated resourcing, such as buddying teams, so that high-performing systems can support those who are struggling through peer-review.

78. **For those most challenged systems that demonstrate limited progress**, we will use a one-team approach to provide a joined-up intervention and support package. Where capacity allows, every site will have experienced clinical and operational improvers from the national teams assigned to them. These specialists will help identify the root cause of the issues, using the available data sources and implementing solutions, before winter, based on the improvement guides. This package will be for a 6-month period and will have personal oversight from the national director, national clinical director, chief nurse and NHS medical directors, delivering a plan that is owned at board and clinician level.

79. Finally, as set out in the Better Care Fund policy framework for 2025/26, the Department of Health and Social Care (DHSC), NHS England and the Ministry of Housing, Communities and Local Government (MHCLG) are adopting a more targeted approach to oversight and support for local authorities and ICBs in their development and implementation of BCF plans. The newly formed Discharge and Admissions Group will work with challenged systems to help drive improvements in discharge and foster effective collaboration between the NHS, local authorities and social care providers to help prevent avoidable admissions. Where there are significant performance challenges with the 3 BCF headline metrics (emergency admissions for over 65s, delayed discharges, care home admissions for over 65s), DHSC, NHS England and MHCLG will work with local areas to agree improvement plans or, where necessary, revised BCF plans.

Detailed actions: roles and responsibilities

NHS England and DHSC	• Undertake an urgent review of UEC data by the end of June 2025. • Simplify the national improvement and capital investment offers to align to the systems where those resources can make the biggest difference. • Expand the use of the National Booking Service for flu so more flu vaccination appointments are available. • Develop the “flu walk-in finder” so that, from October 2025, patients can look up when they can walk into a community pharmacy to get a vaccination. • Communications teams to share details of the most effective staff vaccination programmes from 2024/25. • Work with professional bodies, patient representative groups and charities to support consistent clinical advice about the benefits of flu jabs for patients in clinically vulnerable groups. • Undertake and implement the findings of an evidence-based clinical review of categorisation, with the aim of improving the clinical triage of 999 calls. • Publish and implement the key recommendations from the 111 review to make the 111 service quicker and simpler to navigate. • Allocate £250 million of capital budget to continue the expansion of co-located urgent treatment centres and same day emergency care. • Publish site-level performance data on total A&E attendances, admitted attendances, long waits and prevalence of corridor care. • Continue to work with the Royal Colleges and Societies on updating and sharing sepsis guidance and best practice. • Work with Royal Colleges and Societies to consult, publish and audit trusts against new internal clinical operational standards for the first 72 hours of care. • Allocate £26 million of capital budget to support systems to invest in crisis assessment centres. • Allocate £75 million of capital budget to eliminate out-of-area placements by delivering additional capacity to improve local mental health inpatient provision. • Invest an additional £20 million in the Connected Care Records programme for all systems. • Continue to drive adoption of the NHS Federated Data Platform (FDP).

	• Set national standards for initial priority care technologies and publish guidance to support providers in implementing technology effectively. • Use the new NHS Performance Assessment Framework to drive the required focus and improvement that will support UEC recovery. • Identify which systems require the most support and intervention.
System winter plans should include	• Delivery approach to strengthening the childhood vaccination offer. • Delivery approach to the year-round RSV vaccination programme for older adults and pregnant women, ensuring all those in the older adult catch up cohort (75 to 79) have been offered a vaccination by 31 August 2025. • Stretching plan for flu vaccine uptake by NHS staff with a target percentage increase on last year's uptake. • Winter virus resilience plans against the infection protection and control (IPC) mechanisms available both in and out of hospital, including appropriate policies and procedures, appropriate cohorting spaces and exploring the direct admission of flu patients into community bedded capacity. • How NHS providers and local authorities (through health and wellbeing boards) will improve discharge and admissions avoidance. • How local partners are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for these individuals. • How systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. • How their clinical model will be configured and adapted to make sure that the most appropriate clinician is consistently available to provide continuity of care, proactively identify deteriorating conditions, support rapid assessments and join up more effectively with primary and community teams. • How local mental health providers can evidence that, when mental health patients are admitted to an inpatient setting, their stay will be as short as possible. This should include producing their own % reduction target of re-admissions for their highest intensity users, how the number of patients in out-of-areas placements will be reduced, and how to reduce the number of patients who need a mental health admission waiting over 24 hours

	• Evidence how teams will use FDP real-time data and forecasting tools to better manage demand.
NHS trusts	• Demonstrate plans to improve vaccination rates in health and care workers. • Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments. • Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target. • To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young people's specific services and standards. • Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week. • Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients. • Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorting where it is effective and appropriate to do so.
Systems	• Some systems to test the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children. • Implement the "Release to Rescue" standard without exception, including in the winter months.
Integrated care boards	• Consider commissioning means of local advice and guidance (such as Healthier Together) so parents can navigate local systems and care provisions effectively. • Work with local authorities to ensure that BCF capacity plans include appropriate capacity for surges over winter, both for step-up and step-down care.
Ambulance trusts	• Operate a call before convey principle and enable "see and treat", supported by additional clinicians in emergency operating centres and single point of access. • Expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day. • Reduce the variation in rates of "hear and treat" and "see and treat".

Appendix D

Winter Planning 25/26

Board Assurance Statement (BAS)

Integrated Care Board (ICB)

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the ICB's Board has oversight that all key considerations have been met. It should be signed off by both the ICB Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Integrated Care Board's (ICB) name.

This section gives ICBs the opportunity to describe the approach to creating the winter plan and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Integrated Care Board:	Mid & South Essex

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	Yes	The 2025/26 Mid and South Essex (MSE) System Winter Plan has been formally signed at these committees: - MSE Strategic Winter Group – 04/09/25 - ICB Executive Team – 02/09/25 - MSE Urgent and Emergency Care (UEC) Oversight & Assurance Board – 05/09/25 - MSE Integrated Care Board – 18/09/25 ***(subject to confirmation post Board meeting)***
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Yes	QEIA/EHIIA completed and incorporated within the winter plan.
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	All MSE Health and Social Care partners have been actively engaged in the development of the system-wide winter plan. Each partner has contributed by incorporating their respective organisational plans to ensure a coordinated and comprehensive approach.
The Board has tested the plan during a ICB System led winter exercise, reviewed the outcome, and incorporated lessons learned.	***Scheduled 24/09/25***	MSE Winter Plan Tabletop Exercise is scheduled for 24 September 2025, bringing together all MSE system partners to test national scenarios and injects. The event will be led by Samantha Goldberg, Executive Director of Performance & Planning, and will include attendance from regional NHS England colleagues from both Emergency Preparedness, Resilience and Response (EPRR) and Urgent Emergency Care (UEC). This exercise aims to strengthen system-wide preparedness and ensure a coordinated response ahead of the winter period.

Integrated Care Board:	Mid & South Essex

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Samantha Goldberg, Executive Director Performance & Planning
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	Yes	System-wide and provider-level winter plans across MSE comprehensively address the actions outlined in Section B, covering all components within the domains of 'Prevention', 'Capacity', and 'Leadership'. These plans reflect a coordinated approach to ensuring resilience and readiness throughout winter.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures *(based on OPEL framework)*	Yes	Appropriate mitigations are in place across all escalation levels. These are incorporated within provider plans and OPEL frameworks, with SHREWD Resilience in place to monitor OPEL status and support timely responses to both moderate and extreme winter pressures.
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.	Yes	Fully operational, appropriately skilled, and well-resourced System Co-ordination Centre in place. Operating 7-days a week from 08:30-18:00, the Centre will facilitate the sharing of intelligence, enable real-time monitoring of system pressures using OPEL framework, and support risk balancing across all partners. The Centre is further supported by SHREWD Resilience, using real-time data health and social care providers across MSE, ensuring a coordinated and responsive approach to managing capacity, demand, and flow.

ICB CEO/AO name	Date	ICB Chair name	Date
Tom Abell ***Agreement to be confirmed post Board on 18/09/25***	Xx September 2025	Mike Thorne	Xx September 2025

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Yes	Vaccination programmes across all priority areas are in place and designed to reduce complacency, build confidence, and maximise convenience. The ICS Winter Vaccination Programme includes targeted campaigns for childhood immunisations, RSV vaccinations for pregnant women and older adults, including the 75–79 cohort and the annual flu and COVID-19 campaigns, supported by outreach, incentives, and strategic oversight from the ICS Vaccination Group, with robust monitoring and engagement plans to ensure uptake and accessibility.
2. In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Yes	Targeted care for patients under 65 with co-morbidities is incorporated into system plans. The vaccination programme includes outreach and engagement strategies to encourage uptake among vulnerable groups, supported by community and provider-level initiatives. Pre-winter health checks and access to antivirals are embedded within primary care and community service pathways to support early intervention and continuity of care in the community.
3. Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.		Plans to support urgent care needs at home or in the community wherever clinically appropriate. Plans are supported by a range of services including Unscheduled Care Coordination Hub, Pharmacy First, Urgent Community Response Team, Virtual wards and Integrated Care Transfer Hub. These services enable timely interventions, reduce avoidable admissions, and ensure patients receive the right care in the

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
		right setting. This integrated approach promotes continuity of care and supports system resilience throughout the winter period.
Capacity		
4. The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.		The profile of likely winter-related demand has been modelled across the system, with provider-level plans aligned to ensure patient needs are met, including during peak pressures. The System Coordination Centre (SCC) uses SHREWD Resilience and OPEL frameworks for real-time monitoring and escalation. Daily huddles, structured calls, and mutual aid protocols support coordinated responses, while provider plans include surge capacity, discharge optimisation, and workforce resilience to maintain safe and effective care delivery.
5. Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.		7-day discharge profiles have been shared with local authorities and social care providers. Standards for P1 and P3 discharges have been agreed, with alignment across system partners to support timely and safe discharge planning. The Integrated Care Transfer Hub (ICTH) operates 7 days a week and coordinates discharge activity in line with these standards, supported by daily reviews and escalation protocols.
6. Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.		Acute providers have built elective bed requirements into their winter bed models in line with their operating plans, ensuring dedicated capacity is protected. Additionally, efforts are being made to maximise day surgery throughput and optimise case mix to support elective recovery and maintain patient flow.

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Leadership		
7. On-call arrangements are in place, including medical and nurse leaders, and have been tested.		Robust on-call arrangements are in place across all partners, including coverage by medical and nursing leadership where appropriate. Arrangements have been signed off by provider Boards to ensure reliability and responsiveness, providing assurance that appropriate clinical oversight and escalation pathways are available throughout the winter period. Operational, strategic, and tactical rotas are established across health providers and the ICB. The acute will further reinforced to ensure resilience over the festive three-week period
8. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	The SCC is operational from 08:30 to 18:00, 7-days a week. Plans in place to monitor and report real-time system pressures using the OPEL framework. In addition, system partners utilise SHREWD Resilience to support the monitoring of capacity, demand, and flow from all health and social care providers across MSE, enabling proactive decision-making and timely escalation to maintain system resilience and continuity of care.

Part I Board Meeting, 18 September 2025

Agenda Number: 9

ICB QUARTERLY COMMUNICATION & ENGAGEMENT IMPACT REPORT Quarter 1, 2025/26

Summary Report

1. Purpose of Report

To provide the Board with an overview of performance against the ICB's Communications and Engagement Strategy 2025-2027 during Quarter 1 (Q1) of 2025/26.

2. Executive Lead

Tom Abell, Chief Executive Officer

3. Report Author

Claire Hankey, Director of Communications and Partnerships

Claire Routh, Head of Communications

4. Responsible Committees

Executive Committee

5. Link to the ICB's Strategic Objectives

- 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.
- 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.
- 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.
- 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.

- 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.

6. Impact Assessments

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

7. Financial Implications

Delivery is within the confirmed corporate and associated programme budgets

8. Details of patient or public engagement or consultation

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

9. Conflicts of Interest

None identified

10. Recommendations

The Board is asked to:

- **Note** the strategic delivery and performance of communications and engagement activity during Q1 2025/26, including alignment to the Communications and Engagement Strategy 2025–2027 approved at the Board meeting on 14 November 2024

- **Recognise** the critical enabling role of communications in supporting public confidence, statutory duties, partner collaboration, and workforce resilience during a period of system pressure and organisational transition.

- **Endorse** the proposed focus on prioritising high-impact campaigns and statutory engagement activities considering existing and emerging capacity constraints linked to running cost reductions.

EXECUTIVE SUMMARY

The ICB communications, engagement and partnerships team plays a unique role as planners and convenors, bringing system partners together, coordinating communication and engagement plans and activity across the system. This focuses on commissioning priorities, performance delivery, service transformation/reform and specifically supporting:

- Insight, engagement and consultation: playing a lead role in supporting ICBs to discharge their statutory duty of ensuring commissioning decisions are informed by high quality information, insight, engagement and consultation.
- Transformation programmes: managing system-wide and local strategic and transformation programmes that require formal communication and engagement support (e.g. local service reconfigurations).
- Behaviour change campaigns: leading professional public health, vaccination and service access campaigns and communications based on insight.
- Primary care communications: supporting primary care organisations and professionals who do not have formal communications infrastructure.
- Partnership/stakeholder engagement: ensuring timely responses to parliamentary questions and briefings, maintaining relationships and streamlined, consistent communications with key stakeholders and media.
- System convening: key role in bringing people, teams and organisations together across complex systems to work towards shared communication and engagement plans, consistent messaging and involvement approaches.
- Corporate communications: lead on a range of duties, including producing corporate documents, managing official communications channels, supporting with FOIs, ensuring accessible information standards are met.

This report provides the Board with the latest overview of communications and engagement delivery and impact for **Quarter 1 (Q1) of 2025/26**, aligned to the ICB's **Communications and Engagement Strategy 2025–2027** and is structured around three strategic pillars:

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

Headline achievements in Q1

- **COVID-19 Vaccination Campaign Success** - generated over 36,000 web visits to vaccination information pages. Achieved a significant 15% increase in booster uptake (from 37.65% to 53.14%).

- **Public Health Prevention Campaign Impact –** Successful multichannel, blood pressure awareness campaign reached target audience of over 225,000 people with increase in additional blood pressure checks in pharmacies (March vs February 2025). Oral health campaign reached ~100,000 people, generating 400% increase in website traffic and 350+ toothbrushing chart downloads.

- **Primary Care Access Recovery campaign impact:** significantly boosted digital engagement, helping drive a 50.4% increase in NHS App registrations**,** 45.9% rise in logins**,** and substantial growth in digital transactions including prescription orders (+35.9%) and appointment bookings (+6.7%) when comparing Q1 2024 to Q1 2025. The campaign has also seen 45.5% more referrals and a 321% increase in signposting to community wellbeing support through Frontline Essex, helping to alleviate pressure on GP services.

- **Digital Care Records**: 8.3% increase in average weekly logins per user (7.26 to 7.86). Successful onboarding of new partners including hospices and adult social care services.

- **Internal Communications:** strong engagement with ICB corporate comms channels, intranet homepage: 129,000 views (2.9% increase) with 14-minute average session duration. Ongoing and increasing work to support staff through ICB transition and organisational changes.

- **Primary Care Communications Channels:** Primary Care Hub remain best performing channel: 152,395 page views in Q1 (up from 82,000 in Q4) with 4,000+ active users and MSE Primary Care Bulletin averaging 15% click rate (vs 3-5% public sector average).

- **Media Relations**: 18 press releases generated 78+ proactive media pieces across national, regional and local channels. 38 media enquiries ensuring fair representation of complex health issues.

- **Digital communications:** ICS website visits doubled: 216,712 (vs 108,586 in Q4) following spike in paid for advertising. Email marketing: 1,695 new subscribers in Q1 across all topics – around half of these subscribed to new

'Get the Care you Need Quicker' topic. Social media: 132,633 organic reach without paid promotion around 55% higher compared to reach in Q4.

- **Community Engagement Success:** Secured £30,000 additional NHS England funding for Research Engagement Network. Won £3,500 NIHR PARITY fund for digital exclusion work. Reached Virtual Views platform: Milestone of 1,000+ registered users and vaccination attitudes survey attracted record-breaking 1,400+ responses. Virtual Patient Participation Group (PPG) programme: 7 GP surgeries enrolled with 70+ patients

These activities have contributed directly to strategic priorities including urgent and emergency care pressures, supported key prevention agendas, improved access to services, and supported clear, timely communications to staff through ICB transition.

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

Looking ahead to Q2, the focus will remain on:

- System-wide ICB led campaigns (winter, blood pressure, supporting the frailty programme
- Statutory engagement and insight activity
- Internal communications to support the ICB transition, including the HQ consultation

1. STRATEGIC PRIORITIES

Progress on supporting system strategic priorities through proactive communications campaigns and engagement activity in Q1 2025/26.

Table 1, proactive communications campaigns and engagement activity in Q1 2025/26

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
ICB Medium Term Plan (MTP) launch	Generate awareness, understanding and delivery of NHS local five-year roadmap.	Staff and stakeholders and Senior Responsible Officers,	Approved comms plan and internal narrative shared with NHS system comms leads and ICB senior leadership team (SLT). Dedicated section developed on staff intranet, Connect Online. Dedicated section developed on Primary Care Hub (intranet for primary care). Dedicated section on external facing website. New format stakeholder bulletin	Commitment to share with relevant Trust staff/teams. Launched 13 June Launched 30 June 95 views	Pulse survey to measure awareness planned for Q2.

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
			issued in line with new MTP identity. Programme identity developed and finalised with Insight Hour series and branding webinar planned.	Stakeholder bulletin click rate above industry benchmarks. MTP branded templates and assets uploaded to ICB (free Nonprofit) Canva account	
Urgent & Emergency Care (UEC) & System Flow **Supporting System resilience in Q1**	Supporting uptake of spring COVID-19 Booster vaccine.	Public -targeted to geographic locations, ethnicities who are at-risk/ eligible for COVID-19 booster	Digital-first approach, layering platforms and geographies to maximise reach and cut through via age, interest and location-based targeting. Web signposting: all activity linked to a local 'find a vaccination site' hub on our website.	Find a vaccination site page: 8,744 views / 6,240 unique users South east Essex walk-in sites page: 27,459 views / 15,073 unique users (24.26% of total site traffic during campaign)	15% increase in COVID-19 booster uptake (from 37.65% to 53.14%) Key PCNs in Southend and Thurrock showed significant uplift.
	Support effective system communications around community beds recommenda-tions from	Staff, residents, stakeholders.	System-wide communications plan to support understanding of recommendations / mitigate risks re. misinformation.	Effective media handling /spike in visits to Virtual Views platform to access the recommendations report and	Balanced and factual media coverage around working group recommendations. Clarity on next steps.

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
	Community Working Group			understand next steps.	
	Ensuring effective communications around service provision during Easter bank holidays to support flow.	External audiences and key stakeholders.	Press release, system communications toolkit prepped and cascaded to system partners, email to subscribers, website updated, social media posts	4 pieces of media coverage (2 x print 2 x broadcast) 221 visits to dedicated webpage about alternative services to A&E	During the bank holiday period, MSE ICS maintained stable urgent and emergency care flow despite sustained demand. Targeted communications played an enabling role in managing demand, supporting discharge priorities, and promoting alternative care options in line with system flow objectives.
Prevention and Proactive Care	Delivery of a communications strategy to support uptake of FrEDA	Internal	Collaborative working re. system delivery of 5 Menti surveys and MS Forms to capture insight to inform FrEDA/ FRAIL + comms strategy	170+ survey responses Updated webpage in line with feedback and in partnership with steward. Draft key messages, FrEDA ambassador plan and comms approach shared with stewards for approval	Insight-led communications approach developed – impact to be shared in future reports.

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
	Raise awareness of positive development in Integrated Neighbourhood Teams (INT)	External/ stakeholders	INT case studies add to website/shared with media/ stakeholders.		Increased awareness of progress if specific INT programmes.
Strengthening primary care	To raise awareness of the modern general practice model.	Residents aged 25–65, targeting specific areas that see frequent access to GP services for minor or non-urgent issues. Carers, parents, and digitally-engaged - patients likely to benefit from self-service and app-based options.	Launch of new primary care subscriber email topic - proactively signposting residents to health support in the community and free up GP services. 8 week paid-for Facebook advertising campaign Translated posters and easy-read materials completed and added to communications toolkit	800 people subscribed *new email topic to within weeks of launch in Q1. 8 week paid for Facebook advertising campaign achieved: • Impressions: 150,567 • People Reached: 48,834 • Link Clicks: 1,932 In April and May, 44 social media posts achieved a reach of 10.7k and 80.4k impressions, generating 100 likes, 29 comments, and 34 shares, with video content averaging 9	**NHS App data for mid and south Essex:** • **50.40% increase** in monthly NHS App registrations from Q1 2024 to Q1 2025 • **45.92% increase** in logins from Q1 2024 to Q1 2025 • **35.87% increase** in prescriptions ordered via the NHS App from Q1 2024 to Q1 2025 • **6.7% increase** in appointments booked via the NHS App from Q1 2024 to Q1 2025. **Online consultations:** • **99.04% increase** in online consultation submissions from Q1

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
				seconds of view time across 1,000 views.	2024 to Q1 2025 (total Q1 2024: 203,783, total Q1 2025: 405,600) **Frontline Essex referrals and signposts:** Referrals: • Q1 2024: 811 • Q1 2025: 1,180 **45.50% increase** in referrals Signposts: • Q1 2024: 3,109 • Q1 2025: 13,097 **321.26% increase** in signposts
	Promote improvements in dental service provision.	Public/stakeholders Parents and carers of primary school children.	Media relations and stakeholder engagement around oral health initiative in schools	Eleven pieces of coverage, including TV, Radio, Print and online including BBC Look East, BBC Essex, Echo and other local outlets	Increased public awareness of strengthened dental access and activity to support good oral health. Bolstered reputation of schemes helping engage further schools who have been reluctant to engage.

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
Tackling Inequalities	Support improved early detection of hypertension	Public: adults 40+ in our most deprived communities who are at higher risk of cardiovascular disease (CVD).	Targeted, data-led 'Invincible Feeling, Invisible Danger - *Take a Sec to Check'* CVD campaign to promote blood pressure checks in pharmacies. Targeted YouTube advertising during May Measure Month with local pharmacist.	Reach of over 225,000 target audience. View rate: 61.28% (compared to a typical 15–25% for public health) Click-throughs: 255—outperforming expectations for NHS health campaigns .	Data has two-month lag - latest figures show the number of people accessing blood pressure checks in pharmacies has been steadily increasing. In March 2025, there were 106 more blood pressure checks made in local pharmacies than in February 2025.
	Promote Health Inequalities Annual Report.	Public, internal and stakeholders	Development of comms plan and system-wide communications toolkit linked to Health Inequalities Annual Report.	Press release delivered over nine pieces of media coverage. 169 views of Health Inequalities Annual Report on ICS website.	Awareness of ICB delivering ICS strategy goals around tackling health inequalities.

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
	Promote good oral habits in children to prevent problems and build lifelong dental health during Smile Month	Public in our most deprived communities supporting a reduction in tooth extractions - leading cause of local hospital admissions for children aged 5-9 in mid and south Essex	Multi-channel campaign with a focus on targeted digital advertising and travel screens in Southend and Grays	Reached ~ 100,000 people: seeing a 400% increase in website traffic comparing 7 Apr–10 May vs 12 May–14 June with over 350 downloads of a toothbrushing chart	Evidence of impact re. population oral health and behaviour change take time – however this activity has seen positive communications reach to key audiences to support positive oral health.
Digital transformation	Support onboarding plus integration of new data on Shared Care Record Improve awareness of new data availability Encourage meaningful use of the Shared Care Record to support safer, more joined-up care. Effective co-production of resident	Teams in local hospices Essex County Council Adult Social Care services and hospital outpatient departments. Programme Board and digital transformation leads Comms engagement teams across partner orgs	Cascade of comms toolkits created to support onboarding of new partners Delivered three case studies evidencing the Shared Care Record's impact across multiple care settings to drive engagement and adoption	2,277 new users registered during Q1, bringing total to 10,811 Average logins per user per week increased to 7.99 from 7.79 (an 2.6% increase)	Increased user engagement and utilisation of the Shared Care Record. Improved awareness and confidence in data availability, supporting more proactive and informed care decisions New partners successfully onboarded during Q4 New data from Essex County Council adult social care, and hospital outpatient departments added.

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
	empowerment and engagement chapter of ICS digital strategy, plus support with design and editorial				

2. BUSINESS AS USUAL ACTIVITIES

The section contains a brief description of significant business as usual (BAU) communications, engagement and partnerships work delivered and outcomes achieved.

2.1 Internal communications highlights

Staff intranet and bulletin

The team has continued to strengthen internal communications to improve staff engagement and resilience during organisational change. The ICB intranet continues to serve as the main internal communications hub, with the homepage attracting **129,000 views** during Q1 (an increase of 43% from Q4). User engagement remains strong, with visitors spending an average of 14 minutes per session.

During Q1, the team:

- Developed a new dedicated section on ICB change communications for partners – developed to support colleagues to keep external partners fully informed throughout the ICB change process. This includes regular updates, shared materials and practical resources staff can use to communicate effectively with partners.
- Added a new section developed to support staff understanding of the Greater Essex Devolution Programme – providing guidance, background information and useful resources.
- Provided file migration support: Clear internal comms to guide staff through the move from legacy Clinical Commissioning Group (CCG) servers to OneDrive
- Supported internal communications linked to The Lampard Inquiry, keeping staff informed about upcoming hearings, key issues and important developments related to the inquiry, including a need to retain key documents.
- Ensured regular internal communications including supporting weekly staff briefings and FAQ updates to support staff throughout the organisational change period.
- Hosted first Greater Essex staff briefing to update on ICB transition.
- Launched new series of Insight Hours– comms team leading first two webinars supporting staff to ensure ICB meets legal duties around accessible communications, plus a session on LinkedIn supporting staff through transition.

Staff engagement and briefings

The Viva Engage platform (as part of Microsoft 365 package) continues to drive internal social engagement, with posts from a mix of staff during Q1. This quarter's 12 all-staff briefing sessions drew consistently strong participation, with an average of 294 attendees per session with regular updates on ICB transition, financial efficiency measures and medium-term plan/priorities.

A recent staff pulse survey highlights opportunities to improve clarity around organisational priorities and make information easier to access. Relevance of

communications remains steady, providing a good foundation to build on as we strengthen impact and engagement in the months ahead.

2.2 Primary care communications highlights

Primary Care intranet and bulletin

The Primary Care Hub continues to be our highest-performing resource platform with 152,395 page views in Q1 (compared to 82,000 in Q4) with over 4,000 active users, demonstrating strong engagement from healthcare professionals regularly accessing the hub to support in delivering services to patients.
Top pages visited in Q1 on the Primary Care Hub:

- Medicines optimisation
- MSE Training Hub
- NHS Pay Awards for 2025/26
- Information to support GP practice cyber assurance from AGEM IT team
- Update: Implementation of Tirzepatide for managing overweight and obesity
- Attention Deficit Hyperactivity Disorder (ADHD) Prescribing Update

The MSE Primary Care Bulletin continues to be a well-utilised resource by practices across mid and south Essex achieving high, above standard engagement rates with an average of 15% click rate on Q1 compared to 3-5 % average for public sector. During Q1, split testing of subject lines used saw a significant increase in open rates.
Top topics from the bulletin by clicks:

- HbA1c updates
- ADHD prescribing
- Tirzepatide / weight management

The team has supported with all areas listed above, ensuring regular updates to ensure GP colleagues have the latest information to support effective patient care.

2.3 Media and stakeholder relations

18 press releases issued by the ICB team in Q1 generated **over 78** proactive pieces of media coverage across national, regional and local print, online and broadcast channels. This includes features on the Health Inequalities Annual Report and MSE oral health programmes, rise in utilisation of Pharmacy First, coverage of a range of health care professionals working in GP practices, and the blood pressure campaign.

Timely responses for **38 media enquiries** on a range of topics linked to system performance, quality, estates and financial challenges also ensured fair, accurate representation of complex issues affecting the ICB.

The team also supported with timely and factual responses to nine parliamentary enquiries during Q1.

2.4 Digital communications highlights

ICS Website

Total visits to the ICS website increased by nearly 200% in **Q1: 216,712 compared to 108,586 in Q4,** with 61,272 engaged sessions i.e. people stayed longer than 10 seconds and/or clicked on multiple pages). The increase in visits is largely due to a spike in paid-for campaign activity driving traffic to the website as people search for information.

Website acquisition data shows us that most people visited our site following use of search engines. This indicates the website is likely addressing specific search queries that users are looking for. Proactive media coverage and digital advertising will support this as people seek out more information on priority health topics they hear or read about. Search engine optimisation (SEO) is working effectively with content being indexed and ranked well by search engines.

Top performing content

COVID-19 vaccination pages: Strong performance, with several thousand views in Q1, helping support primary care access recovery.

Information to clarify access to Tirzepatide weight management generated over 1,750 views helping to ensure people have access to the latest accurate information and minimise impact on GP practices.

Email marketing

Following a positive trend identified in Q4 that saw email marketing generating highest conversion rates re. website acquisition, Q1 saw a total of 1,695 new subscribers across all topics listed below. Regular and automated email series have generated 4% of all traffic to the ICB website. This indicated that the content via email is resulting in people actively searching on our website for more information linked to priority health campaigns.

Automated email campaigns, developed by the ICB comms team in partnership with clinical leads, offer an efficient way of getting pre-written key information about service provision in the community to residents, helping people get the right care at the right time from the right service. In Q1 we launched a new topic to support communications objectives around the Primary Care Access Recovery programme. The new topic 'Get the Care you Need Quicker' attracted over 800 new subscribers in the first month.

Current Subscription Topics

Topic
General news
Health and wellbeing matters
Mental health
Children's health matters
Winter communications
Engagement (get involved)
Get the care you need quicker

Topic
Pain management
Women's health and wellbeing
Men's health and wellbeing

Social media

Our social media activity generated a total organic reach of 132,633 across all platforms in Q1 without paid promotion - around 55% higher compared to reach in Q4.

This figure represents the number of times ICB-generated content appeared on users' screens without paid promotion. Increased link clicks indicate improved traffic to services and key health and wellbeing information on the website. Content focused on health prevention i.e. testicular torsion/heatwave advice/ blood pressure/Smile Month campaign and promotion of Talking Therapies. A survey to measure attitudes to vaccinations and information on the whooping cough vaccination were especially well received.

We have, however, seen an increase in negative sentiment in Q1. This is largely linked to concerns around changes to ADHD prescribing and a perception that the NHS is moving people away from seeing a GP and moving to online only.

2.5 Engagement highlights

Activity to support working with people and communities in Q1 has seen:

Funding Successes:

- £30,000 secured from NHS England for the next phase of the Research Engagement Network (REN) project.
- £3,500 awarded from NIHR's PARITY fund to address digital exclusion among underserved groups.

Community Engagement:

- New partnerships formed with Bangladeshi and Indian communities and Southend Association of Voluntary Services (SAVS) community connectors.
- Community champions trained to build trust and guide people to research opportunities.
- Events held to promote research participation:
  - Eid event in Southend: 50+ participants engaged.
  - Multicultural Essex Women's Association picnic: Focused on Genes for Health research.
  - Essex Council for Voluntary Youth Services celebration: Highlighted youth involvement in research.

Strategic Insights:

- Healthwatch Essex produced a comprehensive report from our Research Engagement Network (REN) engagement, informing future planning.

Digital and GP Practice Engagement:

- Virtual PPG programme launched: 7 GP surgeries involved; 70+ patients engaged.
- Supported MSEFT travel survey: 699 responses, 893 informed, 1.3k engaged.

Future Planning:

- Additional REN funding bid submitted to NHS England to further expand engagement and delivery capacity.

Virtual Views

Virtual Views, the digital engagement platform in mid and south Essex, continues to deliver high levels of engagement to support and inform a range of strategic commissioning decisions. Q1 saw us reach a key milestone with over 1,000 registered users of Virtual Views.

A vaccination attitudes survey launched in May received over 1,400 responses – our highest level of engagement for any survey to date. Insights were also gathered around local patient transport services and local experiences of diagnostic services to help inform service improvements.

3. ORGANISATIONAL DEVELOPMENT SUPPORT

Effective internal communications is a key tool in supporting organisational development. Q1 data shows the valuable role internal communications is playing in supporting clear, accessible and timely information around ICB transition - helping maintain staff performance during a period of uncertainty. While easy access to organisational forms, guidance and policies is ensuring the ICB's workforce can comply with organisational expectations and procedures. This protects and supports both employees and the organisation from legal issues, regulatory penalties, and reputational damage. Developments in corporate internal channels in Q1 have ensured the ICB can listen and engage with staff instead of just telling. See section 2.1 for more information.

4. Q1 SUMMARY: what worked well, what didn't, and opportunities to improve

Strengths:

- 43% improvement in staff engagement (visits) via Connect Online and 20% improvement in open rate of Connect Digest compared to Q1.
- Around 200% increase in website visits, partly due to the spike in digital advertising.
- Increase in the average number of media titles covering each press release in Q1 compared to Q4 - indicating strengthened relationship with media and more effective newsworthy content.
- Successful proactive PR (Over 78 pieces of generated media coverage) ensuring key message delivery in line with organisational priorities.
- Timely media statements have ensured balanced reporting, supporting effective reputation management.

- Strong use of data/local insight has effectively informed communications planning and resulted in positive impact (see Table 1 above).
- Early stakeholder involvement and public engagement have helped the ICB successfully manage difficult issues.
- Organic search (predominantly via Google) indicates strong Search Engine Optimisation (SEO)
- Email marketing shows highest return on investment re. website conversion.
- Strong engagement and performance across ICB corporate communications channels ensuring staff are supported with clear, timely information during a period of uncertainty.

Improvement Areas:

- Social media – click rate is an area of improvement – opportunity to evaluate implementation of links in comments section which may be impacted by changes in social media algorithms.
- Negative sentiment around use of digital tools on social media – an opportunity to re-emphasise alternative ways to access care for those who are digitally excluded/ promote the fact digital is freeing up phonelines for others.
- Internal comms – click rate has dropped despite an increase in engagement in internal channels. Connect Digest and Primary Care Bulletin - the click rates are still performing significantly above the benchmarked average for the UK public sector (3-5%)

Opportunities:

- Review engagement with Connect Digest and Primary Care Bulletin– test ways to support increase in click rate
- Expand case study development and digital channel reach.
- Enhance ICS partnerships and leverage relationships with underserved trusted voices who can help amplify campaign messages.
- Test new communications channels such as Spotify to understand effectiveness of reaching key audiences using local insight and data to help address local challenges and improve outcomes.
- Build feedback from stakeholder interests identified through pulse survey into content plans for stakeholder bulletins.
- Broaden the local role of the MSE Research Engagement Network to ensure its sustainability and support the delivery of engagement within our underserved communities.

4.1 Looking ahead

Next Quarter Strategic Communications Priorities

As we enter the next quarter, our key focus will be on:

- Taking the above learning forward
- Delivering key campaigns including: a Know Your Numbers blood pressure campaign, a system-wide winter campaign launch and an internally focussed FrEDA campaign.

- Continuing to support the priority areas outlined in the Medium-Term Plan (MTP) and leading internal communications around ICB transition including HQ consultation.

Risks for Q2 include existing capacity concerns, exacerbated by fixed term posts ending, team resignations/recruitment freezes due to uncertainty coupled with increased workload with ICB transition. ICB running cost reductions and consequential impact of staff consultations around restructure will also naturally present a risk to delivering plans meaning re-prioritisation will be required, as necessary.

5. Recommendations

The Board is asked to:

- **Note** the strategic delivery and performance of communications and engagement activity during Q1 2025/26, including alignment to the Communications and Engagement Strategy 2025–2027 approved at the Board meeting on 14 November 2024

- **Recognise** the critical enabling role of communications in supporting public confidence, statutory duties, partner collaboration, and workforce resilience during a period of system pressure and organisational transition.

- **Endorse** the proposed focus on prioritising high-impact campaigns and statutory engagement activities in light of existing and emerging capacity constraints linked to running cost reductions

APPENDICES:

Appendix A – ICB Impact Report slide deck

Part I ICB Board meeting, 18 September 2025

Agenda Number: 10

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.

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

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

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

Chief Executive's Report

1. Introduction

This report provides the Board with an update from the Chief Executive covering key issues, progress and priorities since the last update. The report also provides information regarding decisions taken at the weekly executive committee meetings.

2. Main content of Report

2.0 ICB transition

Since the last Board meeting progress has been made to establish the leadership of the new ICBs across the East of England (EoE), including conclusion of the consultation process with ICB executive teams across the region.

At the time of writing, interviews are ongoing for the future executive positions across the proposed three new ICBs in the EoE.

Alongside this, we concluded a consultation on the relocation of the headquarters and base working location for Mid and South Essex Integrated Care Board (MSE ICB) staff. This will involve the movement of the HQ from Basildon to Seax House in Chelmsford later this year and the phased introduction of formal hybrid working arrangements with all staff being expected to be in the office at least one day per week. This change will deliver a material reduction in the ICB's running costs and contribute towards the running cost reduction requirement placed on the ICB.

We also received confirmation from the government that the formal merger and creation of the three new ICBs in the EoE, including Essex, will come into effect from April 2027. To support this and the period between October 2025 and April 2026, the board will be considering the proposed transitional governance arrangements elsewhere on the agenda today.

We are now working towards agreeing the next phases of the transition process, with a particular focus on balancing organisational change whilst maintaining service delivery and financial sustainability of the ICB.

2.1 NHS England annual assessment

NHS England is required to undertake an annual performance assessment of each ICB in England. In summary, the areas of improvement noted included:

- The introduction of a more robust approach to managing system-wide quality concerns.
- A strengthened leadership team and governance arrangements.
- Progress being made in reducing mental health out of area placements.
- Improved partnership working and collaboration, particularly with the Voluntary, Community, Faith and Social Enterprise (VCSFE) sector such as hospices.

The areas for opportunity and development included:

- Identification of the change required across the system and within the ICB to support the delivery of acute services including operational delivery, quality and financial performance. This includes commissioning actions to deliver transformation in the demand management of referral to treatment (RTT), Cancer and urgent emergency care (UEC) services, alongside addressing quality concerns.
- Progressing effective partnership working which embraces the 'future shift' agenda at greater pace and scale, including driving forward neighbourhood working building on population health management (PHM) work to date.
- Ensuring strong financial leadership of the system to secure future sustainability, including overseeing and supporting productivity improvements of providers in MSE.
- Developing a robust general practice action plan to address unwarranted variation and improve contract oversight, commissioning and transformation.

In response to this, the ICB developed an action plan setting out work already underway in these areas for development, alongside additional work which is required. This will be aligned with the regulatory actions already in place at an individual organisational level by NHSE and others alongside individual provider improvement plans. This is aimed to help focus our work in the immediate term, alongside supporting the transition of responsibilities between ICBs and other agencies over the coming period.

2.2 Community consultation update

Following the decisions made at our last meeting, we have moved onto the next phase of implementation of the approved recommendations set out within the Decision Making Business Case on community services in MSE. This included attendance and presentation at the Essex, Southend and Thurrock Health Overview and Scrutiny Committees as well as a specific session for the community working group to go through the decisions and set out next steps. A key element of this will be the establishment of a Maldon specific community group to consider and seek to address estate issues in that area, which will be led by providers moving forward.

2.3 Industrial action

As Board members will be aware, between 25 and 30 July 2025 resident doctors in England undertook industrial action. I want to thank everyone within the ICB and across the system who contributed to the response during this period. Overall, it was well managed with significantly reduced disruption to patient care than previous instances of industrial action. We have completed a 'lessons learnt' exercise so we can apply learning identified should further industrial action occur in the coming months.

2.5 Improvements in hypertension management in GP practices

Improving hypertension prevention and management has been a priority for the ICB over the course of the last year and I am pleased to confirm the latest figures show good progress.

As the Board is aware, in March 2024 the ICB was 41st of the 42 ICBs in England for the proportion of people diagnosed with hypertension treated to target in the preceding twelve months. Data published for March 2025 shows an improvement from 67% to 71%, placing the ICB as 13th of the 42 ICBs in England.

During this period, we have also seen consistent improvement in relation to anticoagulation in atrial fibrillation, leading to MSE ICB being the second highest performer of ICBs in England.

This has been the result of significant work including practice engagement drop-in sessions, sharing performance data routinely, and initiatives such as the hypertension stretch Quality Outcomes Framework (QOF), and the Primary Care Network (PCN) led cardiovascular disease (CVD) locally enhanced service (LES) and Community Outreach Grant Scheme.

There remains significant work to be done on CVD prevention and management, but this is solid foundation on which we can base this work going forward.

2.6 Executive Equality, Diversity and Inclusion High Impact Actions

As requested in the action log for Board, with the new Essex ICB there will be a re-set for Executive Team objectives, with each new Executive having a specific and measurable equality, diversity and inclusion (EDI) objective. Assurance in respect of the EDI high impact actions will take place annually, and the assurance will be provided by the ICB People Board (or future equivalent meeting). The timing of this review will follow the results of the annual NHS Staff Survey, and assessments against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), as these instruments include the source data for measuring both the change and impact of many EDI High Impact Actions.

2.7 NHS oversight framework segmentation and performance dashboard

NHS England has published the results of the new oversight framework and public facing performance dashboard for NHS provider organisations, taking account of performance during quarter 1 of this financial year. The purpose of this approach is to provide greater transparency on the relative performance of NHS providers across England and will be used to identify their 'segmentation' and therefore the level of scrutiny, support and intervention they will receive.

Locally, the performance of the two provider organisations which form part of the mid and south Essex integrated care system are as follows:

- Mid and South Essex NHS Foundation Trust – 123 of 134 acute trusts
- Essex Partnership University NHS Foundation Trust – 36 of 61 non-acute trusts

This performance sets out the scale of the challenge faced by the NHS locally and the need for absolute focus on delivery of our agreed plans for the next year, alongside the work of our Medium Term Plan to sustainably improve services for patients, improve value for taxpayers and improve the working environment for colleagues working within NHS services in MSE.

This is a matter which is subject to escalation to the Board from the Finance and Performance Committee given the current deviations from plan in respect of key areas of financial and operational performance, with a recommendation for greater board scrutiny of areas of most significant risk and challenge. This will be considered elsewhere on our agenda today.

3. Executive Committee

Since the last report, there have been eight (8) weekly meetings (from 8 July 2025 to 2 September 2025)

Aside from noting the recommendations from the internal recruitment panel and investment decisions through the triple lock arrangements, the following decisions were approved by the Executive Committee:

- Contract award for procurement of wound care dressings across the system.
- Approval to commission a LES for gynaecology services for an initial period until 31 March 2026, with intention for review prior to longer term commission.
- Launch of a consultation with ICB staff, and associated outcome, for change of location for ICB headquarters to support reduction in running costs.
- Approval of contract for payroll services for the ICB.
- Approval of development for new business case for weight management services across the ICB.
- Approval to commission a local enhanced service for Chronic Kidney Disease (CKD).
- Review and agreement of service specification for care providers across Nursing and Residential Care Homes with ICB funded patient placements.
- Procurement of prescribing software across primary care services.
- Review of all LES currently in place across primary care.
- Re-procurement of translation services across primary care.
- Review and contract award for community dental services across Essex footprint.
- Review of business case to support mental health flow across system, with funding allocated to support six-month pilot.
- Review and approval of the ICB's Corporate Risk Register and Board Assurance Framework.

The Committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability.

All decisions and work undertaken by the Executive Committee continues to be regularly communicated to staff.

4. Recommendation

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

Part I ICB Board meeting, 18 September 2025

Agenda Number: 11

Quality Report

Summary Report

1. Purpose of Report

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 issues in relation to regulatory oversight of providers, and also national changes to the provision of ICB-led services in maternity/neonatal care, and statutory functions following the publication of national guidance.

To note, the members of the Quality Committee did not request anything to be formally escalated to the Board following the most recent meeting in August 2025.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

3. Report Author

Dr Giles Thorpe, Executive Chief Nursing Officer.

4. Responsible Committees

Quality Committee.

5. Link to the ICB's Strategic Objectives

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

To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

None required for this report.

7. Financial Implications

Not relevant to this report.

8. Details of patient or public engagement or consultation

Not applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board is recommended to:

- Note the ongoing regulatory oversight in relation to provider services in Mid and South Essex NHS Foundation Trust
- Note the key changes to the Maternity and Neonatal Independent Senior Advocate (MNISA) service provision and proposed changes to ICB statutory functions following the publication of ICB Good Practice Documents.

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 issues in relation to regulatory oversight of providers, and also national changes to the provision of ICB-led services in maternity/neonatal care, and statutory functions following the publication of national guidance.

2. Regulatory Update

Mid and South Essex NHS Foundation Trust (MSEFT)

2.1. The Care Quality Commission (CQC) and NHS England have convened a Quality Summit on 19 September 2025, which will be chaired by NHS East of England Regional Director. During this meeting ongoing quality issues will be discussed to determine what further support is required for the Trust to deliver a sustainable and systemic approach to quality improvement. The Trust's Well Led inspection report is yet to be published and is currently being taken through CQC and Trust-level reviews for factual accuracy.

Essex Partnership University NHS Foundation Trust (EPUT)

2.2. There are currently no outstanding reports or expected visits for EPUT. The Trust continues to deliver against the actions as outlined in their overarching CQC action plan, with assurance being sought from system partners, and regulators.

3. Cessation of the National Maternity and Neonatal Independent Senior Advocate (MNISA) Service Pilot

3.1. In light of the Secretary of State for Health and Social Care announcing an independent investigation into maternity and neonatal care and a new taskforce, the national Maternity and Neonatal programme board of NHS England agreed that a decision in relation to continuing the MNISA pilot should be taken alongside the development of the next national strategy for maternity and neonatal care. This has been to ensure that any decision is well integrated into the future state of maternity services and forms a coherent part of the approach to supporting bereaved and harmed families.

3.2. In light of this it has therefore been agreed that the pilot phase should be brought to a close and the learning taken to the investigation and taskforce to support the future development of services.

3.3. Within Mid and South Essex Integrated Care Board, which has been a pilot site, we would like to acknowledge and thank Sarah Paxman, our MNISA, for her dedication that she has put into the development of the pilot, her expertise and the support that she has given to women and families to enable them to feel heard and listened to.

3.4. Bringing a close to the pilot in no way reflects on the work of the MNISAs, nor does it prejudge the outcome of the decision still to be made. Indeed, one of the findings in the evaluation by the National Institute for Healthcare Research (NIHR) was that the MNISAs had a significant impact in enabling women and families to feel listened to and heard.

3.5. ICBs will therefore need to plan around a number of areas.

3.5.1. **Closure for new referrals** – while NHS England has provided funding for services to operate until the end of March, the service should close for new referrals now. This is earlier than the October timetable previously communicated and is to avoid raising expectations and to help minimise the risk of additional harm to women and families when the service closes.

3.5.2. It is recognised that some women and families may already have been given information about the MNISAs work, and may still make contact, but ICBs should aim to ensure staff in local Trusts, other referring organisations and local stakeholders are aware that no new referrals are to be made, and the reasons behind this.

3.5.3. **Named contact points** – In anticipation of the close of the pilot, ICBs should identify and agree named individuals within the Trust (e.g. governance lead, complaints manager, bereavement midwife), to act as accessible contact points for women and families. Given that some families may find it difficult to be in contact with the local trust there should also be a contact in the ICB.

3.5.4. **Personalised plans** – MNISAs should develop and regularly update personalised plans for every family they are working with. Personalised plans should be developed with the women and families and take into account their preferences around ongoing support and communication, which should be recorded.

3.5.5. **Communication with women and families** – MNISAs should plan now for communication with women and families, including preparing messaging around why the pilot is coming to a close, handover meetings, preparing accessible information that families can refer to (e.g. Padlet) where possible, and signposting to other relevant support services locally. It will be important that women and families have everything they need to continue independently as the pilot draws to a close.

3.5.6. **Check in** – ICB named contacts should also contact women and families three months after their final MNISA contact to check whether they have any outstanding needs or concerns.

3.6. The ICB's Consultant Midwife will now work with our MNISA to determine her existing caseload of families and plan the closure of the service and transfer of cases to MSEFT by March 2026. Should any further decision be made in relation to future delivery of the MNISA service by NHS England, the Board will be informed accordingly.

4. Model ICB Blueprint – Good Practice Documents

4.1. As part of the ongoing development of the Model ICB Blueprint, ICB good practice documents have been designed to provide greater clarity for ICBs on four key functional areas, which were published on 9 September 2025:

- CHC (Continuing Healthcare)
- SEND (Special Educational Needs & Disabilities)
- Safeguarding
- Medicines Optimisation.

4.2. The good practice documents are intended to support ICBs' work to determine the review and transfer of these services. They do not imply any change to the fundamental direction of travel described in the Model ICB Blueprint overall.

4.3. Within the body of each of the good practice documents the existing statutory and legislative functions of ICBs has been outlined, and a position on where, if any, legislative changes may occur in the future, and/or any delegated authority of functions to providers may be permissible.

4.4. Each document highlights a series of actions the ICBs need to take in 2025/26 and also in 2026/27 in order for it meet the aims of ICB running cost reduction, thereby supporting the wider system in reducing duplication, enhancing efficiency and ensuring that ICBs fulfil their functions as strategic commissioners, reduce health inequalities, and lead on the delivery of neighbourhood health.

4.5. Over the next month the operational leadership teams with responsibility for these functions will undertake an analysis of the current position, the expected future function, with an assessment of any potential risk to delivery, and associated actions to reduce said risk. The Executive Director of Nursing and Executive Medical Director roles will take Senior Responsible Officer (SRO) responsibility and executive leadership for these programmes of work, given their portfolios include these functions currently and are outlined within the new roles for Essex ICB.

4.6. An update will be provided to the Executive Team in Quarter 3. Non-Executive Members will receive a briefing with an expectation that the Board will be appraised of delivery trajectories in line with national timescales in due course.

4.7. The ICB will work closely with system partners to ensure that any implications for other organisations/bodies due to function transfer are highlighted at the earliest opportunity and an agreed timescale for transition will be managed accordingly.

5. Recommendations

The Board is asked to:

- Note the ongoing regulatory oversight in relation to provider services in Mid and South Essex NHS Foundation Trust
- Note the key changes to the MNISA service provision and proposed changes to ICB statutory functions following the publication of ICB Good Practice Documents.

Part I Board Meeting,18 September 2025

Agenda Number: 12

Month 4 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 system during the period ending 31 July 2025 (Month 4).

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

2. Executive Lead

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

Report Author

Jennifer Kearton – Chief Finance Officer
Keith Ellis - Deputy Director of Financial Performance, Analysis and Reporting
Ashley King – Director of Finance & Estates
James Buschor - Head of Assurance and
Analytics.

3. Committee involvement

The most recent finance and performance position was reviewed by the ICB Finance and Performance Committee on 2 September 2025.

4. Conflicts of Interest

None identified.

5. Recommendation

The Board is asked to receive this report for information and note the escalation from the Finance and Performance Committee on financial performance and service delivery performance at month 4. It is recommended that the Board formally request a report on in year financial and performance recovery actions to be shared with the ICB Board.

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 an additional £106m (million) deficit support funding. The system plan is considered very stretching for 2025/26 given the planned efficiency requirement of £219.2m.

NHS England 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, has been supplied for Quarter 1 (Q1) and Q2. 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 4 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB saw an increase of £31.2m between submitted Month 3 (M3) and M4. £15.8m of the increase related to additional allocations to cover the cost of the 2025/26 pay award, £10.2m additional allocations for GP and Community Pharmacy contracts and £2.4m relating to the NHS InSights programme.

Table 1 – Allocation movements between submitted plan and month 4

Allocations	Funding Stream	Current Month £m	Previous Month £m	Monthly Change £m
⊟ Recurrent	Programme	2,366.88	2,352.16	14.72
	Delegated - Specialised	300.23	297.36	2.87
	Co-Comm	258.44	255.96	2.49
	Delegated - DOP	116.80	111.04	5.76
	Running Costs	19.34	19.20	0.14
	Total	**3,061.69**	**3,035.72**	**25.97**
⊟ Non-Recurrent	Programme	215.37	209.77	5.60
	Delegated - Specialised	12.55	12.55	0.00
	Co-Comm	0.39	0.39	0.00
	Delegated - DOP	0.06	0.07	-0.01
	Total	**228.38**	**222.79**	**5.59**
Total		**3,290.07**	**3,258.51**	**31.56**

The ICB position at M4 is in line with the planned position of a £3.0m year-to-date (YTD) deficit, (M3 £3.0m) driven by the profiling of planned efficiencies in year. There are YTD pressures in: Acute (£4.8m) - this is a movement of £4.8m as there was no variance in the prior month; Mental Health (£1.0m); Community Health Services (£1.5m); and Continuing Care (£1.8m) which are being managed in the position through a range of mitigations.

Table 2 – summary of the position against the revenue resource limit for month 4.

Income/Expenditure	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m
⊟ Income	(1,115.09)	(1,115.09)	(0.00)	(3,290.07)	(3,290.07)	(0.00)
Allocation	(1,115.09)	(1,115.09)	(0.00)	(3,290.07)	(3,290.07)	(0.00)
⊟ Expenditure	1,118.09	1,118.09	(0.00)	3,290.07	3,290.07	(0.00)
Acute	531.87	536.71	(4.84)	1,543.29	1,548.17	(4.88)
Community Health Services	83.24	84.69	(1.45)	247.65	252.61	(4.95)
Continuing Care	60.45	62.28	(1.82)	190.20	195.66	(5.46)
Mental Health	108.41	109.42	(1.02)	316.63	318.06	(1.43)
Other Commissioned Services	2.66	(5.90)	8.56	7.51	(8.61)	16.13
Other Programme Services	5.06	5.04	0.03	15.94	16.26	(0.32)
Primary Care	211.45	211.23	0.23	632.78	632.62	0.16
Specialised Commissioning	107.41	107.41	0.00	312.75	312.75	0.00
Corporate	5.69	5.38	0.31	17.79	17.04	0.75
Hosted Services Admin	0.52	0.52	0.00	1.55	1.55	0.00
Hosted Services Programme	1.32	1.32	0.00	3.97	3.96	0.00
Total	3.00	3.00	(0.00)	(0.00)	0.00	(0.00)

2.2 M4 Efficiency Delivery

The M4 financial position includes delivery of £20.5m 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 4.

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	10,233	10,168	(65)	31,809	31,202	(607)	(607)
All-age Continuing Care	719	513	(206)	4,676	2,200	(2,476)	(2,476)
Ambulance	548	548	0	1,643	1,644	1	1
Community Healthcare	2,358	2,234	(124)	8,030	7,752	(278)	(278)
Mental Health	2,131	2,131	0	7,318	7,320	2	2
Other Programme Services	562	1,868	1,306	2,290	6,089	3,799	3,504
Primary Care (inc. Primary Co-Commissioning)	2,730	2,732	2	9,769	9,772	3	3
Running Costs	168	268	100	500	1,004	504	504
Unidentified	1,013		(1,013)	4,349	3,401	(948)	(653)
Total	20,462	20,462	0	70,384	70,384	0	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	1,013	1,052	39	4,349	5,768	1,419
Recurrent	19,449	19,410	(39)	66,035	64,616	(1,419)
Total	20,462	20,462	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 M4 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 4 System Financial Performance

At month 4 the overall health system position was a deficit of £7.1m against plan (M3 £0.4m surplus against plan). The deficit split is £0.6m for EPUT and £6.5m for MSEFT.

EPUT continues to face additional costs in-year relating to servicing the Lampard Inquiry. For MSEFT a mixture of pay and non-pay pressures is being further compounded by slow delivery against their efficiency target for the year. Recovery plans are being developed and will be shared with both the ICB and the Region

Table 5 – summary of the System position against the revenue resource limit for month 4.

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	(1,115,091)	(1,115,091)	0	(3,290,067)	(3,290,067)	0
Total ICB Net Expenditure	1,118,088	1,118,089	0	3,290,067	3,290,068	1
TOTAL ICB Surplus/(Deficit)	(2,997)	(2,998)	(1)	0	(1)	(1)
Income	(770,089)	(768,631)	1,458	(2,285,186)	(2,290,570)	(5,385)
Pay	482,008	491,614	9,606	1,412,015	1,413,610	1,595
Non-Pay	274,225	270,829	(3,396)	821,877	825,837	3,960
Non Operating Items	16,085	15,476	(609)	51,294	51,123	(171)
TOTAL Provider Surplus/(Deficit)	(2,229)	(9,288)	(7,059)	0	0	0
TOTAL ICS Revenue Resource Limit	(1,115,091)	(1,115,091)	0	(3,290,067)	(3,290,067)	0
TOTAL ICS Net Expenditure	1,120,317	1,127,377	7,059	3,290,067	3,290,068	1
TOTAL ICS Surplus/(Deficit)	(5,226)	(12,286)	(7,059)	0	(1)	(1)
Less Non-Recurrent Deficit Support Funding	(43,868)	(43,868)	0	(106,000)	(106,000)	0
ICS Surplus/(Deficit) excluding Non-Recurrent Deficit Support Funding	(49,094)	(56,154)	(7,059)	(106,000)	(106,001)	(1)

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

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 4 the system has delivered £49.8m of efficiencies against a plan of £55.4m a shortfall of £5.6m. 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	20,462	20,462	0	70,384	70,384	0
EPUT	8,302	7,645	(657)	31,335	31,335	0
MSEFT	26,607	21,654	(4,953)	117,487	117,490	3
SYSTEM	55,371	49,761	(5,610)	219,206	219,209	3

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 M4 position shows the system is £0.8m behind on the £24.6m plan submitted to NHSE, but forecasting to spend £0.6m more than the planned total by year end.

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	12.75	4.54	8.21	79.33	79.91	(0.58)
EPUT	1.62	0.67	0.95	18.94	18.94	0.00
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Total	14.37	5.22	9.16	98.27	98.85	(0.58)
⊟ Internally Financed/System CDEL						
MSEFT	12.75	16.71	(3.95)	46.53	46.53	0.00
EPUT	-2.87	1.88	(4.75)	17.19	17.19	0.00
ICB	0.31	0.00	0.31	2.41	2.41	0.00
Total	10.20	18.58	(8.39)	66.14	66.14	0.00
Total	24.57	23.80	0.77	164.41	164.99	(0.58)

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	1.52	1.17
Total	0.00	0.00	0.00	2.69	1.52	1.17

2.8 System Finance Report Conclusion

At M4 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 NHS England colleagues and continues to operate under strengthened internal governance and financial control.

On 2 September 2025, in receipt of the M4 Finance and Performance report the Finance and Performance (F&P) Committee agreed to escalate financial performance and System delivery performance to the Board.

Despite the System being on plan to deliver the breakeven outturn position at year end, the F&P Committee highlighted concern at M4 the overall health system position was a deficit of £7.1m against plan and the risk this posed on receiving system deficit support funding in Q3.

2.9 Urgent and Emergency Care (UEC) Performance

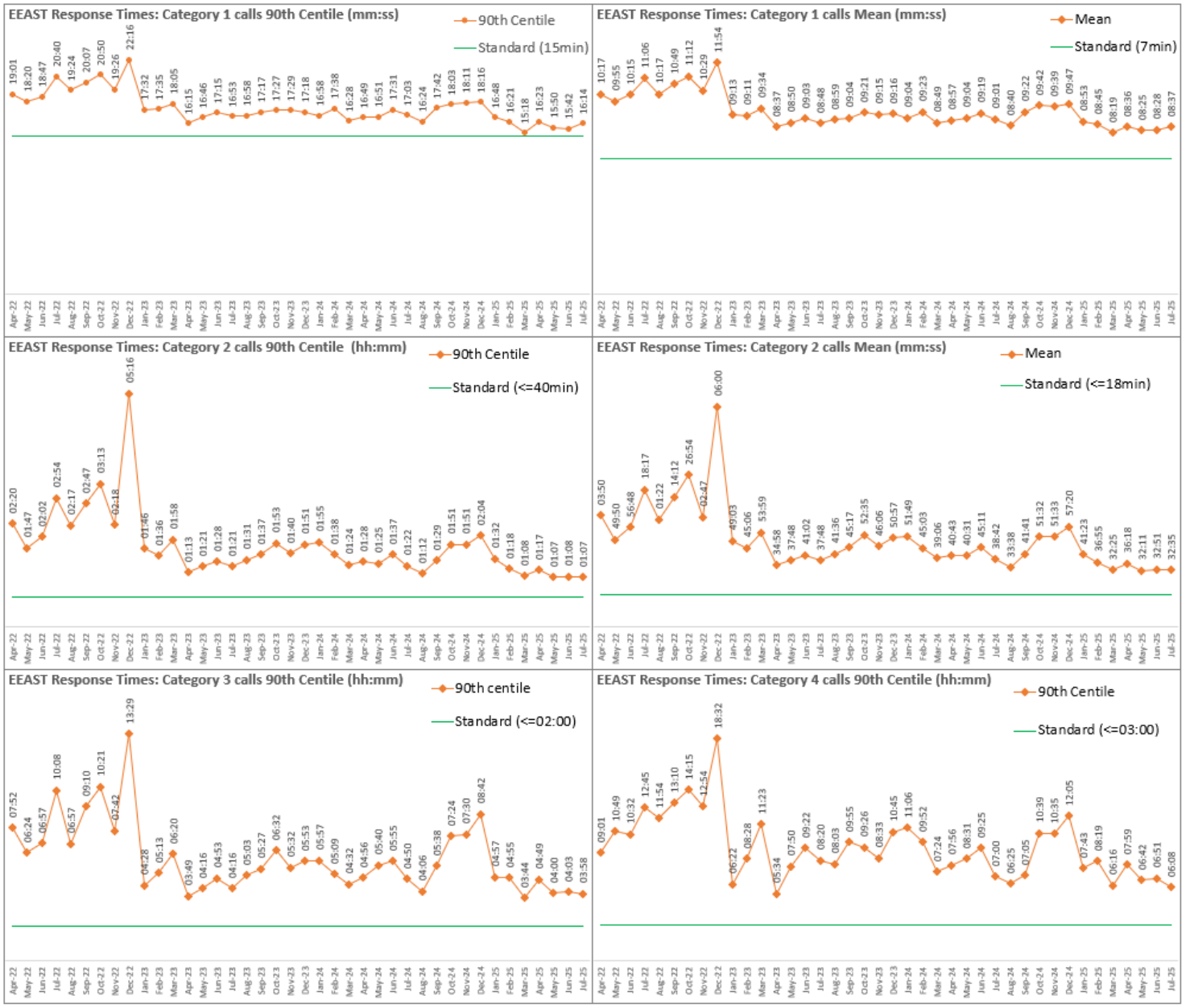
The UEC Oversight & Assurance Committee oversees performance and planning for all UEC services (East of England Ambulance Service (EEAST), NHS111, A&E, Urgent Community Response Team (UCRT), Mental Health Emergency Department (ED) and has members from both health and social care.

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 response times standards for East of England Ambulance Service listed above have not been met as shown in the following graphs.

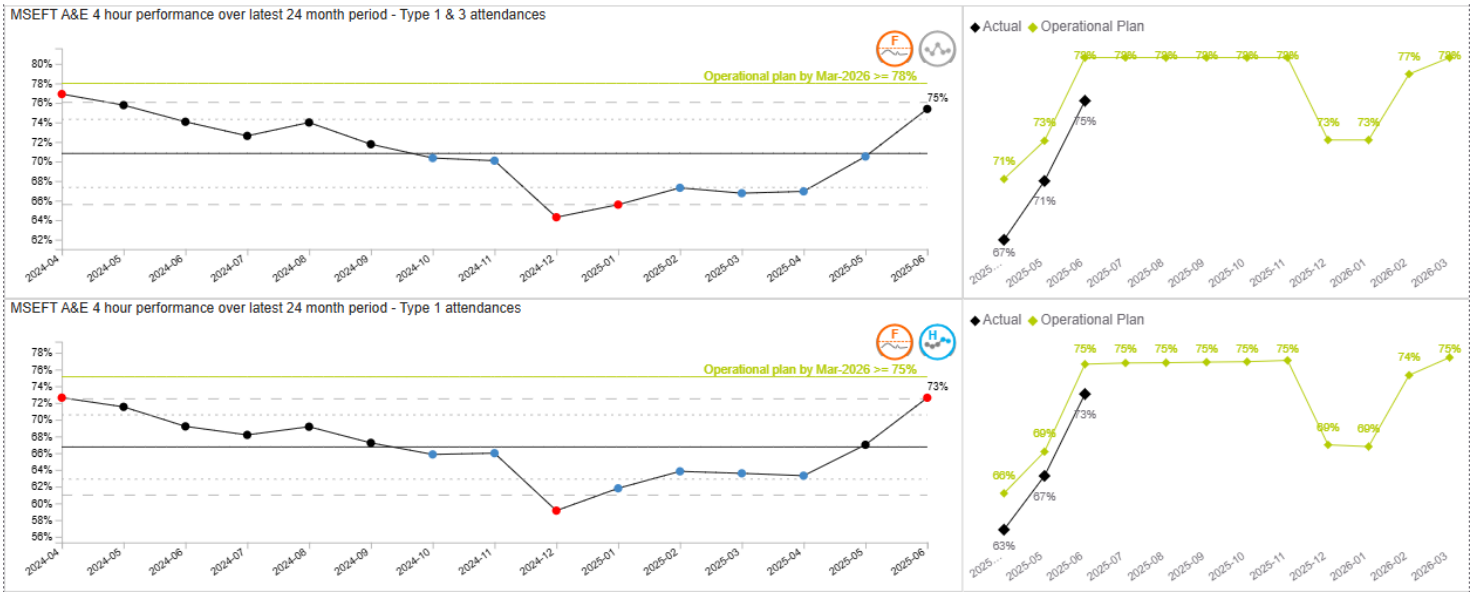


Emergency Department (ED) – waiting times

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.

MSEFT ED performance is not meeting the operational plan YTD (graph below top right). Performance of Type 1 attendances is improving to June 2025 (graph below bottom left), however performance is below plan (graph below bottom right). 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.

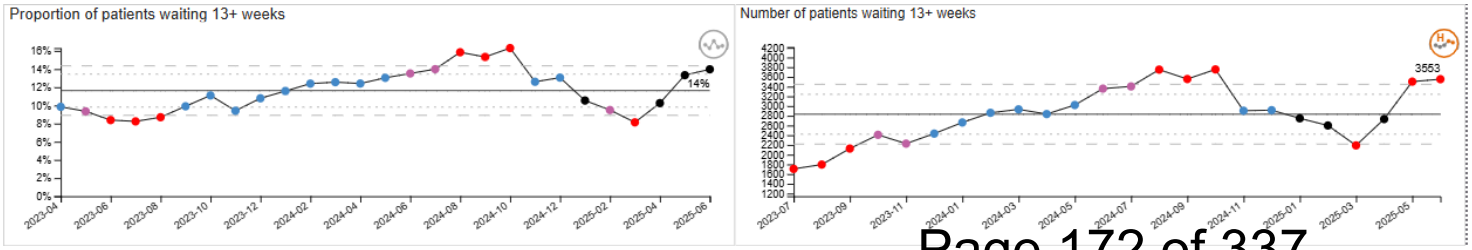
Diagnostics Waiting Times

Standard:

- Increase the percentage of patients that receive a diagnostic test within six weeks.
- No patients waiting 13+ weeks.

Diagnostics waiting 13+ Weeks

The following graphs show the proportion (graph left) and number (graph right) of patients waiting 13+ weeks at MSEFT. The proportion of patients waiting 13+ weeks has been increasing and decreasing over the last couple of years with June-2025 position at 14%. The proportion can be expected to be around 12% (mean) varying between 9% and 14%. The number of people waiting 13+ weeks has increased significantly for May-2025 and June-2025 with June-2025 position at 3,553 patients (graph right).



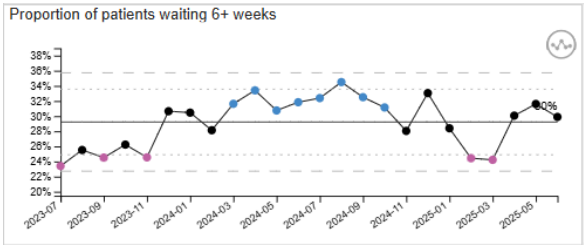
The following table shows the number and proportion of patents waiting 13+ weeks by diagnostic test (June-2025).

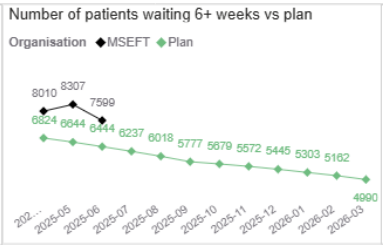
13+ weeks

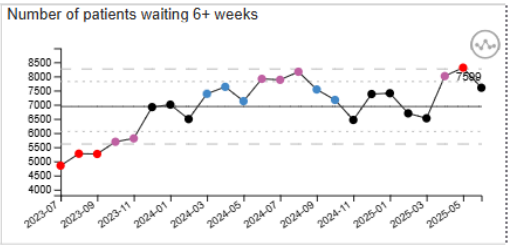
Test	Number	Proportion
PERIPHERAL_NEUROPHYS	279	74%
COLONOSCOPY	821	46%
FLEXI_SIGMOIDOSCOPY	220	45%
GASTROSCOPY	444	35%
SLEEP_STUDIES	130	32%
CYSTOSCOPY	81	30%
ECHOCARDIOGRAPHY	582	18%
NON_OBSTETRIC_ULTRASOUND	940	17%
DEXA_SCAN	10	1%
MRI	40	0%
AUDIOLOGY_ASSESSMENTS	2	0%
CT	4	0%
URODYNAMICS	0	0%
Total	**3,553**	**14%**

Diagmostics waiting 6+ weeks

There has been no significant change in the proportion of patients waiting over six weeks with June position at 30%. The proportion can be expected to be around 29% (mean) varying between 23% and 36% (graph below left). The number of patients waiting 6+ weeks is not meeting operational plan (graph below middle).







The following table shows the number and proportion of patents waiting 6+ weeks by diagnostic test (June 2025).

6+ weeks

Test	Number	Proportion
MRI	1,817	23%
NON_OBSTETRIC_ULTRASOUND	1,493	27%
ECHOCARDIOGRAPHY	1,323	40%
COLONOSCOPY	1,006	56%
GASTROSCOPY	616	48%
PERIPHERAL_NEUROPHYS	319	85%
FLEXI_SIGMOIDOSCOPY	285	58%
SLEEP_STUDIES	223	55%
DEXA_SCAN	198	24%
CYSTOSCOPY	142	53%
CT	127	5%
AUDIOLOGY_ASSESSMENTS	46	5%
URODYNAMICS	4	25%
Total	**7,599**	**30%**

Cancer Waiting Times

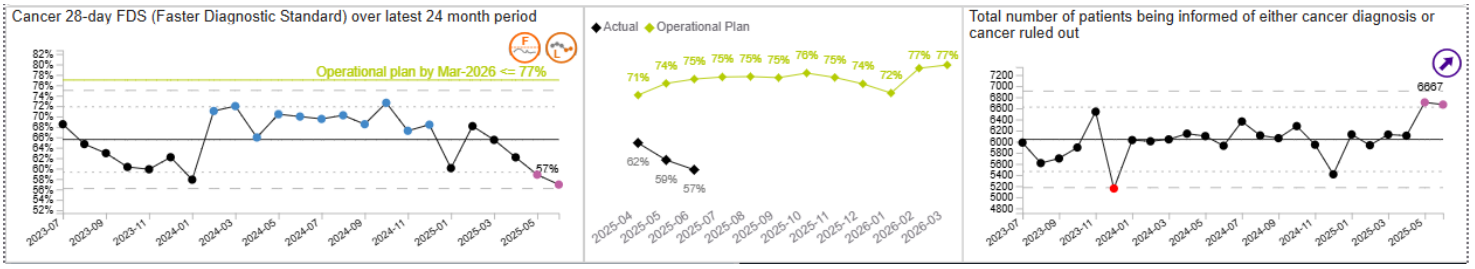
Standards: For people with suspected cancer:

- 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.

Cancer waiting times – 28 days FDS (Faster Diagnostic Standard)

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

The following graphs shows the MSEFT monthly performance for the 28-day Faster Diagnosis Standard. Performance year to date has not met the operational plan (graph below middle) and decreased to almost significant levels May-2025 and June-2025 (graph below left). The number of patients being informed of either cancer diagnosis or cancer ruled out increased to almost significant levels in May-2025 and June-2025 (graph below right).



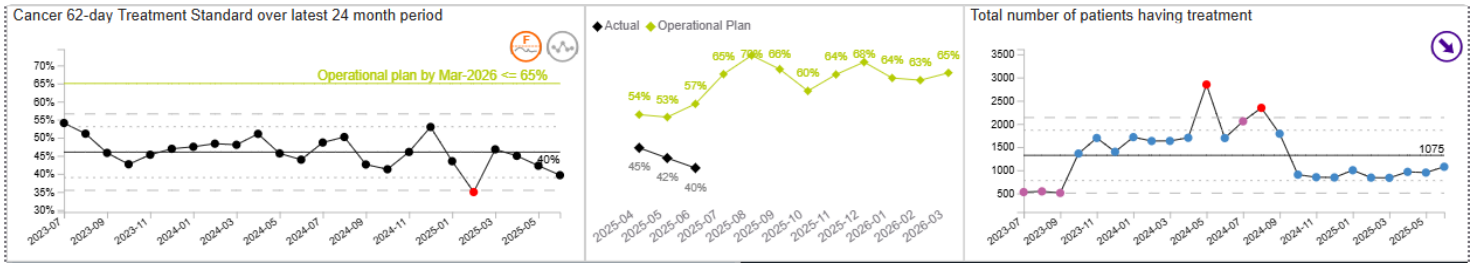
The following table shows the number informed, and proportion informed within 28 days by tumour site pathway (June-2025) flagging green when meeting the operational plan of >=77% by March-2026.

By tumour site

Metric_Description	Total	Within 28 days	Proportion
Suspected head & neck cancer	392	113	29%
Suspected haematological malignancies (excluding acute leukaemia)	58	25	43%
Suspected urological malignancies (excluding testicular)	514	233	45%
Suspected gynaecological cancer	762	364	48%
Suspected other cancer	4	2	50%
Suspected breast cancer	1,045	547	52%
Suspected lower gastrointestinal cancer	1,184	735	62%
Suspected skin cancer	1,987	1,250	63%
Suspected upper gastrointestinal cancer	402	265	66%
Suspected children's cancer	36	28	78%
Suspected lung cancer	197	159	81%
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	55	46	84%
Suspected testicular cancer	10	9	90%
Suspected cancer - non-specific symptoms	21	19	90%
Total	**6,667**	**3,795**	**57%**

Cancer waiting times – 62 day general standard

The following graphs shows MSEFT's monthly performance for the 62-day general standard performance. Performance YTD has not met the operational plan (graph below middle) and at aggregate level, no significant change in performance shown (graph below left).



The following table shows the number and proportion of patients treated within 62 days by tumour site pathway (June-2025) flagging green when meeting the operational plan of >=65% by March-2026.

By tumour site

Metric_Description	Total	Within 62 days	Proportion
Gynaecological	34	7	21%
Lower Gastrointestinal	106	24	23%
Upper Gastrointestinal - Oesophagus & Stomach	34	8	24%
Breast	147	39	27%
Lung	96	35	36%
Urological - Other (a)	49	18	37%
Head & Neck	31	12	39%
Urological - Prostate	271	106	39%
Other (a)	26	14	54%
Skin	171	94	55%
Upper Gastrointestinal - Hepatobiliary	55	32	58%
Haematological - Lymphoma	24	16	67%
Haematological - Other (a)	31	21	68%
Total	**1,075**	**426**	**40%**

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

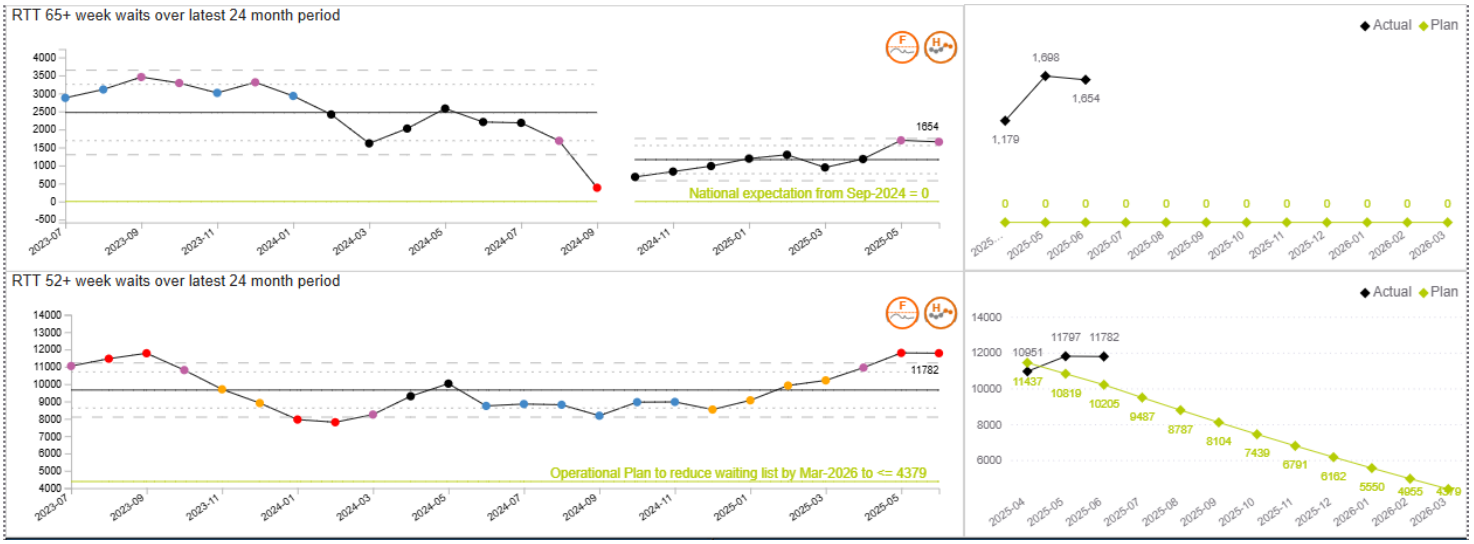
Referral to Treatment (RTT) Waiting Times

Standard:

- 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.

The operational plan to have zero patients waiting over 65 weeks by September 2024 has not been achieved (graph below top right) and increased to almost significant levels for May-2025 and June-2025 (graph below top left).

The number of patients waiting 52+ weeks is not meeting operational plan for May-2025 and June-2025 (graph below bottom right) and has increased significantly for May-2025 and June-2025 (graph below bottom left).



The following tables summarise the latest MSEFT RTT position (June 2025) for both 65+ and 52+ weeks by specialty.

Number and proportion of patients waiting 65+ weeks

Test	65+ weeks	Proportion
Trauma and Orthopaedic Service	496	3%
Ear Nose and Throat Service	206	1%
General Surgery Service	191	2%
Oral Surgery Service	146	3%
Urology Service	104	1%
Other - Medical Services	103	1%
Dermatology Service	65	0%
Other - Paediatric Services	62	1%
Gastroenterology Service	59	1%
Neurology Service	59	1%
Other - Surgical Services	55	1%
Plastic Surgery Service	38	1%
Ophthalmology Service	26	0%
Gynaecology Service	22	0%
Other - Other Services	10	0%
Neurosurgical Service	4	4%
Rheumatology Service	4	0%
General Internal Medicine Service	2	0%
Cardiology Service	1	0%
Respiratory Medicine Service	1	0%
Cardiothoracic Surgery Service	0	0%
Elderly Medicine Service	0	0%
Total	**1,654**	**1%**

Number and proportion of patients waiting 52+ weeks

Test	65+ weeks	Proportion
Trauma and Orthopaedic Service	2,414	13%
Ear Nose and Throat Service	1,689	10%
Dermatology Service	1,377	10%
General Surgery Service	805	9%
Other - Medical Services	696	5%
Oral Surgery Service	615	11%
Urology Service	602	6%
Ophthalmology Service	600	5%
Gastroenterology Service	565	5%
Gynaecology Service	543	4%
Other - Paediatric Services	440	10%
Neurology Service	419	7%
Plastic Surgery Service	367	6%
Other - Surgical Services	275	4%
Other - Other Services	169	5%
Rheumatology Service	125	4%
General Internal Medicine Service	46	2%
Cardiology Service	15	0%
Respiratory Medicine Service	15	0%
Neurosurgical Service	5	5%
Cardiothoracic Surgery Service	0	0%
Elderly Medicine Service	0	0%
Total	**11,782**	**7%**

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: June 2025).

Early Intervention in Psychosis (EIP) access

Standard:

- More than 50% of people experiencing their first episode psychosis commence a National Institute for Health and Care Excellence (NICE) recommended package of care within two weeks of referral.

This standard is being sustainably met across MSE (latest position: June 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 F&P Committee.

Across the System there remains a challenge in achieving delivery of the Constitutional Standards in several areas. The oversight of acute delivery includes the national Tier 1 meetings being held fortnightly and the Urgent Emergency Care Portfolio Board for the Integrated Care System.

At its meeting on 2 September 2025, the F&P Committee agreed to escalate financial performance and System delivery performance to the Board.

The Committee raised concerns in performance against the constitutional standards and specifically on waiting times for the Emergency Department, Referral to Treatment (RTT) and for patients on a cancer pathway of care.

4.0 Recommendation

The Board is asked to receive this report for information and note the escalation from the Finance and Performance Committee on financial performance and service delivery performance at month 4. It is recommended that the Board formally request a report on in year financial and performance recovery actions to be shared with the ICB Board.

Part I ICB Board Meeting, 18 September 2025

Agenda Number: 13

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) and 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

Highlands Surgery has been rated as outstanding by the Care Quality Commission (CQC) following an inspection conducted in May 2025. The surgery, located in Southend, serves approximately 14,600 patients and has received praise for its strong leadership, caring approach, and effective involvement of patients in their care. The CQC highlighted that 89% of patients reported being treated with care and concern, exceeding the national average. The Integrated Care Board has written to the practice acknowledging this achievement.

A provisional review of Local Enhanced Services was presented to the Executive Committee in August. This set out the current provision of enhanced services, activity and associated spend. The paper also set out considerations for the future commissioning of enhanced services including exploring new approaches learning from models currently in place in Suffolk and North East Essex and Herts and West Essex.

The Primary Care Medium Term Plan continues to make progress across a number of key areas of development. This includes primary care access, interfaces with other providers, estates, dental services and ‘left shift’. The progress on this is reported to the Primary Care Commissioning Committee (PCCC) which informs the strategic direction of key elements of the programme.

In July, the Integrated Care Board submitted our local response to the national Action Plan for General Practice. This describes the actions we are undertaking to address unwarranted variation across a number of key metrics through developmental support for practices alongside enforcing contractual compliance.

The Patient Survey published in July 2025 shows that more patients in mid and south Essex (MSE) are reporting positive experiences and taking advantage of new ways to access their GP practice. The recently published national GP Patient Survey reveals that overall patient experience in MSE has improved compared to 2024, up to 72%.

Around seven million appointments were delivered in MSE GP practices in 2024, 5% more than 2023. The survey results show that modern general practice access initiatives launched in May 2023 are delivering benefits for residents, as GP surgeries have been supported to improve their online and telephone services, hire more staff and introduce new efficient ways to access GP services.

Primary Care – Pharmacy

The ICB has now established a Community Pharmacy Commissioning and Transformation Group as a formal subgroup of the PCCC. The role of this group is to develop the role that community pharmacy will play in supporting the MSE population. This forum learns from the successful Dental Commissioning and Transformation Group that led on the implementation of several key pilots alongside strengthening our overall approach to dental commissioning.

An early consideration within the group is prioritising local campaigns that the Integrated Care Board (ICB) will deliver in conjunction with service providers to promote the role of community pharmacy and services they offer.

Primary Care – Dentistry

The dental team have implemented the necessary service provision and pathways to support the ICB deliver its contribution to the national target of 700k additional urgent dental appointments being offered to patients. This builds on the back of an already successful access pilot initiative.

There is continued delivery of the Children and Young Peoples (CYP) pilot. Significant progress has been made on the coverage of schools across MSE 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.

The Care Homes pilot continues to be successful. Several national publications have given positive coverage to the development. The pilot continues to be evolved through a clinically led working party of service providers providing peer to peer support and learning.

Focus of Alliance Teams

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

- Prevention and proactive management in the community
- Urgent and Emergency
- Primary Care
- Learning Disabilities and Autism
- Mental Health

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:

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:

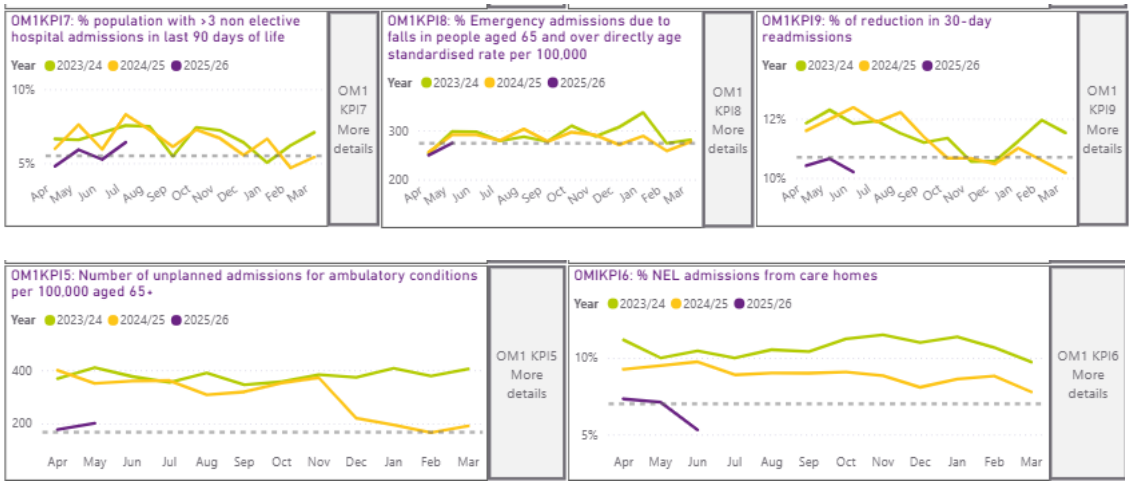
- 17 out of our 24 Integrated Neighbourhood Teams already have a full or partial focus on frailty and end of life (EoL) care within their model. The remaining teams are working to implement the frailty and EoL framework as the focus for 2025/26
- Our INT Cohort Finder and Case Finder tools are now live on Athena to support INTs to identify residents who would benefit from an INT model approach.

- Peer support between clinical directors who have implemented INTs and those that have not, have been established and are beginning to unblock some entrenched areas.

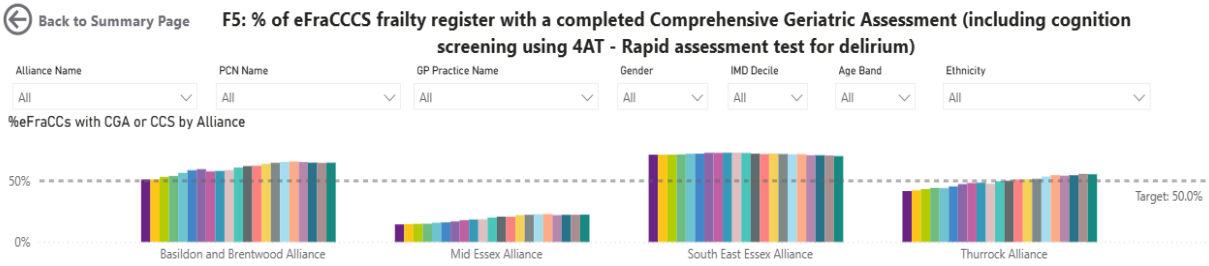
We continue to work to support our 24 INTs to both support their existing good work and to ensure the focus on frailty and EoL is MSE wide. A support tool has been produced and shared to facilitate this with INT leadership teams, and engagement across the system continues.

Across our Key Performance Indicators (KPIs) we are showing an improved trajectory from the pattern last year for:

- percentage of population with 3 or more hospital admissions in the 90 days of life
- the percentage of emergency admissions due to falls
- a reduction in people readmitted to hospital within 30 days of discharge
- a reduction in the number of people from care homes being admitted for a non-elective reason
- and the number of unplanned ambulatory condition admissions which is below the profile for last year.



Within the core deliverables for INTs, we can see an improvement in the number of residents on the frailty register with a comprehensive geriatric assessment



This gives some confidence that the intervention within the Frailty and EoL framework can contribute to improved outcomes for residents when implemented at scale.

National Neighbourhood Health Implementation Programme

A new national programme to accelerate the development of neighbourhoods in line with the NHS 10 Year Plan and Neighbourhood Health Guidelines, the National Neighbourhood Health Implementation Plan (NNHIP) will explore new approaches to

commissioning neighbourhood health services, supporting the development of neighbourhood providers and multi-neighbourhood providers, developing new ways of working and the essential system enablers to underpin this.

The aim of the NNHIP is to build on and not replace work that has already progressed in many places, adopting full flexibility to deliver in ways that are shaped locally and make sense for local populations. The programme will inform the new national neighbourhood contract and future policy, providing a rare opportunity to actively influence how this is shaped.

Each ICB selected one 'place' within their footprint to submit an expression of interest to participate in the programme, generating a network of 42 places to share learning and best practice. The programme will be overseen by a joint taskforce between Department of Health and Social Care (DHSC) and NHS England (NHSE), led by Sir John Oldham, providing national coaching support. The EoL process required endorsement and collaboration from all health and care provider organisations in each place.

South East Essex (SEE) has been selected as the MSE 'place', this decision was multi-factorial and influenced by progress in development of INTs, high levels of deprivation and inclusion in both the new Costal Navigators Network (CNN) and the Sport England Place programme.

Importantly, this is not an ICB or health only programme. The national request was explicit that all partners within the place have a role and accountability to embed this new way of working.

The Plan for Neighbourhoods

The plan for neighbourhoods is a £1.5 billion programme to invest in 75 areas over the next ten years and is part of the government's plan to ensure that nowhere is left behind. It will help revitalise local areas and fight deprivation at root cause by zeroing in on three goals: thriving places, stronger communities, and taking back control.

Canvey Island has been selected for this programme and will receive £20m over the next ten years. Participation in the programme requires the establishment of new Neighbourhood Boards, putting power in the hands of local people to address deprivation and regenerate their local area. Each board will, in partnership with their local authority, develop a 'Regeneration Plan', setting out its vision for the next decade alongside a more detailed 'Investment Plan' for the first four years of the programme.

The SEE Alliance has been invited to join the Canvey Neighbourhood Plan Board and took part in its inaugural meeting in August 2025.

Coastal Navigators Network

The previous Board report noted the submission of an expression of interest to participate in the Coastal Navigators Network (CNN), SEE Alliance is now formally a member. The CNN, created by Sir Chris Whitty, is 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.

SEE Alliance will focus activity on the two coastal communities in its geography, Southend and Canvey Island who will benefit from shared learning and support to

deliver real improvements in population health and deliver meaningful change. Two priorities have been identified 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.

Sport England Place Based Partnership

Almost £10 million funding has been secured to strengthen communities and tackle inequality in activity levels across Greater Essex. The investment, from Sport England, secured by Active Essex, will support the Place Partnership programme.

The Place Partnership programme aims to:

- increase physical activity
- decrease physical inactivity
- provide positive experiences of physical activity for children and young people
- tackle inequalities in local communities.

The latest investment into Greater Essex will see Castle Point, Harlow and Thurrock benefit. Basildon, Colchester and Tendring have also received further funding support, following the work achieved through the Essex Local Delivery Pilot.

Southend-on-Sea City Council

Southend-on-Sea City Council's Adult Social Care services have been rated 'Good' by the Care Quality Commission (CQC) following their recent inspection. This rating reflects the high standard of care and support provided to residents, focusing on safeguarding, prevention, reablement, and community support.

The CQC praised the council for its targeted outreach programs for people with complex needs and its investment in preventative services aimed at keeping people healthier and more independent for longer. The council's partnerships with the voluntary and community sector were also commended.

Better Care Fund

The Better Care Fund (BCF) teams have completed the quarter 1 (Q1) submission to the national team, including refreshing the BCF metrics and updating and confirming the financial allocations and spend in Q1.

The routine timetable of meetings in all localities has been maintained with reporting into the Alliance committees/meetings.

We will concentrate on aligning our 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 current work is to support the transition of our existing bridging capacity into a Home to Assess (H2A) model is now fully live across MSE. The procurement of the new

H2A model has now closed and will be in place as a fully mobilised service by November 2025.

An overview of other core funded projects within the BCF has been maintained.

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 the 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 the INTs and Primary Care Networks.

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 within the realms of the information available currently.

2. Recommendation

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

Part I ICB Board meeting, 18 September 2025

Agenda Number: 14.1

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 strategic objectives, these being:

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.

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 Executive Committee, which reviews the BAF and red rated risks (monthly), and the Audit Committee which reviews the BAF and corporate risk register at each committee meeting.

The ICB's other main committees also receive excerpts from the BAF in relation to risks within their remit, alongside registers of risks recorded on Datix (the ICB's risk management system) relevant to their areas of responsibility.

The above arrangements are supported by regular review of risks by risk leads who record updates on Datix.

2. Review of Risks on the Board Assurance Framework

The Board Assurance Framework now includes seven strategic risks **all of which are currently rated red** (scored between 15 and 25):

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

All BAF risks are cross-referenced with directorate level risks recorded on Datix.

The BAF also includes a summary of Mid and South Essex NHS Hospitals Trust and Essex Partnership University NHS Trust red-rated risks.

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, September 2025.

NHS
Mid and South Essex

Appendix 1

Board Assurance Framework

September 2025

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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 / S Morrison	People Board / No specific Board report / People Board Minutes	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 ASSURANCE OF 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 E Hough	Transition Committee / Chief Executive Report	4 x 4 = 16 ⟺

BAF

The risks that make up our BAF and their scores (Impact x Likelihood)

	Workforce	4 x 4=16
53	Expansion of clinical capacity	4 x 4=16
54	Reduce non-clinical headcount	3 x 5=15
55	R&R to reduce B&A (Provider)	4 x 4=16
	Primary Care	**4 x 4=16**
3	PC Demand & Capacity	4 x 4=16
21	PC Workforce R&R	4 x 3=12
	Primary Care Estate (Capital)	**4 x 4=16**
58	Insufficient Capital	4 x 4=16
	Quality Assurance of Services	**4 x 5=20**
5	MH Acute quality assurance	4 x 3=12
6	Neurodivergent Children	4 x 4=16
11	AACC	4 x 4=16
15	Acute quality assurance	4 x 5=20
17	Maternity	4 x 4=16
127	AACC CQC	4 x 4=16

	Access to Services	4 x 4=16
1	RTT	4 x 4=16
2	Diagnostics performance	4 x 4=16
13	Cancer performance	4 x 4=16
26	Ambulance Handovers	3 x 3=9
93	Mental Health patient flow	4 x 4=16
	System Financial Performance	**4 x 4=16**
7	Efficiency Programme	4 x 4=16
14	System Financial Performance	5 x 3=15
42	ICB Financial Performance	4 x 3=12
	Transition	**4 x 4=16**
138	Critical Programmes/Decisions	3 x 3 = 9
139	Business as Usual Continuity	3 x 3 = 9
140	Loss of Talent/Disengagement	3 x 4 = 12
141	Gaps in Quality/Regulatory Oversight	3 x 3 = 9
142	Human Resources Capacity	3 x 3 = 9
143	Alignment with Local Govt Reform	3 x 3 = 9
144	Redeployment of resource	4 x 5 = 20

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, 54, and 55.

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 for onward approval of NHSE regional team.
- Both EPUT and MSEFT embarking on corporate staffing review
- 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 and retention of existing staff.

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.

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 analyitics) will be picked up via the system efficiency programme of the MTP.
5. Clarity on ICB running cost reduction programme..

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

- Continued 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 is a key focus for Alliances in 2025/26.
- Implement the Action Plan for General Practice (June 25 onwards) reporting through progress to the Primary Care Commissioning Committee.
- 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 perf. reviews against constitutional standards: Weekly Elective Recovery & Transformation Board, bi-weekly Tier 1 Meeting for Cancer & Elective &monthly UEC Oversight & Performance &Diagnostic Prog Board meetings

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, including maximising new CDC diagnostic capacity

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.
- Diagnostic: delays to CDC build and start dates
- Workforce challenges (See Workforce Risk slide).

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.

Next Steps (Actions)

- Continuous monitoring of daily operations
- Quality Improvement Programmes at MSEFT to improve ED performance. Phase one completed, phase 2 commencing September 2025.
- ED Front Door Model: Redirect to Pharmacy First and streaming to alternative urgent care services.
- Expansion of Unscheduled Care Co-ordination Hub and Integrated Care Transfer Hub with increased subject matter experts to support attendance avoidance and reduce discharge delays.
- Ongoing monitoring of CDC delivery

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 for Consultant and VDT 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 East of England (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 in 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 failure to deliver on agreed plans, 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 138, 139, 140, 141, 142, 143 & 144.

How is it being addressed? (Current Controls)

- Establishment of ICB Transition Committee and Executive led subgroups, alongside establishment of a Greater Essex working group.
- Engagement plan in place, including weekly staff updates, engagement with partners and provision of staff support offer.
- Conclusion of designate Chair, Chief Executive and Executive Team consultation and appointment processes during September 2025 to provide leadership stability during the transition.
- Continuing to run programmes across the system, ensuring that provider plans are not impacted by the ICB transition (via Medium Term Plan (MTP) Delivery Board) and establishment of Board reporting.
- Central Programme Management Office (CPMO) continues to manage projects and report to the MTP Delivery Board.

Barriers (Gaps)

- National policy will lead expected changes therefore certain actions out with ICB direct control
- Current workforce change timescales and planning assumptions not yet confirmed (e.g. redundancy / Mutually Agreed Resignation Scheme (MARS) / Suitable Alternative Employment (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.
- Agreement of future transitional governance arrangements to establish shadow operation of Essex ICB prior to legal entity changes.
- Waiting for HMT confirmation of support for redundancy implications and any financial support

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.
- Establishment of transitional governance and leadership arrangements during Q3.

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

- 'Model Region' blueprint will support future function design – not yet published.
- Funding stream for redundancy/MARS required, if we are required to proceed with transition without financial support, there is a risk that resources will need to be redirected which could have an impact on delivery within MSE.

Partner self-identified Red Risks (and scores)

MSEFT - 10 Red Risks (as per June 2025 BAF report to Trust Board – NB: MSEFT's BAF is reported to every other public Board meeting. The next update will be October 2025).

- 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 per July risk Dashboard (reported to EPUT Trust Board, 6 August 2025)

- Capital resource for essential works and transformation programmes (20)
- Use of Resources: control total target / statutory financial duty. (20)
- Statutory Public Inquiry (16)
- Organisational Development (16)

Part I ICB Board Meeting, 18 September 2025

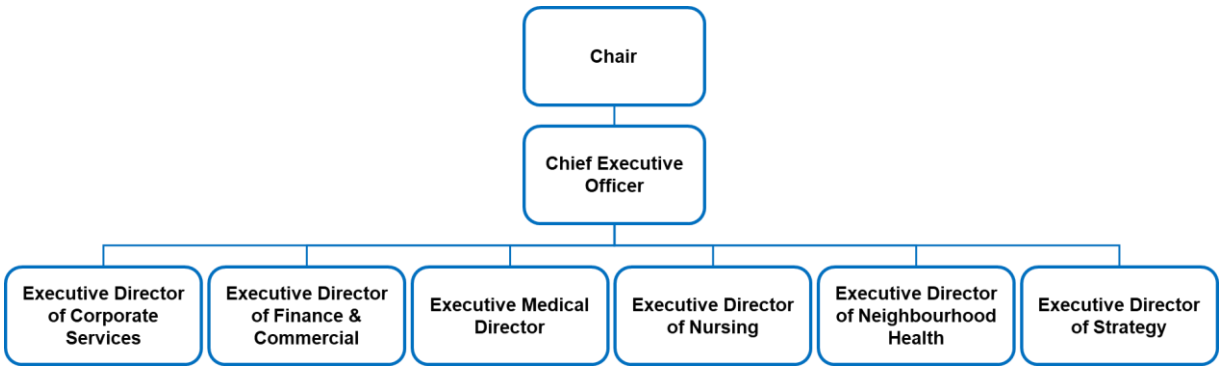
Agenda Number: 14.2

Amendment to the ICB Constitution and Executive Committee Terms of Reference

Summary Report

1. Purpose of Report

Following the consultation regarding Executive Officer re-structure, the ICB Constitution and the terms of reference for the Executive Committee have been amended to take account of the new Executive Structure (see below).



Key changes reflected in the Constitution include the removal of the Chief People Officer both from the Executive structure and as a member of the ICB Board and the updating of titles for the Director of Finance and Director of Nursing.

It should be noted that within the Constitution, the Director of Corporate Services, Director of Neighbourhood Health and Director of Strategy are not members of the ICB Board.

Those listed within the Constitution as ‘attendees’ has also been updated.

The membership of the Executive Committee has reduce significantly to reflect the new structure and consequently quoracy for the committee has reduced to 3 members.

2. Executive Lead

Tom Abell, Chief Executive Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The Board retains responsibility for approval of changes to the Constitution, after which final approval rests with NHS England.

5. Link to the ICB's Strategic Objectives

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.

6. Impact Assessments

An impact assessment is not required for this change.

7. Financial Implications

There are no financial implications.

8. Details of patient or public engagement or consultation

Not required.

9. Conflicts of Interest

None identified.

10. Recommendation/s

The Board is asked to approve:

- Minor changes to the Constitution prior to submission to NHS England for approval.
- Changes to the membership and quoracy of the Executive Committee.

Mid and South Essex
Integrated Care Board

NHS Mid and South Essex Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
v1.0	N/A	1 July 2022
V1.1	N/A	Minor changes
V1.2	9 May 2024	Minor changes
V1.3-1.5	N/A	Minor changes – drafting
V2.0	15 May 2025 19 May 2025 (NHS England)	19 May 2025
V2.1	17 July 2025 (proposed)	17 July 2025 (proposed)
V2.2	17 July 2025	Final Board and NHS England approved
V2.3		Minor changes – update following Executive restructure.

CONTENTS

1 Introduction

1.1. Foreword

1.1.1 NHS England has set out the following as the four core purposes of ICSs:

a) Improve outcomes in population health and healthcare.
b) Tackle inequalities in outcomes, experience and access.
c) Enhance productivity and value for money.
d) Help the NHS support broader social and economic development.

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- Improving the health of children and young people.
- Supporting people to stay well and independent.
- Acting sooner to help those with preventable conditions.
- Supporting those with long-term conditions or mental health issues.
- Caring for those with multiple needs as populations age.
- Getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is the NHS Mid and South Essex Integrated Care Board ("the ICB").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB comprises the Borough of Basildon, District of Braintree, Borough of Brentwood, Borough of Castle Point, City of Chelmsford, District of Maldon, District of Rochford, City of Southend-on-Sea, and the Borough of Thurrock.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution which must comply with the

requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published at www.midandsouthessex.ics.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act).
c) Duties in relation children including safeguarding, promoting welfare etc. (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).
d) Adult safeguarding and carers (the Care Act 2014).
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35).
f) Information law, (for instance, data protection laws such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018 and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) Section 14Z34 (improvement in quality of services).
b) Section 14Z35 (reducing inequalities).
c) Section 14Z38 (obtaining appropriate advice).
d) Section 14Z40 (duty in respect of research)
e) Section 14Z43 (duty to have regard to effect of decisions).
f) Section 14Z45 (public involvement and consultation)
g) Sections 223GB to 223N (financial duties).
h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) Where NHS England varies the Constitution of its own initiative (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chief Executive may periodically propose amendments to the Constitution, which shall be considered and approved by the Integrated Care Board prior to making an application to vary the Constitution to NHS England.
b) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

a) **The Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map** - a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes:
   - The above documents a) – c).
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   - The up-to-date list of eligible providers of primary medical services under clause 3.7.2.
   - Detailed arrangements for the nomination and selection process of board members, as required.

e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it, including:
   - Standards of business conduct policy.
   - Conflicts of interest policy and procedures.
   - Patient and public engagement policy.

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.midandsouthessex.ics.nhs.uk

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) A Chair.
b) A Chief Executive.
c) At least three Ordinary members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) Three executive members, namely:
   - Director of Finance (known locally as the ~~Chief Finance Officer~~Executive Director of Finance and Commercial).
   - Executive Medical Director.
   - Executive Director of Nursing ~~(known locally as the Chief Nurse)~~
b) At least two non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below:

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description.
- The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description.
- The upper tier local authorities that are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors. The ICB is

seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.

2.2 Board membership

2.2.1 The ICB has 6 Partner Members:

a) Two members, one of whom brings the perspective of the acute sector and the other of whom brings the perspective of the mental health sector delivering services across the ICB's area.
b) One member nominated and selected to bring the perspective of the primary care sector within the ICB area.
c) Three members nominated by the upper tier local authorities whose area coincides with or includes the whole or any part of the ICB's area.

2.2.2 The ICB has also appointed the following further Ordinary members to the board:

a) One additional Non-executive Member.
~~b) Chief People Officer.~~

2.2.3 The board is therefore composed of the following members:

a) Chair.
b) Chief Executive.
c) 2 Partner members NHS trusts and foundation trusts.
d) 1 Partner member primary medical services.
e) 3 Partner members local authorities.
f) 3 Non-executive Members (one of which, but not the Audit Committee Chair, will be appointed the Deputy Chair and one of which, who may be the Deputy Chair or the Audit Committee Chair, will be appointed the Senior Non-Executive Member).
g) ~~Chief Finance Officer.~~Executive Director of Finance and Commercial
h) Executive Medical Director.
i) ~~Chief Nurse~~Executive Director of Nursing.

~~Chief People Officer.~~

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular participants and observers at board meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

a) 3 Associate Non-Executive Members
b) Executive Director of Strategy
~~b)~~c) ~~Executive Director of Strategy and Corporate Services~~Executive Director of Neighbourhood Health
~~c) Executive Chief Digital Information Officer~~
~~4 Alliance Directors~~
d) Chief Executive of Partner Organisations not represented on the Board

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and/or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the standing orders.

3 Appointments Process for the Board

3.1 Eligibility criteria for board membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the “fit and proper person test”.
b) Be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles).
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.
d) Be willing to uphold the principles of the East of England Leadership Compact.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member (“the candidate”) is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health

service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) In the United Kingdom of any offence, or
b) Outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the Chair, a Member, a Director or a Governor of a health service body, has been terminated on the grounds:

a) That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.
b) That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.
c) That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.
d) Of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Healthcare Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) The person's suspension from a register held by the regulatory body, where that suspension has not been terminated.
b) The person's erasure from such a register, where the person has not been restored to the register.

c) A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be a maximum of three years and the total number of terms a Chair would normally serve is two terms (a maximum of six years).

3.3.5 The chair may serve a further term (three years) following a rigorous review and agreement with NHS England (not exceeding a total of nine years).

3.4 Deputy Chair and Senior Non-executive Member

3.4.1 The Deputy Chair is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-executive Member is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.5 Chief Executive

3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.5.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Subject to clause 3.5.3(a), they hold any other employment or executive role other than chief executive of another Integrated Care Board (ICB).

3.6 Partner Members – NHS trusts and foundation trusts (FTs)

3.6.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs that provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

a) East of England Ambulance Service NHS Trust.
b) Essex Partnership University NHS Foundation Trust.
c) Mid and South Essex NHS Foundation Trust.
d) North East London NHS Foundation Trust.

3.6.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be a CEO or Executive Director of one of the NHS Trusts or FTs within the ICB's area.
b) One member must provide current and on-going experience of the acute hospital sector.
c) One member must provide current and on-going knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
d) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.6.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.6.4 These members will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.6.1 will be invited to make one nomination for each role (one for acute and one for mental health).
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
- In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is

initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3.
- The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is three terms. However, where more than one trust can act on behalf of their sector the nomination and selection process will be revisited at the end of each term at the discretion of the Chair.

3.7 Partner Member - providers of primary medical services

3.7.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area and that are primary medical services contract holders responsible for the provision of essential services within core hours to a list of registered persons for whom the ICB has core responsibility.

3.7.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this constitution.

3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be registered with the General Medical Council.
b) Be a practising provider of primary medical services within the ICB area.
c) Work as a GP in the ICB area for a minimum of 1 session per week.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role specification.

3.7.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.7.5 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.7.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation described at 3.7.1 and listed in the Governance Handbook will be invited to make one nomination.

- Each nomination must be seconded by one of the other eligible organisations described at 3.7.1 and listed in the Governance Handbook.
- Eligible organisations may nominate an individual from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
   - If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
   - In the event that there is more than one suitable nominee for the role, the full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.3 and 3.7.4.
   - The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

c) Chair's approval:
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this Partner Member will be three years, subject to re-appointment following the process described above, and the total number of terms they may serve is three terms. One term may be extended (in extenuating circumstances as defined by the Board) for up to one year subject to approval by the Chair.

3.8 Partner Members - local authorities

3.8.1 These Partner Members are jointly nominated by the upper tier local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Essex County Council
b) Southend on Sea City Council
c) Thurrock Council

3.8.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.8.1.
b) The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.
a) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.8.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.8.4 This member will be recommended for appointment by the ICB Chief Executive subject to the approval of the Chair.

3.8.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.8.1 will be invited to make one nomination for each role.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
- In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.

- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.
- The panel will select the most suitable nominee for appointment via the shortlisting, interview and selection process set out in the Governance Handbook.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.8.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is three terms.

3.9 Executive Medical Director

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Medical Practitioner.
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.9.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.10 Executive Director of Nursing ~~(known as the Chief Nurse)~~

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Nurse.
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.10.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.11 Executive Director of Finance and Commercial ~~(known as the Chief Finance Officer)~~

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.11.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.11.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.12 Non-Executive Members

3.12.1 The ICB will appoint three Non-executive Members.

3.12.2 These members will be appointed at the recommendation of the selection panel subject to the approval of the Chair of the ICB.

3.12.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be employee of the ICB or a person seconded to the ICB.
b) Not hold a role in another health and care organisation in the ICB area.
c) One member shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee.
d) One other member should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
e) A third member with specific knowledge, skills and experience that makes them suitable for their role.
f) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.12.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) They hold a role in another health and care organisation within the ICB area.

3.12.5 The term of office for a non-executive member will be three years and the total number of terms an individual may serve is three terms, after which they will no longer be eligible for re-appointment.

3.12.6 Initial appointments may be for a shorter period in order to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.12.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of a non-executive member up to the maximum number of terms permitted for their role.

~~**3.13 Other Board Members – Chief People Officer**~~

~~3.13.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:~~

~~a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act.~~

~~3.13.2 Individuals will not be eligible if:~~

~~a) Any of the disqualification criteria set out in 3.2 apply.~~

~~3.13.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.~~

~~3.14~~3.13 Board Members: Removal from Office

~~3.14.1~~3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment and application of the relevant ICB policies and procedures.

~~3.14.2~~3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance.
b) If they fail to attend two consecutive meetings to which they are invited or show a pattern of absence (unless such absence has been agreed with the Chair in extenuating circumstances). A subsequent meeting with the Chair shall take place to determine whether the individual is able to continue to hold office.
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to

dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.

e) If they are deemed to have failed to uphold the Nolan Principles of Public Life.
f) If they are deemed to have failed to uphold the principles of the East of England Leadership Compact.

~~3.14.3~~3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.14.2 apply.

~~3.14.4~~3.13.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

~~3.14.5~~3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

~~3.14.6~~3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) Terminate the appointment of the ICB's Chief Executive; and
b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

~~3.15~~3.14 Terms of Appointment of Board Members

~~3.15.1~~3.14.1 A proposal for the Chair or non-executive to serve on the board for longer than six years will be subject to rigorous review to ensure their ongoing independence, and they will not serve as a board member for longer than nine years in total.

~~3.15.2~~3.14.2 With the exception of the Chair and Non-executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB website, and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by a Non-executive Member remuneration panel, as set out in the Governance Handbook.

~~3.15.3~~3.14.3 Other terms of appointment will be determined by the Remuneration Committee.

~~3.15.4~~3.14.4 Terms of appointment of the Chair will be determined by NHS England.

4 Arrangements for the exercise of our functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.

4.2 General

4.2.1 The ICB will:

a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations.
b) Comply with directions issued by the Secretary of State for Health and Social Care.
c) Comply with directions issued by NHS England.
d) Have regard to statutory guidance including that issued by NHS England.
e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) Any of its members or employees.
b) A committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter into partnership arrangements with a Local Authority under which the Local Authority exercises specified ICB functions or the ICB exercises specified Local Authority functions, or the ICB and Local Authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation (SoRD)

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full in the Governance Handbook on the ICB website.

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) Those functions that are reserved to the board.
b) Those functions that have been delegated to an individual or to committees and sub committees.
c) Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published in the Governance Handbook on the ICB website.

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB.
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body.
d) Functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB will be required to:

a) Submit regular decision or assurance reports to the board.
b) Ensure attendance at board meetings of either the Chair or deputy Chair, when requested by the ICB Chair.
c) Comply with internal audit and external audit recommendations and the recommendations of committee effectiveness reviews.
d) Specify the arrangements for their meetings in their terms of reference in line with the standing orders or any specified alternative arrangements.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of or include persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this constitution, including the Standing Orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit Committee:** This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

   The Audit Committee will be chaired by a Non-executive Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a Non-executive Member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- Conducting the business of the ICB.
- The procedures to be followed during meetings.
- The process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and forms part of this constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook on the ICB website.

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website.

6.1.3 All board, committee and sub-committee members and employees of the ICB will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict and is subject to the provisions of this constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.
c) Support the rigorous application of conflict of interest management principles and policies.
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the principles of the East of England Leadership Compact, and the following principles:

a) Subsidiarity: arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale.
b) Population-focused vision: decisions should be consistent with a clear vision and strategy that reflects the four core purposes
c) Shared understanding: partners should have a collective understanding of the opportunities available by working together and the impact of individual organisational decisions on other parts of the system.
d) Co-design and co-production: addressing system challenges and decision-making should involve working with people, communities, clinicians and professionals in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.
e) Timely access to information and data: system partners should share accurate and complete data (quantitative and qualitative) in an open and timely manner to enable effective decision-making.
f) Clear and transparent decision-making: system partners should work in an open way ensuring that decision-making processes stand up to independent scrutiny.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB.
b) Members of the board's committees and sub-committees.
c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:

a) Act in good faith and in the interests of the ICB.
b) Follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).
c) Comply with the ICB Standards of Business Conduct Policy and any requirements set out in the policy for managing conflicts of interest.
d) Be willing to uphold the principles of the East of England Leadership Compact.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Principles

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The constitution and Governance Handbook will be published as well as other key documents including but not limited to:

a) Conflicts of interest policy and procedures.
b) Registers of interests.
c) Other key documents and policies, as appropriate.

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the “Joint Forward Plan”). The plan will, in particular:

a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions
b) Explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards), and sections 223GB and 223N (financial duties).
c) Set out any steps that the ICB proposes to take to implement the three joint local health and wellbeing strategies.
d) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.

e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and Decision Making

7.3.1 At least three Non-executive Members will be appointed to the board, including the Chair, and all of the board and committee members will comply with the Seven Principles of Public Life (the Nolan Principles) and meet the criteria described in the fit and proper person test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) The establishment of a provider selection regime review group and governance structure to deal with any challenges to decisions about provider selection.

b) Maintaining the audit trail of decision making for transparency purposes.

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.3.5 The ICB will comply with the current procurement regulations at the time for all non-clinical goods/services purchases.

7.4 Annual Report

7.4.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) Explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards).
b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan).
c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) Review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard

under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees.

8.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.2 The board has established a Remuneration Committee which is chaired by a Non-executive member other than the Chair or Audit Chair.

8.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) HR advisers being in attendance at meetings.

8.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook on the ICB website.

8.6 The duties of the Remuneration Committee include:

a) Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
b) Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
c) Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Change Terms and Conditions.
d) Overseeing any discretionary payments outside of Agenda for Change pay policy for all staff.
e) Determining the arrangements for termination payments and any special payments for all staff.

8.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) The planning of the commissioning arrangements by the Integrated Care Board.
b) The development and consideration of proposals by the ICB.
c) Changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them.
d) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.2 In line with section 14Z54 of the 2006 Act, the ICB has made the following arrangements to engage with its population on its system plan:

a) Overarching strategic communications and involvement planning through the system communications and engagement network in collaboration with partners across the ICS including NHS, local authority, community and voluntary sector organisations and through alliances.
b) Partner-led local conversations and awareness raising, community assets and place-based involvement plans.
c) Clinical and managerial involvement.
d) Communications and conversations with the population that are clinically and professionally informed and led.
e) Patient and public involvement in the development of communication materials and assets as appropriate.
f) Detailed conversations with professional bodies and trade unions.
g) Complying with Health Overview and Scrutiny requirements.

9.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities, set out below.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.

d) Build relationships with excluded groups – especially those affected by inequalities.
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
g) Use community development approaches that empower people and communities, making connections to social action.
h) Use co-production, insight and engagement to achieve accountable health and care services.
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.4 In addition, the ICB has set out its vision for community involvement in more detail in the Mid and South Essex patient and public engagement policy which can be found on the ICB website.

9.5 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.6 These arrangements include a range of engagement activities, including, but not limited to patient participation groups, 'Virtual Views' citizens' panel and targeted outreach sessions. The ICB will have lead responsibility for the ICS engagement framework and provide advice, guidance and training to encourage a culture of co-production among wider teams to support its delivery as close to our communities as possible.

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders. In Mid and South Essex these are also referred to as 'Alliances'.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in

	accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description. • The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Director of Finance	Known locally as the ~~Chief Finance Officer~~Executive Director of Finance and Commercial.
Health Service Body	Health Service Body as defined by (a) section 9(4) of the NHS Act 2006 or (b) NHS foundation trusts.
Health Care Professional	An individual who is a member of a professional regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Appendix 2: Standing Orders

1 Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of Mid and South Essex Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's constitution.

2 Amendment and review

2.1 The Standing Orders are effective from 19 May 2025.

2.2 The Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per clause 1.5.2 of the Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3 Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB constitution and as per the definitions in Appendix 1.

3.2 These Standing Orders apply to all meetings of the board, including its committees and sub-committees, unless otherwise stated. All references to the board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the board, members of committees and sub-committees and all employees should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.

3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4 Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two calendar days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting that is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the board.

4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair shall preside over meetings in the Chair's stead.

4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest, the assembled members are to appoint a temporary Deputy for the purpose of chairing the meeting.

4.2.4 The ICB board, acting on the advice of the Chair, shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.midandsouthessex.ics.nhs.uk

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be reviewed in accordance with the arrangements published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak but may not vote on their behalf.

4.5.2 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.5.3 If a member of the ICB is unable to attend two consecutive meetings, other than as a result of illness or other exceptional circumstances, the member will meet with the Chair to determine their future ability to fulfil their role.

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this. Arrangements for governing this process are included in the Governance Handbook.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be seven members, including at least the following:

a) Either the Chair or Deputy Chair.
b) Either the Chief Executive or the ~~Chief Finance Officer~~Executive Director of Finance and Commercial.
c) Either the Medical Director or the ~~Chief Nurse~~Executive Director of Nursing.
d) At least one other independent member

e) At least one Partner Member.

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest shall no longer count towards the quorum.
c) A nominated deputy permitted in accordance with standing order 4.5 will not count towards quorum for meetings of the board.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) For a limited period, the quorum will be reduced by one per vacancy.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional participants and observers will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent Decisions

4.9.4 In the event of extraordinary circumstances requiring urgent decisions to be taken, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply:

4.9.5 The powers which are reserved or delegated to the board may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances (minimum of one other member).

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board (or committee in the case of committee urgent decisions) for formal ratification and Board urgent decisions will be reported to the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be approved by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the board.

5 Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6 Use of seal and authorisation of documents

6.1 The ICB will use a seal for executing documents where necessary.

6.2 The seal shall be kept by the Chief Executive or a nominated manager in a secure place.

6.3 The following individuals or officers are authorised to authenticate use of the seal by their signature:

- The Chief Executive.
- The ICB Chair.
- The ~~Chief Finance Officer~~Executive Director of Finance and Commercial.

6.4 The full procedure and other conditions for the use of the seal, including the register of sealing, are included in the Governance Handbook.

Mid & South Essex Integrated Care Board

Executive Team

Terms of Reference

1. Constitution

1.1 The Executive Team (the Committee) is established by the Integrated Care Board (the Board or ICB) and is a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Committee is a formal committee of the ICB, which has delegated authority from the ICB, details of which are set out in the Scheme of Reservation and Delegation. The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

2.2 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.

2.3 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD.

3. Purpose

3.1 The purpose of the Committee is as follows:

3.2.1 To provide oversight and assurance to the Board regarding the operational management of the ICB and delivery of its strategic objectives.

3.2.2 To contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the following areas:

- Objective oversight and scrutiny of proposed business cases / decisions ensuring support of system recovery
- Recommending the strategic direction
- Robust decision making (approval of/providing support for investment /disinvestment/decommissioning decisions in line with the ICB Scheme of Reservation and Delegation)
- Identify key issues and risks requiring discussion or escalation to the Board

3.3 The duties of the Committee will be driven by the ICB's objectives and the associated system risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

3.4 The Committee has no executive powers, other than those delegated in the SoRD and specified in these ToR and those held by the individual attending the meeting.

4. Membership and attendance

Membership

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

4.2 The Board will appoint no fewer than 6 members of the Committee who shall directly report to the Chief Executive Officer.

4.4 Membership will comprise:

- Chief Executive Officer
- Executive Director of Corporate Services
- Executive Director of Finance & Commercial
- Executive Medical Director
- Executive Director of Nursing
- Executive Director of Neighbourhood Health
- Executive Director of Strategy

Chair and vice chair

4.6 The Chair of the Executive Committee will be the Chief Executive Officer.

4.7 The Chair of the Committee may appoint a Vice Chair of the Committee from amongst its members.

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

4.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

4.10 Only members of the Committee have the right to attend Committee meetings, however, meetings of the Committee may also be attended by the following individuals who are not members of the Committee by invitation only:

- Director of Communications and Partnerships
- Chair of ICB Operational Group (IOG).
- Executive Director of System Recovery
- Executive Director of Performance and Planning
- Chief of Staff

4.11 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.12 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from health partners.

Attendance

4.13 Where an attendee or member of the Committee is unable to attend a meeting, a suitable alternative deputy may be agreed with the Chair. The deputy may vote on behalf of the absent Committee member.

5. Meetings Quoracy and Decisions

5.1 The Committee will meet at least 12 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned weekly subject to there being necessary business to transact.

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

5.4 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of 3 Members of the Committee are required, including the Chair or Vice Chair of the Committee.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

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

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

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

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.

5.12 Where this is not possible an urgent decision may be exercised by a virtual meeting (either via email, video or conference call) of at least 6 members to reach a quorate decision.

5.13 The exercise of such powers shall be reported to the next formal meeting of the Committee for ratification.

6. Responsibilities of the Committee

6.1 To ensure appropriate multi-professional diligence, scrutiny, and strategic alignment over the operation of the ICB and the delivery of its objectives

- To ensure our people our empowered to deliver the projects and programmes that support the achievement of objectives.
- To be responsible for the ICB Equality, Diversity, Inclusion and belonging agenda, ensuring compliance with legislation and best practice, and creating an inclusive culture.
- To support and contribute to financial sustainability through robust decision making as delegated through the SORD.
- To ensure consistent message across the ICB in relation to its strategic direction and the delivery of financial turnaround.
- Review and collective ownership of finance, quality, performance, and operations ahead of formal scrutiny by Board sub-committees.
- To oversee and own the corporate risk register ensuring it is regularly updated and actions are being taken to address identified risks.
- To provide advice, guidance and clear decision making to the Senior Leadership team.
- To support the Board and other sub committees of the board to discharge their responsibilities effectively.
- To set the standard and example for matrix working across the ICB
- To oversee the response to regulatory review (e.g., NHSE, CQC).

6 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out including the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.6 Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

7 Accountability and reporting

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

8.4 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

8.5 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.6 The decisions of the meetings, including any virtual meetings, shall be formally recorded by the secretary, and submitted to the Board in accordance with the Standing Orders.

8.7 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.8 The ICB Operational Group (IOG) shall be accountable to the Executive Committee and ensure that proposals to the Executive Committee have completed all relevant due diligence and are supported by key stakeholders.

8.9 The ICB Inclusion and Belonging Group shall be accountable to the Executive Committee and ensure that proposals to the Executive Committee have completed all relevant due diligence and are supported by key stakeholders.

8 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained, and the Board is prompted to renew membership and identify new members where necessary.
- Notes of the meeting are taken (the meeting will not be formally minuted), but a robust register of decisions will be maintained, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept, in accordance with the standing orders.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

9 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: PROPOSED – ICB Board 18 September 2025

Date of review: 18 September 2026

Part I ICB Board Meeting, 18 September 2025

Agenda Number: 14.3

Mid and South Essex Integrated Care Board self-assessment of effectiveness for 2024/25

Summary Report

1. Purpose of Report

To provide the Board with a report on the outcome of a self-assessment of the Board's effectiveness for 2024/25, which includes a summary of the ICB's achievements and challenges, along with proposed action to improve the effectiveness of the Board going forward.

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The ICB Board is responsible for regularly assessing its effectiveness.

5. Link to the ICB's Strategic Objectives

- 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.
- 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.
- 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.
- 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.

- 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.

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

None identified.

10. Recommendation/s

The Board is asked to approve the assessment of Board Effectiveness 2024/25 and action identified to improve the effectiveness of the Board going forward.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Mid and South Essex Integrated Care Board self-assessment of effectiveness for 2024/25

Contents

Chairs Foreword

As I reflect on my time as Chair of the NHS Mid and South Essex (MSE) Integrated Care Board (ICB), I am struck by the scale of transformation we have undertaken and the strength of our collective resolve. While we are under no illusions about the challenges that face us to meet the rightly held public expectations, we have nevertheless managed to make exceptional progress in some areas.

It has been a privilege to lead the Board through a period of significant change, challenge, and progress – anchored in our shared commitment to improving the health and wellbeing of the 1.2million people we serve.

This year's Board effectiveness self-assessment reaffirmed our strengths in strategic focus, leadership behaviours, and risk oversight. It also highlighted areas for development, including assurance processes, stakeholder engagement, and the need to better harness the diverse skills and experiences of our Board members.

A board seminar provided a valuable opportunity to reflect on our governance, culture, and readiness for future challenges. The assessment will guide our next development phase, ensuring that our Board continues to be insightful, inclusive and impactful.

Alongside this internal reflection, our Annual Report showcases the breadth of work delivered across the system, making tangible progress in areas that matter deeply to our communities. The new Discharge Cell has significantly reduced hospital delays, while innovations such as teledermatology and targeted lung health checks have improved cancer diagnosis and outcomes. Our commitment to inclusion is evident in the expansion of dental services into care homes, the launch of our Equality Strategy, and the delivery of over 1,200 diabetes checks in areas of greatest need.

We have also seen an improvement in staff engagement, with our NHS Staff Survey response rate rising to 79% and a notable increase in staff recommending the ICB as a place to work. This reflects the success of our organisational development plan and our efforts to foster a culture of compassion, flexibility and belonging.

Partnership working remains at the heart of our Integrated Care System. Whether through our place-based Alliances, Integrated Neighbourhood Teams, or the Stewardship programme, we continue to demonstrate the power of collaboration in tackling health inequalities, improving access, and delivering care closer to home.

As I conclude my tenure, I do so with pride in what we have achieved together. The road ahead will not be without difficulty (financial pressures, workforce challenges, rising demand), but I am confident that the foundations we have laid will enable the system to meet these challenges with resilience and purpose.

Thank you to all our partners, staff, and Board members for your unwavering commitment. It has been an honour to serve as Chair, and I leave knowing that the MSE system is well placed to continue its journey of transformation and improvement.

Professor Michael Thorne CBE
Chair, NHS Mid and South Essex Integrated Care Board

1. Executive Summary

1.1. On 16 January 2025, the Mid and South Essex Integrated Care Board (MSE ICB) conducted a Board Effectiveness Self-Assessment seminar to reflect on its performance, governance and readiness for future challenges. The session was designed to provide a safe and constructive space for Board members to evaluate how effectively the Board was fulfilling its statutory duties, supporting system leadership, and enabling strategic decision-making.

1.2. The seminar was informed by national guidance, including NHS England's Insightful Board framework and Making Data Count, as well as internal documentation such as the Board Assurance Framework (BAF), committee self-assessments, and a Board Skills Assessment. An online survey completed by Board members provided further insight into perceptions of roles, behaviours, values and priorities.

1.3. The session was structured around four thematic group discussions:

- Boad function and assurance
- Board development
- Living our values and working cohesively
- Preparing for future challenges

1.4. Each group explored key questions and generated recommendations to inform future Board development, governance improvements, and strategic planning. The outcome of the session will support the refinement of the Board workplan, strengthen assurance processes, and guide the next phase of Board development.

1.5. In summary the groups discussions:

- Emphasised the need for the Board Assurance Framework to actively drive the Board's agenda and committee outputs. Highlighted the importance of empowering partner members and improving integration of primary care, estates and the 'left shift' agenda. **Group 1 (Chief Executive Officer)**
- Noted that current seminar sessions felt reactive and one-directional. Recommended moving to quarterly, two-day development sessions with a focus on relationship-building, strategic themes (e.g. devolution, MTP), and skills assessment. **Group 2 (Chief Finance Officer)**
- Called for clearer behavioural expectations and leadership values, with a focus on inclusivity, compassion, and storytelling. Suggested better utilisation of Board members' skill mix and more structured development around safeguarding, mental health, and hospice care. **Group 3 (Chief Medical Officer)**
- Reiterated the need for better data, clearer accountability, and more strategic Board reporting. Highlighted the importance of understanding external

pressures and ensuring actions are making measurable difference. **Group 4 (Chief Nursing Officer)**

1.6. Board members reflected and recognised the successes of the ICB acknowledging significant progress across the MSE Integrated Care System (ICS) with a strong focus on inclusion, integration and innovation. Staff engagement reached record levels, with the NHS Staff Survey and Pulse Survey showing marked improvements in morale, flexibility, and organisational culture. The launch of the Shared Care Record has transformed data sharing across 145 GP practices and system partners, enhancing care coordination and decision-making. Maternity services achieved 94% smoke-free rates among pregnant people, reflecting targeted support and prevention efforts. Our commitment to inclusive quality was evident through the expansion of staff networks, safe spaces, and the delivery of the Equality, Diversity, Inclusion and Belonging Strategy. Local authority partnerships have deepened, enabling joint delivery of the Better Care Fund and strategic alignment across health and wellbeing boards. Integrated Neighbourhood Teams expanded to 23, supporting frailty care through the FrEDA tool and reducing hospital admissions. Dental services in care homes delivered over 4,500 treatments, dramatically improving access and wellbeing. Winter pressures were met with coordinated partnership working, while Babies, Children and Young People and SEND collaboration strengthened multi-agency support for vulnerable children. Innovations such as Connected Pathways and estates digitisation have improved access, freed up clinical space, and supported more responsive community-based care.

1.7. In conclusion, the Board self-assessment highlighted many strengths and successes in the journey of the ICB over 2024/25 but acknowledged that there were many challenges with more to come in 2025/26. The self-assessment process has enabled the Board to identify ways to strengthen how it operates in the coming year to better discharge its functions and responsibilities on behalf of the population it serves.

2. Background

2.1. The Mid and South Essex Integrated Care Board (MSEICB) undertook a Board effectiveness self-assessment on 16 January, as part of its commitment to continuous improvement and good governance. The session was designed to reflect on the Board's performance, assess its effectiveness, and identify areas for development in preparation for the challenges ahead.

2.2. The assessment was informed by:

- National guidance including NHS England's Insightful Board Framework and Making Data Count principles.
- Internal documentation such as the Board Assurance Framework (BAF), committee self-assessments, and the Board skills assessment.
- Feedback from online survey completed by Board members, covering understanding of roles, values, behaviours, and perceived challenges.

2.3. The seminar was structured around four thematic group discussions:

- Board Function and Assurance
- Board Development
- Living Our Values and Working Cohesively
- Preparing for Future Challenges

2.4. Each group was tasked with exploring key questions and generating recommendations to inform future Board workplans and development priorities.

3. Methodology

3.1. The self-assessment was delivered through a structured seminar held on 16 January 2025. In preparation for the seminar a desktop exercise was undertaken to provide the Board with key information that could be used to assess its performance and effectiveness. This included:

- Composition of the Board and its sub-committee structure
- Attendance at the Board, Quoracy and the Board cycle of business
- Decisions made by the Board
- The schedule of Board seminar sessions
- Feedback from Committee Self-Assessments
- Background as to the core purpose and functions of the ICB and ICS and how it was required to discharge its functions.
- Background on future challenges and changes for ICBs, as well as developmental guidance such as 'Insightful Board'

3.2. Prior to the seminar, Board members were also sent two surveys. Firstly, members were asked to consider how they performed as a Board over the year and secondly, members were asked a series of questions regarding the skills they bring to their role. The results of the survey were analysed and presented

to the Board to inform their considerations during the seminar session.

3.3. Board members were divided into four groups, each focussing on a specific theme. Discussions were guided by the pre-prepared slide packs and survey data, with facilitators capturing feedback and recommendations.

3.4. Supporting materials included:

- Board self-assessment slide deck
- Group questions pack
- Information pack with survey and skills assessment results.

3.5. Feedback was collected through handwritten notes and group presentations, which were subsequently analysed to identify key themes and actions.

4. Key Findings

4.1. The Board considered its strengths to be strategic focus, leadership behaviours and risk oversight.

4.2. Development areas included Board dynamics, assurance processes and stakeholder engagement. The self-assessment seminar surfaced several important themes:

Board Function and Assurance

4.3. Group 1 was facilitated by the Chief Executive Officer focussing on how the Board functions and receives assurance. The group used the information pack to consider:

- The Board workplan
- The suggested agenda approach from Insightful Board
- The ICB Functions and Decisions Map
- Reports to the Board
- Survey questions 1, 2, 3, 4, 9, including feedback from the survey of the members on what the Board should have ‘more of’, ‘less of’, or continue
- Board Assurance Framework Risks.

4.4. The three key questions considered by the group were:

- What should our Board agenda look like? What are we missing, what do we focus on too much? – draft an agreed list of More/Less/Continue
- Do we know what our committees are doing for the Board, and do we have confidence in relying on what they are doing?
- Can the flow between committees and the Board be more effective to provide assurance that we are discharging our duties? How?

4.5. There was consensus on the need to refine the Board agenda to focus more on strategic issues, reduce operational detail, and improve the flow of assurance from committees. Members highlighted the importance of clearer reporting and

better alignment with the Board's statutory duties. Agreed actions included:

- Strengthening the use of the Board Assurance Framework to drive the Board workplan and committee outputs.
- Enhancing data use to support information flows and triangulate plans, risks, and outcomes.
- Increasing visibility and empowerment of partner members to contribute meaningfully.
- Improving integration of primary care, estates and the 'left shift' agenda into strategic discussions.
- Considering thematic time allocation (e.g. Primary Care, Mental Health) to improve focus and alignment.
- The need for a clearer distinction between strategic, assurance and performance roles.
- Improved clarity and focus of Board papers.

Board Development

4.6. Group 2 was facilitated by the Chief Finance Officer exploring the effectiveness of current Board development approaches. The group used the information pack to consider:

- Survey questions 7 and 9
- Response to skills assessment
- Seminar topics.

4.7. The three key questions considered by the group were:

- Is our current approach to Board development / seminars effective? How can we strengthen it?
- Are there any skills gaps / gaps in understanding we need to address?
- What topics do we want to see in the year ahead for Board development / Seminars?

4.8. While seminar sessions were valued, there was recognition that seminars were not always well attended and often felt one directional. There was a desire to strengthen development through more structured and engaging formats, including training on data interpretation, quality improvement, and system leadership. Skills gaps were identified in areas such as population health, digital transformation, and collaborative working. Agreed actions included:

- Scheduling dedicated time for development with pre-reading and clearer thematic focus.
- Prioritising quality over quantity in seminar content, with a rhythm aligned to executive planning cycles.
- Introducing tools such as Myers-Briggs or Belbin to support relationship-building and team dynamics.
- Addressing skills gaps through a refreshed skills matrix and broader development opportunities. Identifying skills gaps in system leadership, data interpretation, and quality improvement.

- Including topics such as devolution and Medium Term Plan in future sessions.
- Seminars being consistently attended and engaging.

Living Our Values and Working Cohesively

4.9. Group 3 was facilitated by the Chief Medical Officer examining how well the Board demonstrates its values and works as a cohesive unit. The group used the information pack to consider:

- Survey questions 5, 6, 7, 1, 2, 4
- Board attendance

4.10. The three key questions considered by the group were:

- Is there an opportunity to better demonstrate our values in the way we work?
- Are we using the skill-mix of our Board effectively to live our values?
- Are we realising the benefits of a unitary (system) Board? Could we work differently or more effectively?

4.11. The Board was seen to demonstrate respectful and collaborative behaviours, but members felt that inclusivity and active listening could be strengthened, and that behaviours and expectations should be more explicitly framed in discussions and decision-making. Opportunities exist to better utilise the Board's skill-mix and strengthen the unitary system approach. Agreed actions included:

- Developing a framework for Board behaviours and expectations, aligned to regional leadership standards.
- Encouraging safe challenge and welcoming expertise from across the system.
- Better application of Board members' skills and qualifications, particularly in health domains.
- Refreshing seminar content to reflect government direction and support translation of values into practice.
- Capturing and communicating the impact of the Board through values-led outcomes.
- Developing a behavioural framework.

Preparing for Future Challenges

4.12. Group 4 was facilitated by the Chief Nursing Officer focussed on the Board's readiness for the challenges ahead, particularly in the context of planning for 2025/26. The group used the information pack to consider:

- Survey question 8
- Insightful Board
- Making Data Count
- Board workplan
- NHS Reform announcements
- Skills assessment

4.13. The three key questions considered by the group were:

- What are the challenges we face moving into 2025/26? Are we equipped for them? What do we need to change at the Board for us to be assured we are addressing them?
- How can we improve what we present to the Board and how it provides assurance we are meeting our priorities?
- Will our processes for decision making at Board need to change as decisions become more difficult?

4.14. Members identified a range of strategic risks and opportunities, including financial pressures, workforce resilience, financial pressures, digital maturity, and service transformation. Members emphasised the need for improved data quality, clearer decision-making processes, and early engagement with providers to navigate complex decisions. Agreed actions included:

- Improving the quality and consistency of Board reporting, with a stronger focus on data-driven insights, risk profiling and benefits realisation.
- Clarifying accountabilities and ensuring follow-up actions are tracked through evolving reporting structures and decision logs.
- Strengthening assurance processes to move beyond reassurance, with clearer links between risks, actions and outcomes.
- Enhancing Board understanding of external developments such as devolution, national planning guidance and workforce policy changes.
- Ensuring that investment decisions and strategic planning are informed by robust analytics and system-wide intelligence.
- Managing key risks including financial pressures, workforce challenges and system integration.

Celebrating our successes

4.15. The Board reflected on the last year and discussed highlights demonstrating the positive impact of the ICB.

Staff survey and pulse surveys

4.16. In 2024/25, staff engagement acrost the ICB reached new heights. The NHS Staff Survey response rate rose to an impressive 79%, up from 62% the previous year, reflecting growing confidence and connection among colleagues. Satisfaction with flexible working opportunities increased to 86%, and the proportion of staff recommending the ICB as a place to work nearly doubled. These results are a testament to the ICB's commitment to inclusion, wellbeing, and organisational development, supported by vibrant staff networks and a robust engagement strategy.

Shared Care Record

4.17. The successful implementation of the Shared Care Record has transformed care delivery across MSE. With over 7,000 users and nearly 300,000 moments of care supported, the system enables seamless access to patient information

across 145 GP practices, acute trusts, mental health services, adult social care, and more. This innovation reduces duplication, enhances decision-making, and improves patient outcomes-demonstrating the power of digital transformation in integrated care.

Maternity smoking rates

4.18. The Local Maternity and Neonatal System (LMNS) has made significant strides in promoting smoke-free pregnancies. In five of the last six months (of 2024/25), 94% of pregnant people remained smoke-free, contributing to healthier outcomes for both parents and babies. This achievement reflects the strength of collaborative working and targeted support services across the system.

Safe Space and Inclusive Quality

4.19. The ICBs Inclusion and Belonging Steering Group continues to foster a culture of safety, respect and empowerment. The launch of a neurodiversity network and the expansion of peer support groups have created safe spaces for staff to thrive. These efforts are underpinned by monthly reviews, staff champions, and a system-wide commitment to inclusive quality improvement.

Diversity Agenda

4.20. In 2024, the ICB was confirmed as Public Sector Equality Duty compliant by the European Human Rights Group. Through reciprocal mentoring, career development programmes, and robust data reporting, the ICB has embedded equity and diversity into its core. Staff networks and the Culture and Diversity sub-group have amplified lived experiences, driving meaningful change across the workforce.

Local Authority Partnerships

4.21. The ICB's partnerships with Essex County Council, Southend City Council, and Thurrock Council have deepened through joint governance, shared strategic priorities, and collaborative delivery of the Better Care Fund. These relationships are central to the system's ability to deliver integrated, person-centred care and respond to local needs effectively.

Integrated Neighbourhood Teams (INTs)

4.22. The expansion of INTs from 9 to 23 had laid the foundation for community-led care. Focused on frailty and end-of-life support, INTs have reduced A&E attendances, hospital readmissions, and social isolation. This model exemplifies the strength of local partnerships and the value of whole-person care.

Dental in Care Homes

4.23. The Care Home Dental Pilot has revolutionised oral health for residents, covering all 8,424 care home beds in MSE. With over 4,500 treatments delivered and waiting times reduced from over 100 weeks to under 12, this initiative has significantly improved wellbeing and access to essential care.

Frailty (FrEDA)

4.24. The FrEDA tool, co-designed by Ageing Well Stewards, has enabled proactive, personalised care for over 12,000 people with frailty, dementia, or end-of-life needs. It has led to a 50% reduction in unplanned admissions and a 70% drop in readmission in high-usage INTs – demonstrating the impact of integrated, data-driven approaches.

Partnership working over winter

4.25. Winter pressures were met with resilience and collaboration across the system. Transfer of Care Hubs, virtual wards and multi-disciplinary teams ensured safe discharges, reduced hospital stays and supported residents with complex needs. These efforts highlight the system's agility and commitment to coordinated care.

Babies, Children and Young People and Special Education Needs and Disabilities Partnership working.

4.26. The ICB's work with safeguarding boards and SEND partnerships has strengthened multi agency collaboration. Initiatives such as inclusive dental pilots for Looked After Children and deep-dive reviews into lived experiences have ensured that children and young people receive safe, equitable, and responsive care.

Connected Pathways.

4.27. Connected Pathways have enhanced access across primary care, pharmacy and optometry. Campaigns supporting Access Recovery Plan and the Pharmacy First Service freed up GP capacity and improved patient experience – demonstrating the value of joined-up communication and service design.

Estates

4.28. The Lloyd George Record Digitisation Programme has unlocked £15.7million in capital savings and created new opportunities for service delivery. By freeing up space and improving access to records, the ICB has established the groundwork for more efficient, modern and patient-friendly environments.

Reflecting on Challenges Faced in 2024/25

4.29. During 2024/25, the system continued to experience significant strain across multiple domains. Key challenges included:

- **Workforce pressures**, with difficulties in recruitment and retention leading to reliance on temporary staffing and concerns about future pipeline sustainability.
- **Primary care demand** consistently outstripped capacity, impacting patient experience and access.
- **Financial constraints** across the system, including a revised deficit plan and the need to reduce running costs by 50% in line with national directives.

- **Hospital flow and discharge delays**, despite improvements, remained a concern for system-wide coordination and capacity management.
- **Elective recovery and diagnostics performance** fell short of national standards, with long waits and Tier 1 escalation for diagnostic services.
- **Cancer care performance** remained below target, requiring intensive oversight and recovery planning.
- **Mental health service quality** assurance highlighted risks to patient safety and access.
- **Capital limitations** restricted the ability to invest in transformation and infrastructure.
- **Persistent health inequalities**, particularly in deprived communities, continued to challenge equitable service delivery.

Expected Challenges in 2025/26

4.30. Looking ahead, the ICB anticipates several ongoing and emerging challenges:

- **Delivering financial sustainability** while meeting the central government's mandate to reduce organisational running costs.
- **Managing increased demand** across urgent, elective, and community services, with expectations for improved access and transparency.
- **Sustaining workforce resilience**, particularly in the face of further reorganisation and change.
- **Improving performance in cancer**, diagnostics, and elective care to meet national standards.
- **Navigating system reform**, including changes to NHS England's structure and the integration of functions with the Department of Health and Social Care.
- **Maintaining momentum in tackling health inequalities** and embedding inclusive, preventative care models.
- **Ensuring digital maturity** and infrastructure readiness, especially with the rollout of the Unified Electronic Patient Record and expansion of Community Diagnostic Centres.

5. Conclusion

5.1. The 2024/25 Board Self-Assessment has provided a valuable opportunity for reflection, learning, and forward planning. It has reaffirmed the Board's strengths in strategic leadership, values-driven behaviours, and system-wide collaboration, while also identifying clear areas for development in assurance, stakeholder engagement, and governance maturity. The recommendations arising from this process will inform a refreshed Board development plan and strengthen our ability to discharge statutory duties effectively.

5.2. As we look ahead to 2025/26, we do so in the context of significant national reform. The creation of the new Essex Integrated Care Board from 1 April 2026 marks a pivotal moment for our system. This transition presents both opportunities and challenges: to build on the strong foundations laid in MSE, to

streamline governance, and to deliver more integrated, equitable, and sustainable care for our population.

5.3. The Board recognises the importance of maintaining continuity, clarity, and compassion through this period of change. Our focus will remain on supporting our workforce, improving outcomes, and ensuring that the values and behaviours we have cultivated continue to shape the new organisation. The insights gained through this self-assessment will be instrumental in guiding the Essex ICB as it establishes its leadership, priorities, and culture.

5.4. In closing, the Board expresses its gratitude to all members, partners, and staff for their contributions throughout the year. Together, we have demonstrated resilience, innovation, and a shared commitment to improving lives. Consequently, we are well placed to carry that momentum into the next chapter of integrated care in Essex.

6. Recommendation

The Board is asked to approve the assessment of Board Effectiveness 2024/25 and action identified to improve the effectiveness of the Board going forward.

Part I ICB Board Meeting, 18 September 2025

Agenda Number: 14.4

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

Jennifer Kearton, Chief Finance Officer
Dr Giles Thorpe, Executive Chief Nursing Officer
Siobhan Morrison, Interim Human Resources Lead

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Audit Committee (Chaired by George Wood, Non-Executive Member)
Quality Committee (Chaired by Neha Issar-Brown, Non-Executive Member)
Remuneration Committee (Chaired by Joe Fielder, Non-Executive Member)

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. Policies approved by relevant Committees

Since the last Part I Board meeting, the following policies were approved by relevant committees, as per the authority set out in their terms of reference.

Committee / date of approval	Policy Ref No and Name
Audit Committee 4 September 2025	The committee approved the following revised policies: • 021 Health & Safety Policy • 023 Freedom to Speak Up (Whistleblowing) Policy • 026 Counter Fraud, Bribery and Corruption Policy • 030 Business Continuity Policy The committee also approved an extension of the review dates of the following policies until March 2026 to enable revised policies to be developed for the new ICB. • 017 Risk Management Policy • 024 Incident Reporting Policy • 027 Forensic Readiness Policy • 031 On Call Director Policy.
Quality Committee 27 June 2025	The committee agreed a further extension of review dates of the following policies until March 2026 due to capacity within teams and to enable sufficient time for any changes required as a result of ICB reorganisation to be considered: • 062 Complaints Policy • 064 Safeguarding Supervision Policy • 068 All Age Continuing Care Policy • 069 PHB Implementation Policy • 071 Prevent Policy.
Remuneration Committee 4 June 2025	The committee approved the following revised policies: • 023 Freedom to Speak Up (Whistleblowing) Policy (subject to comments from Audit Committee). • 049 Maternity, Adoption and Paternity Policy. The committee also reviewed first drafts of the following human resources policies and supported these, subject to requested amendments. • 042 Grievance Policy • 045 Disciplinary Policy • 055 Organisational Change Policy. Final drafts will be submitted to the committee for formal approval.

2. 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.

3. Recommendation

The Board is asked to note the revised policies set out in this report.

Part I ICB Board meeting, 18 September 2025

Agenda Number: 14.5

Approved Committee Minutes

Summary Report

1. Purpose of Report

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

- Audit Committee (AC) – 15 April 2025, and extraordinary meetings on 23 April and 17 June 2025.
- Finance & Performance Committee (FPC) – 1 July and 5 August 2025.
- People Board (PB): 3 July 2025.
- Primary Care Commissioning Committee (PCCC): 9 July 2025.
- Quality Committee (QC): 27 June 2025.
- System Oversight and Assurance Committee (SOAC): 27 June 2025.

2. Chair of each Committee

- George Wood, Chair of AC
- 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 meetings held (once approved by the committee) are presented to the Board to provide assurance and feedback on functions and decisions delivered on its behalf.

2. Main content of Report

The following summarises key items discussed, and decisions made by committees as recorded in minutes approved since the last Board meeting.

Audit Committee, 15 April 2025

The following issues were considered:

- The latest iteration of the Board Assurance Framework and Corporate Risk Register was reviewed by the committee.
- An update was provided on workshops to pilot the NHS England guidance on the assessment of system risks.
- The revised Management of Conflicts of Interest, Gifts and Hospitality and Commercial Sponsorship Policy and Standards of Business Conduct Policywere approved. The committee also approved an amendment to the Procurement Policy and agreed to extend the review dates of three other policies within its remit.
- An update on the timetable and governance processes for approval of the ICB's 2024/25 Annual Report.
- The Individual Funding Request (IFR) Annual Report was approved, as was the revised IFR Policy, including the terms of reference for the IFR Panel.
- The quarterly report on Information Governance was noted and revised Information Governance Policies.
- Quarterly Emergency Planning, Resilience and Response update.
- Health and Safety update.
- Use of the ICB Seal.
- The latest iteration of the Register of Procurement Decisions.
- Waiver report.
- Losses and Special Payments update (there were none to report).
- Internal Audit update, including the draft Head of Internal Audit Opinion. The committee also approved the draft Internal Audit Plan for 2025/26.
- Local Counter Fraud Specialist and Local Security Management Specialist update. The committee also approved the draft Counter Fraud Strategy and Annual Plan 2025/26.
- External Audit update.
- Draft Health Inequalities Information Statement Annual Report 2024/25.

Extraordinary Audit Committee, 23 April 2025

The focus of this meeting was to consider the following:

- Draft ICB Annual Report 2024/25
- Draft ICB Annual Accounts 2024/25

Extraordinary Audit Committee, 17 June 2025

The following items were considered:

- Approval of the final ICB Annual Report 2024/25.
- Approval of the final ICB Annual Accounts 2024/25.
- External Audit update on completion of the annual audit of the ICB's financial statements and Value for Money audit.
- Audit Committee effectiveness review 2024/25.
- NHS England guidance outlining the assurance of delegated specialised commissioning responsibilities.
- Service auditor assurance reports.

Finance and Performance Committee, 1 July 2025

The following items of business were considered:

- Review of risks within the remit of the committee.
- Month 2 system finance and performance report.
- Medium Term Plan update.
- Deep dive on urgent and emergency care.
- Minutes of the System Finance Leaders Group (SFLG) held on 28 April and minutes of the System Investment Group (SIG) held on 19 May 2025 were presented for information.

Finance and Performance Committee, 5 August 2025

The following items of business were considered:

- Deep dive on referral to treatment.
- Month 3 system finance and performance report.
- Primary care estates, utilisation and modernisation fund – prioritisation of schemes.
- Programme Management Office tracker update for Financial Recovery Plan.
- Medium Term Plan update.
- Indicative Activity Plans 2025/26, process and progress.
- The minutes of the System Finance Leaders Group (SFLG) held on 23 June and minutes of the System Investment Group (SIG) held on 30 June 2025 were presented for information.

People Board, 3 July 2025

The following items of business were considered:

- 2024 Ethnicity Pay Gap data.
- Provider workforce assurance reports (bank and agency usage)
- Education workforce update.
- Integrated Care System efficiencies – workforce delivery programme.
- ICB change process update.
- Supporting Services Delivery Board Programme – Medium Term Plan update.
- Review of risks within the remit of the committee.

- Highlight reports from the chairs of the following workstreams: Clinical Capacity Expansion Education Innovation; Colleague Engagement, Wellbeing and Retention; and Culture.

Primary Care Commissioning Committee, 9 July 2025

The following items of business were considered:

- ICB transition and cost reduction programme.
- An update on development of the Primary Care Estates Strategy.
- Neighbourhood Health and ICB Model Blueprint.
- Demand management.
- Integrated Neighbourhood Teams update.
- Pharmaceutical Needs Assessment.

Quality Committee, 27 June 2025

The following items of business were considered:

- A deep dive relating to maternity services, including perinatal mortality.
- Executive Chief Nurse's update.
- Mid and South Essex NHS Foundation Trust / acute care update.
- Primary care update
- Patient experience update.
- Patient safety update, including Central Alerting System Policy update.
- Learning Disabilities, Autism and Neurodiversity update.
- Babies, Children and Young People update.
- Palliative and End of Life Care up-date.
- Medicines Management update.
- Patient Safety and Quality risks, including an update on the NHS England pilot regarding the assessment of system risks.
- Provider Quality Accounts 2024/25.
- The committee approved a revised version of the Patient Choice Policy (Ref 005) and the Mid and South Essex Cross System Response Policy (Ref 075). The committee also agreed extended review dates for two other policies within its remit.
- The committee approved the outcome of the review of Quality Committee Effectiveness 2024/25, revised Terms of Reference and workplan for 2025/26.

System Oversight and Assurance Committee, 27 June 2025

The following items of business were considered:

- The Executive Director of Finance advised that at Month 2, the system presented a balanced position against plan, albeit the plan was a £3 million deficit.
- A deep dive on primary care services was presented.
- Update on community waiting lists.
- The review of SOAC effectiveness 2024/25, revised terms of reference and committee workplan for 2025/26 were considered, all of which were subsequently approved virtually.

3. Recommendation

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

Minutes of the Audit Committee Meeting

Held on 15 April 2025 at 1.30pm

via MS Teams and Face to Face at Phoenix Court

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.

Other attendees

- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Nicola Adams (NAd), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Head of Financial Services, MSE ICB.
- Iain Gear (IGe), Information Governance Manager, MSE ICB.
- Jim Cook (JC), Deputy Director of EPRR and Operational Resilience, MSE ICB.
- Helen Chasney (HC), Corporate Services & Governance Support Officer, MSE ICB.
- Sara O'Connor, (SOC), Senior Manager, Corporate Services, MSE ICB.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB (Item 8 only).
- Janette Joshi (JJ), Deputy Director System Purchase of Healthcare, MSE ICB (Items 13 & 14 only).
- Emma Larcombe (EL), Director, KPMG (Item 18 only).
- Nathan Ackroyd (NAc), Lead Engagement Manger, KPMG.
- Dakshita Takodra (DT), Senior Audit Manager, TIAA.
- Hannah Wenlock (HW), Anti-Crime Specialist, TIAA (Items 17 & 18 only).
- Inge Damiaens (ID), Anti-Crime Manager, TIAA.

Apologies

- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.
- Jai Gundigara (JG), Director of Audit, TIAA.
- Jane King (JKi), Corporate Services and Governance Support Manager, MSE ICB (Minutes via recording).

1. Welcome and Apologies

GW welcomed everyone to the meeting. Apologies were noted, as listed above.

2. Declarations of Interest

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

There were no further declarations raised.

3. Minutes and Action Log

The minutes of the ICB Audit Committee on 21 January 2025 were received and the following amendments agreed:

The Director of Audit, TIAA (JG) to be added to the list of attendees. For Item 9, 'Understanding Sexual Misconduct training' was a new requirement added in November 2024, not 2025 as stated.

The action log was discussed and noted that all actions were complete.

Outcome: The minutes of the meeting held on 21 January 2025 were approved as an accurate record, subject to the amendments required.

4. Board Assurance Framework & Corporate Risk Register

NAd presented the latest iteration of the Board Assurance Framework (BAF) which was submitted to the Part I ICB Board meeting on 13 March 2025.

There were 8 ICB red rated risks outlined in the BAF. A summary of Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust's (EPUT) red rated risks were also included.

A copy of the Corporate Risk Register was also presented detailing 61 active directorate level risks. Since the last committee meeting, 4 risks were closed and 8 new directorate/corporate level risks opened.

The ICB's Operational Group (IOG) and Executive Team continued to be updated on the monthly progress of updating risks. At the time of writing there were 7 outstanding risk updates, all of which would be updated prior to the next Quality Committee meeting on 25 April 2025.

Following an internal review of risk management processes, the BAF presented to the committee showed a greater level of detail and movement of risks. A review of risk profiles with executive leads led to a rebasing of risks and a more consistent approach of reporting.

GW noted that under the mental health quality assurance risk, out of area (OOA) mental health placements were off plan, however, there was no detail on the actions being taken to mitigate the risk. NAd explained this would be covered under Item 5, Risk Assessment of System Risks.

GO noted that MSEFT had not met the Refer to Treatment (RTT) elective care/cancer performance targets and enquired what action was being taken to get on track. JKe advised that MSEFT were working on proposals to clear the waiting lists and meet

performance targets. The mitigations to this risk would be set out on future iterations of the BAF. The RTT delays were also being discussed at national level.

Outcome: The Committee NOTED the Board Assurance Framework and Corporate Risk Register.

5. Risk Assessment of System Risks

NAd provided an update on the new NHS England risk management pilot for assessing system risks within an Integrated Care System.

The pilot looked at two key risks identified by the Executive Committee. The first was the movement of mental health patients through Urgent and Emergency Care (UEC) and the second was Palliative and End of Life care (P&EOLC) and the inconsistent offer across mid and south Essex (MSE). Workshops had taken place with key ICB staff and system partners to collectively review the risks.

The Mental Health workshop identified the UEC Programme Board as the forum responsible for managing the flow of patients through UEC. Learning identified from the workshop was around the need to identify and understand the ownership of issues. A further in-person session was required to understand why there was a high number of OOA placements.

The P&EOLC workshop identified good ownership of the issues and resolution seeking. Learning from the mental health workshop was taken on board, leading to an action plan and follow up programme.

In parallel, work was taking place with the Executive risk leads to develop the ICB BAF alongside the risk pilot. The ICB was looking at how system risks were represented on the BAF and where they would be received following the ICB transition.

In response to GO, NAd advised that system risk management guidance provided the ability to undertake technical risk assessments to plot different aspects of patient pathway and the risks scores, showing how changes to pathways could highlight areas where risk would increase or decrease and provide better outcomes for patients. The technical risk assessments were not appropriate for the workshops that took place.

NAd advised that learning from the system risk pilot would be rolled out as far as possible. Despite the ICB transition to a new organisation, risk management was fundamental and it was expected that system risk management would continue in some form.

Outcome: The Committee NOTED the Risk Assessment of System Risk update.

6. Policy Update

NAd provided an update on progress with the review of existing ICB Policies, including those within the remit of the Audit Committee.

Due to changes in NHS England (NHSE) guidance, the Management of Conflicts of Interest, Gifts and Hospitality and Commercial Sponsor Policy (018) had been updated, as well as the Standards of Business Conduct Policy (019) . Both policies were presented to the committee for approval.

The committee were requested to approve an extension to the review dates of the Health & Safety Policy (021), Incident Reporting Policy (024) and Forensic Readiness Policy (027) to 31 July 2025.

The Risk Management Policy (017) was due for review in July 2025 and would be updated to reflect the implementation of the Datix system, new risk management arrangements (including the content of the Board Assurance Framework recently discussed with Board members) and the management of system risks.

GW enquired whether Conflict of Interest (CoI) training was up to date. NAd explained that NHSE had provided an additional level 2 CoI training for decision makers and level 3 training which was aimed at CEO & NEM level. Training compliance was on the workplan for the next meeting.

JKe advised that a minor change was required to the Procurement Policy (003), as a result of a procurement challenge. The change would allow the ICB to source external subject matter experts to sit on the Provider Selection Regime Panel. An updated policy would be circulated to attendees and uploaded to the website.

Lessons learned from the procurement challenge would be brought to a future Audit Committee.

ACTION: JJ/JKi to circulate the updated Procurement Policy to the Audit Committee.

ACTION: JKe/JJ to bring lessons learned from the procurement challenge to future Audit Committee.

Outcome: The Audit Committee APPROVED the revised Management of Conflicts of Interest, Gifts and Hospitality and Commercial Sponsor Policy, and Standards of Business Conduct Policy.

Outcome: The Audit Committee APPROVED an extension to the review dates of the Health & Safety Policy, Incident Reporting Policy and Forensic Readiness Policy to 31 July 2025.

Outcome: The Audit Committee APPROVED the change to Procurement Policy as discussed.

7. Draft Annual Report

NAd presented the latest iteration of the draft annual report, explaining that updates were awaited from section leads. An updated report would be shared with the Audit Committee for comment before the Extraordinary Audit Committee on 23 April 2025, to approve the draft annual report for submission to NHSE.

Outcome: The Committee NOTED the update on the timetable and governance for the 2024/25 ICB Annual Report.

8. Individual Funding Request Governance

Following the 2024/25 committee effectiveness reviews, the Executive Committee agreed that the Individual Funding Request (IFR) process would transfer from the Quality Committee to the Audit Committee to provide assurance that the process was followed

robustly and consistently. There was no requirement for the Audit Committee to be involved in arbitration and IFR trends would be shared by the IFR team with Alliance teams.

PW presented the IFR annual report to provide assurance that the ICB was compliant with the timescales laid out in the IFR policy, was consistent in its decision making, had a process in place to receive feedback from patients and requesting clinicians, and contributed to on-going process improvement. There had been no formal appeals against the IFR process since the ICB was constituted.

The IFR Policy (076) had been updated to include the introduction of a Clinical Review Group (CRG) to strengthen the clinical oversight of the process and supported the work of the administrative funding team. The CRG would meet monthly, as required, and consist of clinicians, public health and commissioners relevant to the IFR applications for review. The CRG was able to approve an IFR request, ask for further information from the referrer, refuse the request without reference to the IFR Panel or refer to the IFR Panel. The updated IFR policy, which included the terms of reference for the IFR Panel, was presented for approval.

GW queried how the ICB ensured the most vulnerable of the population were aware of accessing care through the IFR process. PW explained that the Service Restriction Policy (SRP) and IFR Policy were available on the public facing website and clearly written. General enquiries into the ICB of this nature were directed to the ICB website or to the GP / health professional for further information. Equality and Health Inequality Impact Assessments (EHIIA) were undertaken as part of the SRP policy process to ensure particular groups were not disadvantaged.

GW suggested it would be useful to overlay IFR outcomes with postcodes to help identify health inequalities. PW confirmed data was available by registered GP practice but suggested it would be difficult to identify where areas fell within the deprivation scale.

In response to GW, PW confirmed the ICB's process with largely the same as in place for other ICBs.

Outcome: The Committee NOTED the IFR Annual Report and APPROVED the IFR Policy, including the terms of reference for the IFR panel.

9. Information Governance Update

IGe provided the committee with an overview of the work undertaken towards the Data Security Protection Toolkit (DSPT) submission, the associated DSPT audit, and wider Information Governance (IG) related work across the ICB and Integrated Care System (ICS).

The ICB was working towards the DSPT (aligned with the Cyber Assurance Framework) completion and submission at the end of June 2025. As reported to the Information Governance Steering Group, the ICB would not meet the DSPT standards expected this year. Nationally, this was recognised as a challenge for many ICBs, largely due to the change in format from last year's toolkit and the additional work required.

The Cyber Audit final report gave an opinion of 'substantial assurance' with one recommendation which had been completed. The DSPT audit was underway.

The minutes of the Information Governance Steering Group (IGSG) were shared with the committee.

For all IG policies, changes had been made to reflect new Information Asset Owner responsibilities. The committee were asked to approve the Information Governance Framework and Policy (010), Information Sharing (011); Records Management (012), Access to Information Policies (013) and Information and Cyber Security Policy (014) and extensions to review dates.

GO noted there were incidents related to unauthorised access to information and queried how robust the system was. IGe explained these were not major issues and related to a technical issue that was quickly resolved.

GO enquired whether staff knew how to report data breaches. IGe explained the IG and IT teams had developed clear guidance on how to report an incident on Datix which was available on the staff intranet. Additionally, the IG team were well known across the organisation and accessible.

GW acknowledged there was lots of complexity and rules around information governance and enquired how training was accessible for people to understand. IGe explained that information asset owners would be appointed for each area to receive a higher level of IG training and would be a middle contact point for staff.

Outcome: The Committee NOTED the quarterly report on Information Governance.

Outcome: The Committee APPROVED the following policies and review dates:

- Information Governance Framework & Policy – review date of October 2025.
- Information Sharing; Records Management; and Access to Information Policies - review date of October 2026.
- Information & Cyber Security Policy – extend the policy until September 2025.

10. Emergency Planning, Resilience and Response Update

JC presented the Emergency Planning, Resilience & Response (EPRR) and the System Co-ordination Centre (SCC) report.

The paper highlighted a new risk with an initial rating of ‘high’ which related to the EPRR implications associated with the construction and operation of the Lower Thames Crossing on the system.

The ICB had responded to a mandated request by the UK Covid-19 Public Inquiry relating to the approach to testing, tracing and isolation during a specified period.

The EPRR and SCC continued to work across the ICB and with system partners to manage operational pressures and prepare for, respond to and recover from incidents and emergencies.

GO enquired whether key learning from the Covid Inquiry had been identified. JC confirmed there was a national workstream looking at pandemic readiness and learning from the Inquiry was being collated as part of this work.

Outcome: The Committee NOTED the quarterly EPRR Update.

11. Health & Safety Update

SOC presented the Health and Safety (H&S) report to the Audit Committee which included the work of the Health & Safety Working Group (H&SWG).

Online training materials, shared by the Local Security Management Specialist (LSMS), that could potentially provide complementary conflict resolution training were being reviewed to assess their suitability for relevant teams.

The ICB's defibrillator at head office had been removed from use and staff advised that another defibrillator was available at the main reception of the building.

Compliance in health and safety related mandatory training saw an increase since the last report.

Incident reporting on Datix was now live and all incidents reported during 2024/25 had been inputted.

Outcome: The Committee NOTED the Health & Safety update.

12. Use of the ICB Seal

The ICB Seal was used for the Brentwood Community Hospital Lease Agreement, between NHS Property Services Limited & NHS Mid and South Essex ICB, for leasing part of the hospital building. The authorised signatory was the Chief Executive Officer and witnessed by the Associate Director of Corporate Services and Executive Director of System Recovery.

A record of the sealing of every document was maintained by the Chief Executive Office.

Outcome: The Committee NOTED the use of the ICB Seal for the Brentwood Community Hospital Lease Agreement, between NHS Property Services Limited & NHS Mid and South Essex ICB, on 25 March 2025 to lease part of the hospital building.

13. Contract Governance & Procurement Register

JJ presented the Register of Procurement Decisions detailing the 34 decisions (which had a published Contract Award Notice (CAN) on the 'Find a Tender' service, for Mid and South Essex Integrated Care Board) for contracts awarded between 20 December 2024 and 19 March 2025.

The latest Procurement Register would be published on the ICB website following review by the Audit Committee.

NAd noted that the dermatology procurement decision was included on the register and highlighted that the point at which the decision was captured on the register should be made clear. In the instance referred to, there had been a procurement challenge, NAd highlighted that decision may differ on completion of the new procurement process. JJ confirmed the regular was factually correct at the time of publication but the procurement was subject to ongoing conversations.

ACTION: Before the Procurement Register is published on the website, a comment should be included to say under Provider Selection Regime review (JJ & JKi).

Outcome: The Committee NOTED the Contract Governance update and the latest iteration of the Procurement Register.

14. Waiver Report

JJ presented the Waiver Report. There were two procurement waivers signed since the last Committee totalling £107,954.

There were no comments or questions raised.

Outcome: The Committee NOTED the Waiver Report.

15. Losses and Special Payments

There were no losses and special payments to note.

Outcome: The Committee NOTED the losses and special payments update.

16. Internal Audit

DT presented the Internal Audit Progress Report, detailing the progress of work undertaken against the 2024/25 Internal Audit Plan. Since the last committee meeting, final audit reports (Key Financial Controls, Cyber Security and Primary Care Delegated Commissioning had been issued, all providing 'substantial assurance'. Final reports were also issued for the Fit and Proper Persons Test Framework and Contract Management audits, both received 'reasonable assurance'.

A full copy of the Primary Care Delegated Commissioning final report (review of self-assessment for General Medical, Pharmacy, General Ophthalmic and Dental services) was provided to the committee for assurance.

Due to changes previously agreed with the Executive Committee within the 2024/25 audit plan, available audit days would be utilised for a review of Autism Spectrum Disorder referrals.

The draft Internal Audit Annual Report, including the Head of Internal Audit Opinion (HoIAO) 2024/25, was presented to the committee. The HoIAO provided 'reasonable assurance' and would form part of the ICB's Annual Governance Statement.

The Draft Annual Internal Audit Plan 2025/26 was presented to the committee. The plan had previously been shared with the Executive Committee and updated to reflect the comments received. JKe commented that, given the transition of ICBs in September 2025, consideration must be given to internal audit coverage to ensure MSE ICB could meet its statutory assurance reporting requirements for 2025/26.

JKe requested DT to investigate whether any ICBs serviced by TIAA had refocused their attention due to the imminent transition of ICBs and highlight any identified trends/priorities MSE ICB might wish to consider.

ACTION: DT to highlight potential trends/priorities MSE ICB may wish to consider due to the imminent transition of ICBs.

Outcome: The Committee NOTED the Internal Audit update and Draft Head of Internal Audit Opinion and APPROVED the Draft Internal Audit Plan for 2025/26.

17. LCFS/LSMS

HW presented the Draft Counter Fraud Strategy & Annual Plan 2025/26 which focused on key risks to the ICB and would enable a fully compliant submission to the NHS Counter Fraud Authority.

The Anti-Crime (Counter Fraud) progress report summarised the proactive work completed against the 2024/25 work plan.

Five referrals into the Local Counter Fraud Services (LCFS) had been received since the last meeting. Since the report was produced, of the referrals received, four were closed with no further action required by the ICB, and one remained open whilst enquiries were underway.

The Counter Fraud Annual Return deadline was 31 May 2025.

In response to GO, HW advised that there were no concerns regarding the overdue recommendations arising from completed investigations or proactive reviews.

ID gave an update on the security management work undertaken since the last meeting and presented the 2024/25 Security Management Annual Report. The report included updates relating to the Violence Prevention and Reduction Standard.

Outcome: The Committee NOTED the update from the Local Counter Fraud and Security Management Services and APPROVED the Draft Counter Fraud Strategy & Annual Plan 2025/26.

18. External Audit

NAc presented the final audit plan for the 2024/25 financial statement, including the Value for Money (VfM) risk assessment.

There were no significant changes to the planned audit to highlight. Materiality had increased from £40m in 2023/24 to £47.5m, primarily due to an increase in forecast total expenditure but this could change at year end, depending on actual total expenditure.

The paper outlined the identified significant audit risks and other audit risks, with KPMG's planned audit response for each.

The auditors did not anticipate there would be any significant estimates or judgements to report on the accounts.

The audit was on track for the final accounts to be approved at the Extraordinary Audit Committee on 17 June 2025, prior to the NHS England 23 June 2025 submission deadline for audited accounts.

The VfM risk assessment covered the areas of Financial Sustainability, Governance and Improving Economy, Efficiency and Effectiveness. A significant risk was identified associated with the financial sustainability of the system. KPMG outlined the procedures they intended to perform in order to understand and respond to the risk.

GW and GO welcomed the final audit plan and thanked the auditors for their work.

Recognition and appreciation were shown to the Finance team for the work undertaken to enable the audit to run smoothly. GW commended the team's professionalism, particularly during the period of uncertainty around changes to ICBs.

Outcome: The Committee NOTED the update from External Audit.

19. Draft Health Inequalities Annual Report 2024/25

The draft Health Inequalities Information Statement Annual Report 2024/25 was presented to the committee for information. The report outlined the achievements, challenges and forward trajectory of the work undertaken across MSE towards inequalities improvement.

GW & GO acknowledged the significant amount of work being undertaken by the ICB to reduce health inequalities across the system. It was suggested that a foreword or executive summary was included at the beginning of the document to highlight the work taking place.

Outcome: The Committee NOTED the draft Inequalities Annual Report 2024/25.

20. Any other Business

GW enquired how the business of the Audit Committee would be captured/understood in terms of the ICB transition.

JKe explained there was an ICB transition working group and the appropriate people would be drafted into the group as and when required to look at specific areas of transition. Work previously undertaken to prepare the five former Clinical Commissioning Groups' transition to the MSE ICB would provide a helpful reference point.

All decisions undertaken by the Executive Committee since November 2024 had been retested to ensure they stood up under a slightly different geography.

21. Items to Escalate

There were no items to escalate to the BAF, Board or other committees.

22. Effectiveness of Meeting

The Committee agreed the meeting was well run and effective. The Chair thanked attendees for the rich discussion and contributions.

23. Date of Next Meeting

Extraordinary Audit Committee meetings were scheduled (via Microsoft Teams) for 23 April 2025 and 17 June 2025 to receive draft/final Annual Report & Accounts respectively.

1.30 pm–3.30 pm, Tuesday 15 July 2025.

Via Microsoft Teams or F2F at HQ, Pritchard Room, Phoenix Court, Basildon.

Minutes of the Extraordinary Audit Committee Meeting

Held on 23 April 2025 at 3.30pm

via MS Teams

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.

Other attendees

- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Senior Financial Control Manager, MSE ICB.
- Chris Cullen (CC), Corporate Services & Governance Support Officer, MSE ICB. (Minutes)
- Mark Bailham (MB), Associate Non-Executive Member & ICB Finance & Performance Committee Member, MSE ICB.

Apologies

- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Joe Fielder (JF), ICB Finance & Performance Committee Chair, MSE ICB.

1. Welcome and Apologies

GW welcomed everyone to the meeting and explained that the focus of the meeting was to review the draft ICB annual accounts and annual report, hence the auditors were not required to attend.

Apologies were noted as listed above.

2. Declarations of Interest

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

There were no further declarations raised.

3. Draft ICB Annual Report 2024/25

NA presented the latest iteration of the draft annual report. The main section of the report focused on the work of the ICB and its performance against NHS Constitutional standards. The performance section of the report would be updated with 2024/25 data once available, and would not impact the report narrative.

The Remuneration Report was being updated. Although part of the annual report, it was not required to be submitted with the draft annual report.

MH agreed to review and send any additions or amendments on behalf of the local authorities to NA.

NA advised that the Chair and Chief Executive Officer (CEO) had signed off the foreword and introduction, which was rewritten with a change in tone, following the recent national announcements on the future of ICBs.

NA confirmed to GO that the annual report included references to the voluntary care sector. The Research and Engagement Network was highlighted in the communications section and equality, diversity and inclusion (EDI) performance was included within the Health Inequalities section. The Staff Report included data on workforce composition and referenced the organisation's EDI and Belonging Strategy.

The deadline for submission of the draft annual report was 9.00 am, Friday 25 April 2025.

Outcome: The Committee APPROVED the draft ICB Annual Report, subject to any final amendments.

4. Draft ICB Annual Accounts 2024/25

NB provided an overview of the accounts advising the ICB had achieved its statutory duties, staying within the cash limit and running costs allocation, with a £67k surplus against the break-even plan. The accounts also showed the ICB was within the capital spending limit. The provisional accounts were subject to audit.

DM presented the draft annual accounts to the committee.

GW queried why there was an increase in assets from the previous year. DM advised this was due to the IFRS 16 accounting standard which set out how the ICB accounted for the lease agreement taken out against Brentwood Community Hospital in 2024/25.

NB confirmed that the annual accounts were prepared in line with the National Accounting Standards. The loss previously reported to the Audit Committee and exit packages incurred for the financial year were included in the accounts.

NB advised that the ICB was on track to submit draft annual accounts by NHSE's deadline of 25 April 2025.

Outcome: The Committee NOTED the draft ICB Annual Accounts.

There was no other business discussed and the meeting closed.

Minutes of the Extraordinary Audit Committee Meeting

Held on 17 June 2025 at 3.30pm

via MS Teams

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.

Other attendees

- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Nicola Adams (NAd), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Ashley King (AK), Director of Finance and Estates, MSE ICB.
- Darren Mellis (DM), Senior Financial Control Manager, MSE ICB.
- Jane King (JKi), Corporate Services & Governance Support Manager, MSE ICB. (Minutes).
- Mark Bailham (MB), Associate Non-Executive Member & ICB Finance & Performance Committee Member, MSE ICB.
- Emma Larcombe (EL), Director, KPMG.
- Nathan Ackroyd (NAc), Senior Manager, KPMG.
- Simran Kaur (SK), Manager, KPMG.

Apologies

- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.
- Joe Fielder (JF), ICB Finance & Performance Committee Chair, MSE ICB.

1. Welcome and Apologies

GW welcomed everyone to the meeting, explaining the focus of the meeting was to review the final ICB Annual Report and Accounts 2024/25, hence the internal auditors were not required to attend.

Apologies were noted as listed above.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the

meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

There were no further declarations raised.

3. ICB Annual Report 2024/25

NAd presented the final iteration of the annual report, highlighting the areas that required minor amendment, following the draft submission to NHS England. The Third Party Assurance reports were included in the annual report. An unqualified assurance report was received for NHS Shared Business Services (SBS), however, NAd confirmed assurance was received from the ensuing action plan.

The Remuneration and Staff report was complete.

The final audited annual report would be presented to the ICB Board on 17 July 2025 and published on the ICB website. An Insight Hour session (an opportunity for staff to learn and connect with colleagues) would be held for staff regarding the key messages in the annual report.

The committee agreed that the final annual report was a comprehensive, well written document highlighting many achievements for the ICB in 2024/25.

GO enquired whether the annual report had been shared with the local Health & Wellbeing Boards (HWB). NAd confirmed the local HWBs had been involved in the content of the report and the final version would be shared with key stakeholders, including HWBs, after going through the governance process.

GW suggested the top 10 highlights from the annual report were compiled as a reference document for NEMs and Board Members.

ACTION: NAd to share the Insight Hour presentation on the highlights from the 2024/25 Annual Report as a reference document for NEMs and Board Members.

Outcome: The Committee APPROVED the final ICB Annual Report 2024/25.

4. ICB Annual Accounts 2024/25

DM presented the final ICB Annual Accounts for 2024/25 following the end of year audit undertaken by KPMG. It was noted that very few changes were required. DM gave thanks to KPMG for their support.

GW enquired whether there was provision in the 2024/25 budget for redundancy payments, arising from the future ICB transition. DM advised there was provision only for redundancy payments agreed in 2024/25. JKe highlighted that the latest cost reductions were announced in the new financial year, 2025/26, and guidance on how redundancy payments would be funded was awaited from the Treasury.

Outcome: The Committee APPROVED the final ICB Annual Accounts 2024/25.

4a. External Audit

EL advised that the annual audit Mid and South Essex ICB financial statements as at, and for the year ended, 31 March 2025, undertaken by KPMG, were complete. One area of underspend was identified in the 2023/24 Mental Health Investment Standard (MHIS) audit (undertaken a year in arrears). As a result, the control efficiency was downgraded.

JKe added that a modified audit opinion would be issued and the CEO disclosure in the annual report would be updated to reflect this. JKe gave context to the situation, explaining there was no material difference on the delivery of the MHIS and the underspend was due to an expenditure being lower than the accrual and amounted to 0.01%.

JKe did not envisage any remedial actions to be instructed from the national team in relation to the MHIS underspend.

The MHIS and KPMG audit opinion would be signed off in advance of the final submission.

In response to GW, JKe confirmed that the Executive Committee and Head of Communications were aware of the change to the MHIS audit opinion should there be any enquiries.

NAc presented the ISA 260 Report, which was confidential and not for publication.

One significant audit risk was highlighted in respect of the Management Override of Controls, however, no issues were identified.

The Value for Money (VfM) Audit did not identify any significant weaknesses in the ICB's arrangements for achieving VfM.

The Remuneration Report required minor correction in relation to fair pay disclosures. which had been actioned.

NAc presented the Auditors Annual Report, a public facing document. The report was required to be published by the ICB alongside the annual report and accounts. It highlighted that the ICB achieved the financial sustainability targets, that the system was moving into a better financial position, and was improving economy efficiency and effectiveness.

The Representation Letter of Mid and South Essex ICB was included in the meeting pack.

The annual report and accounts would be submitted ahead of the 23 June 2025 deadline, the National Audit Office Checklist would be completed prior to the submission

EL extended thanks to the ICB for their support with the audit.

GW was happy with the outcome of the audit and thanked all teams involved.

ACTION: JKi to draft a note of thanks to Finance Team from GW.

Outcome: The Committee NOTED the KPMG update.

5. Audit Committee Effectiveness Review 2024/25

NA presented the outcome of the annual committee effectiveness review which concluded that the committee had operated effectively in 2024/25.

The terms of reference were updated to reflect the Executive Committee's recommendation for the Individual Funding Request governance process to be overseen by the Audit Committee to ensure the process was robust and consistent. The 2025/26 workplan was approved at the January 2025 meeting, no further changes were required.

GO extended thanks to all involved with the Audit Committee and commented on the high standard of papers presented to committee which helped with engagement and decision making.

In response to GW, NA advised that the action to schedule a deep dive on transition risks followed a suggestion arising from the members committee effectiveness survey.

GW commented that improvements were required to external reports presented to Board or Board sub-committees to ensure assurance was clearly set out.

GW thanked the Governance Team for the comprehensive report.

OUTCOME: The Committee NOTED the outcome of the Audit Committee Effectiveness Review and APPROVED the updated terms of reference.

6. Delegated Specialised Commissioning

The NHS England guidance outlining the Assurance of Delegated Specialised Commissioning Responsibilities was provided to the committee for information.

The ICB's Delegated Specialised Commissioning assurance statement was included in the 2024/25 annual report.

7. Service Auditor Assurance Reports

The Service Auditor Assurance reports were provided to the committee for information.

GW noted the reports were internally focused and gave very little assurance on the quality of services provided. JKe advised that service auditor reports looked at the transactional services of an organisation, not performance or quality review.

8. Items to Escalate

There were no items to escalate.

9. Any Other Business

There was no other business.

10. Date & Time of Next Meeting

1.30pm–3.30pm, Tuesday, 15 July 2025

Via Microsoft Teams or in person at ICB HQ, Pritchard Room, Phoenix Court, Basildon.

Minutes of the ICB Finance and Performance Committee

Held on 1 July 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, MSE ICB
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Julie Parker (JP) Non-Executive Director, Mid and South Essex NHS Foundation Trust (MSEFT)
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Clare Angell (CA) Deputy Director Babies, Children and Young People, SEND & Specialised Commissioning, Senior Responsible Officer Learning Disabilities and Autism (agenda item 5)
- Cherry West (CW) Hospital Managing Director (agenda item 9)
- 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, Non-Executive Director EPUT, Sam Goldberg Executive Director of Performance and Planning and Nicola Adams, Associate Director of Corporate Services.

2. Declarations of interest

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

JF declared a potential conflict of interest for agenda item 5, Mental Health Support Teams Business Case. It was agreed as this was a non-direct interest JF would remain present but not participate in the decision making.

Outcome: The Register of Interests was noted.

3. Minutes of previous meetings

The minutes of 3 June 2025 were agreed as an accurate record.

Outcome: The minutes of 3 June 2025 were approved.

4. Action Log / Matters arising

The action log was discussed and noted accordingly.

The Committee were informed NHS England were making a change to current metrics for the National Oversight Framework (NOF), work was taking place to reflect this into reporting.

Business cases

5. This item has been minuted confidentially.

Financial Governance

6. Finance Risk Register

The Committee were presented with the latest position on ICB financial risks.

Following a query from JP, it was clarified the inclusion of IT related risks would fall within the remit of the Digital and Data Technology Board (DDAT) and risks on access to Primary Care and wider dependencies would be reported to the Primary Care Commissioning Committee unless there was a financial impact. The Committee noted the broader performance risk on access to and the readiness of primary care.

MB requested an update at a future meeting showing the trend on how risks had developed overtime.

JF asked if the changes imposed on ICBs to reduce its running costs could have a detrimental impact on risk ID64 Retrospective and Appeals (AACC) an area that already had resource constraints.

It was noted the changes on ICBs could cause disruption within the team. TA advised of actions being undertaken on the transformation function to ensure the ICB was operating as effectively as it could. JK highlighted potential opportunities to learn from partners in the new greater Essex footprint.

Following a request from MB for the Committee to be sighted on metrics to provide assurance the Retrospective and Appeals AACC backlog was reducing, it was agreed this would be incorporated in future Finance and Performance Committee reports.

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 had been closed since the last report to the Committee.**

Action: An update showing the trend on how risks had developed overtime was to be reported to a future meeting.

Action: Reporting on metrics for the Retrospective and Appeals AACC backlog to be incorporated into future Finance and Performance Committee reports.

Assurance

7. System Finance and Performance Report – Month 2

The Month 2 System position showed a £300k surplus year to date (YTD) against the planned deficit of £3.5m as per the plan agreed with NHS England. The System plan anticipated a favourable movement in Month 5.

At Month 2, the delivery of System efficiencies were off plan by £3m. JK noted the risk of non-recurrent efficiencies compared to the number of recurrent efficiencies delivered.

There was a focus on workforce at the Month 2 Regional Financial Review meeting and an ask for MSEFT to provide fuller detail on the profile of workforce efficiencies.

The ICB was monitoring All Age Continuing Care (AACC) and prescribing**,** as these were areas of high risk. It was noted it was too early in the financial year to assess if there were any concerns regarding delivery at this stage.

There was a request for risks and mitigations to be included in monthly reporting requirements to NHS England.

Following a query from JP, it was clarified the System would only receive deficit support funding where the System remained on plan as agreed with NHS England. JK advised formal guidance had been requested.

JK provided an update on performance on behalf of SG.

The Committee noted a small improvement to 79% on the number of patients who had begun cancer treatment within 31 days following the decision to treat cancer (trajectory was 77%).

Action plans were in place to support recovery for the 62-day standard and Faster Diagnosis Standard (FDS) as performance had deteriorated since it was last reported to the Committee.

For Elective care, MSEFT were unable to achieve compliance on zero patients waiting 65 weeks at the end of 2024/25. There were 1396 people waiting 65 weeks plus for treatment across the following specialities: Orthopaedics, Ear Nose & Throat (ENT) and General Surgery. Additional capacity and Independent Sector Provision (ISP) had been put into place to help address the backlog.

A number of trust actions were underway including the continuation of validation sprints (a focused effort to improve the accuracy of patient data, on waiting lists, to enhance reporting and performance). into Quarter 2, standardisation of clinic templates and outsourcing for non-admitted patients in Ear Nose & Throat (ENT), Trauma and Orthopaedics (T&O), Gynaecology, General Surgery and Urology.

There was a discussion on the balance to achieve performance trajectories as well as financial sustainability. It was clarified additional outsourcing of activity had been factored into the ICB Plan with the ICB only paying where activity was delivered.

Outcome: The Finance and Performance Committee noted the Month 2 System Finance and Performance report.

8. Medium Term Plan (MTP)

JC advised governance arrangements for Portfolio Boards had been refreshed, work was underway on reporting requirements to ensure the Portfolio Board and subsequent forums were provided with adequate assurance in terms of delivery.

Further work was taking place to understand the specific opportunit**y** programmes the MTP could deliver.

JF queried the impact a potential change of leadership could have on some programmes following the changes **im**posed on ICBs. JC recognised the risk and confirmed live discussions were taking place. The ICB were working with ICBs/stakeholders in greater Essex to gather any learning and assess where plans aligned, and opportunities could be gained on a larger scale.

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

9. Deep Dive on Performance – Urgent and Emergency Care

CW provided an overview of the operational challenges that lead to poor patient experience in Urgent and Emergency Care. Within the Trust, the Simplify Access to Fast and Efficient Urgent and Emergency Care (SAFE) was established to improve performance against the constitutional standards for Urgent and Emergency Care.

Four workstreams had been developed to ensure patients were accessing the right pathway, provide 24/7 senior decision-making and timely registration of patients in ED, seamless discharge, safe continuity of care and 24/7 evidence based advanced discharge planning.

Each Managing Director was accountable for the delivery of the programme at the site level.

A number of initiatives had been deployed including speciality pathways, a centralised flow hub, peer reviews and a missed opportunity audit. As a result, the Trust saw a small improvement in ambulance handover delays and the number of patients in hospital over 7 days.

In April, ED 4 hr performance was 68.4%, this had improved to 76.3% in June 2025, further work was required to achieve the plan of 78%.

Next steps were to embed recommendations from the peer review, continue work to improve specialty pathways including Medicine, Surgical, Frailty and Trauma and Orthopaedics (T&O), develop criteria-led discharge and explore the use of Artificial Intelligence (AI) to support the prevention agenda.

In response to a query from JF on when the Trust would achieve 78% for ED 4hr performance, CW advised although individual sites had achieved 78% this was not the case across all three sites. CW highlighted getting the basics right, flow and timely discharge was key.

A recent piece of work undertaken within the Trust highlighted 25% of admissions could have been seen outside of the department. CW raised opportunities from prevention work, which formed the next phase of the review.

Outcome: The Finance and Performance Committee noted the update on Urgent and Emergency Care.

10. Triple lock ratification

No items presented for this meeting.

11. Feedback from System groups

The minutes of the System Finance Leaders Group (SFLG) held on 28 April and minutes of the System Investment Group (SIG) held on 19 May 2025 were presented for information.

Following concern on the development of the Pitsea Community Diagnostic Centre (CDC), assurance was received the CDC would progress as per the planned timetable. A detailed update on the timeline would be presented at the Diagnostic Board on 15 July.

JK took an action to provide further detail on the reference to solar funding of £3.9m received by MSEFT stated within the SIG minutes of 19 May 2025.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted

Action: JK to provide further detail on the reference to solar funding of £3.9m received by MSEFT noted within the SIG minutes of 19 May 2025.

12. Any other Business

No items raised

13. Items for Escalation

To the ICB Board:

- Mental Health Support Teams (due to the total contract value)
- the deterioration in performance

14. Date of Next Meeting

Tuesday 5 August 2025
2.00pm - 4.30pm
Microsoft Teams Meeting

Minutes of the ICB Finance and Performance Committee

Held on 5 August 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
- Emily Hough (EH) Executive Director of Strategy, MSE ICB
- Dave Hughes (DH) Non-Executive Director, Mid and South Essex NHS Foundation Trust (MSEFT) (attending on behalf of Julie Parker)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSEICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Sam Goldberg (SG) Executive Director of Performance and Planning, MSEICB
- Janette Joshi (JJ) Deputy Director of Contracting, MSEICB (agenda item 11)
- Ashley King (AK) Director of Finance and Estates, MSEICB
- Alex Gregg (AG) Director of Performance, Planning and Healthcare Analytics, MSEFT (agenda item 6)
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes by recording)

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate.

Apologies were received from Laura Davis-Hughes, Local Authority representative, Essex County Council (ECC), Diane Leacock, Non-Executive Director EPUT, Matt Sweeting, Executive Medical Director and Julie Parker, Non-Executive Director, MSEFT noting Dave Hughes was attending on her behalf.

2. Declarations of interest

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

JF advised of a change to his declaration of interest and would update prior to the next meeting. It was noted the declaration did not impact any items on the agenda.

Outcome: The Register of Interests was noted.

Action: An updated Register of Interests to be provided at the September meeting.

3. Minutes of previous meetings

The minutes of 1 July 2025 were agreed as an accurate record.

Outcome: The minutes of 1 July 2025 were approved.

4. Action Log / Matters arising

The action log was discussed and noted accordingly, there were no matters arising.

5. Business cases

It was noted there were no items to discuss.

Assurance

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

MSEFT was in the NHS England Tier One process for Referral To Treatment (RTT) recovery. In recognition of the need to improve performance, the Trust had mobilised a turnaround governance approach to RTT.

MSEFT's 2025/26 Annual Plan sets out to achieve the minimum standards of 60% <18 week waiting times (total), 67% for <18 week waiting times to first outpatient appointment, and no more than 3% of the waiting list size to be waiting longer than 52-weeks for treatment at the end of March 2026.

AG highlighted the Trust were performing better than plan for the percentage of patients waiting no longer than 18 weeks for their first their appointment, but that waiting times were impacted by a delay to the reopening of two Orthopaedic theatres and the Braintree Procedure Room following the need for remedial works. AG noted the Braintree Procedure Room was now operational, theatre works remained underway. The Trust had repurposed underspends in other areas to support the number of patients waiting for treatment and were working with the ICB to maximise the use of provision from independent sector providers.

Following a query from MB, AG reported closure of the theatres was due to the requirement for urgent refurbishment, AG would clarify the timeline of when the two theatres would be reopened.

An outpatient transformation programme was underway within the Trust that included the standardisation and centralisation of outpatient bookings. Following a query from EH, AG clarified the Trust were booking an additional 6,300 new appointments per month than previously to increase clinic utilisation across specialties.

JF queried the financial consequence of the Trust not meeting the 100% planning target for elective and day case performance. JK clarified the contract mechanism was cost and volume, the Trust would receive payment for the activity delivered.

JF highlighted the significant improvement for the 'did not attend' (DNA) rate at MSEFT and queried if the trajectory would be recalibrated. AG took an action to check.

Outcome: The Finance and Performance Committee noted the update on Referral to Treatment (RTT).

Action: Timeline to be clarified for the reopening of two Orthopaedic theatres at Basildon Hospital currently closed for urgent refurbishment.

Action: The Committee be advised of any future plans for the trajectory for the 'did not attend' (DNA) rate at MSEFT following significant improvement over recent months.

SG left the meeting.

7. System Finance and Performance Report – Month 3

JK presented an update on the System financial position for Month 3. Work was underway to enhance the performance element of the reporting pack in line with the new NHS England National Oversight Framework and triangulate with the Medium-Term Plan programmes of work.

The System year to date (YTD) position showed a £0.4m surplus against plan with forecast outturn on plan to deliver the planned deficit agreed with NHS England.

The delivery of efficiencies across the system was £6.5m off plan YTD at Month 3. The Workforce Whole Time Equivalent (WTE) had reduced for MSEFT but Pay costs had not reduced at the same rate. A reprofiling of the workforce efficiency savings had been requested and a deep-dive on workforce would take place at the System, Oversight Assurance Committee (SOAC).

KE highlighted the underlying position showed a forecast £138.7m deficit across the system (ICB £19.1m, MSEFT £101.5m and EPUT £18.1m). The Committee noted the improvement on the underlying position to previous years.

There was a discussion on productivity following a query from DH on actions to address the financial gap. Specifically, MB queried the mitigating actions if there was a case that the deficit support funding was not secured. He raised that the level of non-recurrent efficiencies compared to what was being delivered recurrently was a significant risk. There was recognition on the transformation requirement to shift the level of non-recurrent efficiencies to recurrent.

JK advised formal guidance on the new National Oversight metrics was awaited and understood a System first solution was required where organisations did not receive deficit support funding where it was off plan.

AK highlighted the growth in All Age Continuing Care (AACC) and the Right to Choose for ADHD and Autism Spectrum Disorder (ASD) assessments. Actions on mitigating growth were underway; however, there was a resulting pressure on the YTD forecast position.

The Committee noted the update provided on AACC 2025/26 Quarter 1 Performance. It was suggested as AACC was a high-risk area the Committee would request a deep dive at a future meeting to receive an update on actions being undertaken within the team.

Outcome: The Finance and Performance Committee noted the Month 3 System Finance and Performance update.

Action: A deep-dive on All Age Continuing Care be scheduled for a future meeting.

8. Primary Care Estates, Utilisation and Modernisation Fund – Prioritisation of Schemes

AK presented an overview of the Utilisation and Modernisation Fund (UMF) set up to provide further capital resource in 2025/26 to support improvements to the primary care estate.

The ICB received 47 expressions of interests from GP practices across mid and south Essex. Following a review, 45 expressions of interests were submitted to NHS England for consideration. The indicative total value was £4.32m.

27 schemes were approved by NHS England, 1 scheme was then formally withdrawn by the practice and a further 6 schemes were not progressed. The ICB was working with practices to develop Project Initiation Documents (PIDs) for the remaining 20 schemes. PIDs would be aligned

to priorities within the Medium-Term Plan (MTP) and work underway within alliances on Neighbourhood Health Centres.

AK confirmed a live tracker was in place to monitor PIDs and would provide an update under the Capital section in future Committee reports. TA welcomed an update on progress for spend of Section 106 monies.

Outcome: The Finance and Performance Committee noted the update on Primary Care Estates, the Utilisation and Modernisation Fund and prioritisation of Schemes.

Action: Update on the progress of spend for the Utilisation and Modernisation Fund (UMF) and Section 106 monies to be included within the Capital update in future reporting to the Finance and Performance Committee.

9. Programme Management Office (PMO) Tracker update for Financial Recovery Plan (FRP)

SD shared an overview of the Month 4 ICB PMO tracker set up to provide robust monitoring and reporting of the delivery of efficiencies. There was an aim to provide a regular PMO update to the Committee and expand its scope to System level.

SD advised a formal change control mechanism was in place for requests to change the scope, milestones or the forecast outturn for efficiency schemes.

Following a query from MB on the level of efficiency challenge within Medicines Management, JK advised the target was based on Productivity opportunities highlighted by NHS England.

In reply to a question from MB on how unidentified efficiencies would be mitigated, SD advised this was partly mitigated by the over delivery for some schemes. There was a focus within the ICB to identify further schemes, with a further push anticipated in September.

Outcome: The Committee noted the PMO tracker update for the Financial Recovery Plan (FRP).

10. Medium Term Plan (MTP)

JC provided an update on the work to progress the MTP, noting that the ICB awaited the Planning Framework from NHS England, which was expected imminently. JC advised work was progressing to triangulate the reporting between Programme Delivery Boards (managing workstreams identified in the MTP) with financial assumptions on savings and improvement against outcomes.

An enhanced focus to identify recurrent schemes would commence in September to reinvigorate the idea pipeline.

Outcome: The Finance and Performance Committee noted the update on the Medium-Term Plan.

11. Indicative Activity Plans 2025/26: Process and Progress

JJ presented the report to provide an overview of the Indicative Activity Plan (IAP) development process for 2025/26 and update on progress. JJ further explained that the NHS Standard Contract and NHS Payment Scheme for 2025/26 was developed to greater assist commissioners in the management of variable activity and to deliver elective performance targets and balanced financial plans.

A strengthened Contract Activity Management process was developed to provide commissioners with greater control in the management of activity based on a Contract Indicative Activity Plan (IAP). One of principles introduced in the 2025/26 Contract Activity Management process enabled commissioners to set an IAP if none had been agreed within 3 months of the Service Commencement

Date. Having followed the Activity Management process set out within the Contract, if a commissioner and provider are unable to agree an Activity Management Plan (AMP), the commissioner would be able to set an AMP.

It was noted the development of AMPs and IAPs for contracts, the ongoing monitoring and more intensive activity management was significantly more resource intensive for contracts, contract finance and BI teams and a risk there would not be sufficient capacity to hold all providers to account for activity levels delivered under the contract.

Work was underway within the team to ensure triangulation between IAPs and the submission of the Operational Plan.

The Committee noted the value of the Specialised Commissioning element of the contract for one inter-System Provider was not yet agreed. All other contracts with inter-System Providers were agreed.

Outcome: The Committee:

- **noted the contents of the report**
- **endorsed the approach to agreeing and or mandating IAPs for the ICB's applicable variable activity contracts**
- **noted the resource impact on the ICB, specifically the contracts, contract finance and BI teams**

12. Triple lock ratification

No items presented for this meeting.

13. Feedback from System groups

The minutes of the System Finance Leaders Group (SFLG) held on 23 June and minutes of the System Investment Group (SIG) held on 30 June 2025 were presented for information.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

14. Any other Business

There were no items raised.

15. Items for Escalation

There were no items raised for escalation.

16. Date of Next Meeting

Tuesday 2 September 2025
2.00pm - 4.30pm
ICB Headquarters

Minutes of People Board Committee Meeting

Held on 3rd July at 11:00am

In person, Boardroom, ICB Headquarters and via Microsoft Teams

Attendees

Members

- Joe Fielder (JF), Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB) – Chair
- Siobhan Morrison (SMo), Interim People Director, MSE ICB
- Selina Dundas (SD), Chief People & Organisational Development Officer, Mid and South Essex NHS Foundation Trust (MSEFT)
- Kelly Gibbs (KG), Associate Director People, Essex Partnership University NHS Foundation Trust (EPUT) – *Deputy for Andrew McMenemy*
- Di Sarkar (DS), Chief Nursing & Quality Officer, MSEFT

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)
- Jenni Aylen (JA), Director of People and Change, Essex Cares Limited
- Sarah Crane (SC), Associate Medical Director for Development, MSE ICB
- Rachel Stinson (RSt), HR Business Partner, MSE ICB (Item 4)
- Nunzio Toscano (NT), Undergraduate Retention Lead, MSE ICB
- Shayna Pearson (SP), Employee Experience Manager, EPUT – *Deputy for Serena Lawley-Rayner*
- Michelle Angell (MA), Director of Delivery, MSE ICB (Item 9)

Apologies

- Andrew McMenemy (AMc), Chief People Officer, EPUT
- Lorraine Hammond Di-Rosa (LHD), Director of Culture & OD, MSEFT
- Anna Davey (AD), ICB Partner Member (Primary Care), 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
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB
- Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB

- Lee Brown (LB), Deputy Chief People Officer, MSEFT
- Eileen Marshall (EM), Chief Executive, St Luke's Hospice, Hospice Representative

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. Introductions were made for new attendees.

JF addressed the group with the rationale regarding the proposed new approach to People Board meetings moving forward. It was concluded from the last committee effectiveness review that the meeting required some changes to get better attendance from members, to ensure effective use of member's time and better deliver the key objectives of the committee. JF asked that the new format was trialled to gain feedback.

Consequently, the meeting was split to address strategic issues in the first instance and operational issues in the latter part of the meeting.

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 were 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 1 May 2025 were received and the group approved as an accurate record.

Outcome: The minutes of the meeting held on 1 May 2025 were approved as an accurate record.

The action log was reviewed and updated.

4. 2024 Ethnicity Pay Gap Data

RSt presented the 2024 Ethnicity Pay Gap Data to the committee as part of an action from Remuneration Committee (RemCom). RSt stated that as of April 2025, there was a requirement to produce this report as part of ICB process for being inclusive in accordance with associated legislation and best practice guidance. JF commented it would be useful to understand the pay gap on an age profile alongside the gender pay gap reporting. SMo added it would be useful to have a professional lens on the data i.e. medics, nursing etc.

Outcome: Members noted the Ethnicity Pay Gap report.

5. Provider Workforce Assurance (Bank and Agency Usage)

KG shared the latest data from EPUT with the committee regarding Bank and Agency usage. Quarter 1 showed reduced Bank (5% below target) and Agency (25% below target) usage. Workforce was 22 whole time equivalent (WTE) under plan (i.e. 1%). Usage was driven by vacancies and mental health acuity, in particular mental health observations. Medical recruitment remained a concern. In addition, spend was rising due to long-term sickness. Key risk areas for workforce Key Performance Indicators (KPIs) related to mandatory training, which was improving; supervision and appraisal processes were also under review and the risk log was to be refreshed. A key action was to increase the utilisation of the apprenticeship levy to 50% by year 1.

SD shared the latest data from MSEFT regarding Bank and Agency usage. It was noted that May data showed lower substantive WTE due to sickness and maternity. Bank usage was slightly over plan and Agency usage was above plan, but with fewer than five Agency doctors. Daily oversight had improved rostering and manager training, and sickness reduction initiatives were underway. Further, joint discussions were being held with EPUT on mental health staffing. Appraisal and mandatory training was under review and medical recruitment was progressing well.

JF raised concerns about a disconnect between education pathways and job availability, stressing the need for long-term planning. SMo noted Bank usage often related to sickness and leave rather than vacancies, which supported the importance of future planning. SMcD promoted working with Health Education Institutions to improve post-qualification employment. Finally JF welcomed the strategic focus of the discussion.

Action: EPUT to feedback on current apprenticeship levy usage.
Action: SD to share MSEFT training video on reducing sickness.

6. Education Workforce Update

SMcD provided a report highlighting a significant employment gap for newly qualified undergraduates, noting that 47 midwives had qualified but only one post was available across the system. The paper detailed current figures, actions taken, and recommendations. KG added that regional correspondence had been received, including a questionnaire seeking input on how support should be provided going forward. SMcD noted that a regional task and finish group had been established to help address the issue. DSa reported that the regional team was exploring standardised support across acute trusts, which would be beneficial. Feedback from wards indicated staffing shortages in paediatrics, critical care, and theatres, despite midwifery being at expected establishment. Most ward vacancies were small (0.25-0.6 WTE), with high levels of Health Care Assistant (HCA) and maternity leave gaps. MSEFT had written to students to clarify expectations and encourage proactive engagement with ward managers. Additionally, 26 student nurses were offered roles within the Community Collaborative.

7. ICS Efficiencies

KG provided an update on the workforce delivery programme, confirming that progress was on track. The first meeting was held on 22 May, with the next scheduled for the end of July. A potential risk was noted regarding the payroll tender, as MSEFT and the ICB were at different stages, which may impact timelines. If delays occur, a joint payroll tender may not be feasible, particularly as EPUT required a solution in place by 1 April 2026. JF requested a further update in September. Discussions were ongoing with Princess Alexandra Hospital NHS Trust regarding their interest in joining the programme, in light of the proposed establishment of an ICB across the Essex footprint.

Action: An update on progress with the payroll tender to be provided to the September People Board.

8. ICB Change Process

SMo provided a brief update on the change process across the ICBs in Essex, noting that the Executive Consultation was underway. Once the process was live, changes were expected to progress quickly. It was essential to maintain business continuity while managing the transition in a considered manner, particularly considering potential impacts on Providers. Further information was expected by the end of July, or early August.

9. Supporting Services Delivery Board Programme

MA provided an update on the Medium Term Plan (MTP), which aligned with national priorities and would run from 2025 to 2030. The Plan included multiple improvement programmes, with workforce identified as a key interdependency. A priority for the year was the development of the Workforce Analytics Unit, which would support demand and capacity modelling in collaboration with finance teams. In response to JF's query, MA confirmed that the unit would be based within the Integrated Care System (ICS) to serve Provider needs. The Providers present agreed the approach was welcomed and necessary.

10. Risk Report

JF addressed the risk report and confirmed he was not comfortable with removing risk ID113. JF asked for all the risks to be revisited.

Action: Risk report to be reviewed with system partners - meeting to be arranged by SMcD.

11. Highlight Reports from Workstream Chairs

Clinical Capacity Expansion / Education Innovation Workstream (CCEI)

SC reminded the committee that several subgroups were part of the CCEI workstream. The previous meeting had focused on undergraduate, recruitment, retention and student initiatives, with the main risk identified as NT's departure from the team, which impacted the

Student App and post-graduation placement capacity. The next area of focus was the Health Care Academy, which had launched a refreshed "Our People, Your Future" website. Risks were noted around the availability of placements for work experience and T Level students, as well as changes to Further Education (FE) college qualifications. BTEC qualifications were being phased out and replaced by Technical Occupational Qualifications (TOQs) and T Levels, which required 355 placement hours – posing a challenge for the system to accommodate. RS offered to present further information at a future meeting if needed. The funded work experience portal had completed the procurement process and was ready for launch but was delayed. Additionally, sourcing placements to advertise remained difficult.

SMcD updated the committee on progress of the Central Placement Management System (CPMS) project, which was fully funded. MSEFT was required to ensure all the student data is on the system.

Action: AMc to assist in unblocking IG issues with EPUT to progress the work experience portal project.

Action: Data required from providers on demand for work experience placements for the portal.

Action: Offline conversation with MSEFT regarding requirement for CMPS to ensure full understanding of system.

Outcome: Members noted the CCEI highlight report.

<u>Colleague Engagement, Wellbeing and Retention (CEWR) Group</u>

SP presented the report on the engagement, wellbeing and retention workstream and confirmed there were no concerns. SP highlighted key statistics that Mental Health' accounted for 22% of all sickness absence across the system, which included Provide Community Interest Company and North East London Foundation Trust (NELFT), followed by minor illness at 18%, musculoskeletal at 17% and other causes at 15%. The 2024 staff survey showed a slight increase in reported discrimination by leaders or colleagues (from 9.2% to 9.47%) and in harassment, bullying or abuse from service users and the (from 20.69% to 21.27%). Ambulance staff reported the highest levels of discrimination, followed by medical staff. In response, the workstream planned to collaborate with the new Chair to develop system-wide support and action plans to improve staff experience and wellbeing. Provide's Learning and Development week in May 2025 was noted as a successful and well-attended event. JF observed that mental health related absence appeared more prevalent among white and mixed race staff, and requested SP's support in exploring this further. JF also emphasised the need for future People Promise data to be streamlined to and presented to the People Board with clarity and purpose, consistent with all reports submitted to the group.

Outcome: Members noted the CEWR highlight report.

Culture Workstream

SMcD informed the committee that each Provider had identified three priorities within the Culture workstream, which were actively being progressed. NT was invited to present the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) High Impact Actions (HIA) report. The RAG (Red, Amber, Green) ratings indicated an increase in red ratings, likely influenced by staff survey results, and no green ratings were present as the report focussed on highlighting risks. Data inconsistencies were noted, with one provider collecting data differently and excluding Primary Care information. JF expressed concern that the report lacked narrative and context to support the ratings. SMo commented on discrepancies in Provide's data, while SD raised concerns about MSEFT's level of completion if based solely on staff survey data, suggesting a need for more evidenced-based reporting. JF reiterated the importance of contextualising the report. NT clarified that the data used was selected by NHS England based on the 6 HIA. KG agreed that the report should be aligned with internal reporting to address potential data mismatches.

Outcome: Members noted the Culture highlight report.

12. Any Other Business

SMo reported that a meeting had taken place to discuss HCA footfall and planning requirements. SMo requested that system partners provide supporting data to inform those discussion.

Action: EPUT and MSEFT to provide projections of current year (next 9 months) and the subsequent 12 months of total compliment of HCA requirement and a sense of frequency/delivery pattern to assist with further discussions.

JF asked the committee for feedback on the proposed new meeting format. SD felt the meeting was positive and encouraged more open conversation. SC noted the challenge of joining partway through and emphasised the importance of ensuring Primary Care representation throughout the meeting. JF highlighted the need for consistent and concise reporting to allow materials to be fully reviewed in advance. SMcD added that the meeting membership would need to be confirmed for each section. JF thanked members for their feedback.

13. Items to Escalate

No items to escalate.

14. Date of Next Meeting

4th September 2025, 11:00 – 13:00 – via Teams

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 9 July 2025, 9.30am–11.30am

Via Microsoft Teams

Attendees

Members

- Dr Anna Davey (AD), ICB Primary Care Partner Member (nominated deputy Chair).
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- 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.
- 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.
- Katherine Cornish (KC), Fuller Implementation Lead
- Chris Cullen (CC), Corporate Services and Governance Support Officer (Minute taker).
- 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.
- Ruth Rankine (RR), Director of Primary Care Network, NHS Confederation (Item 7 only).
- George Johnston (GJ), NHS Confederation (Item 7 only).

Apologies

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Dr Matt Sweeting (MS), Executive Medical Director.

- Viv Barker (VB), Director of Nursing.
- Dr James Hickling (JH), Deputy Medical Director
- David Barter (DBa), Head of Commissioning.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Jane King (JKi), Corporate Services and Governance Support Manager.
- Bryan Harvey (BH), Chairman, Essex Local Dental 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 11 June 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 11 June 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly.

Other actions were completed.

Outcome: The updates on actions were noted.

5. ICB Transition and Cost Reduction Programme

PG provided an update on the ICB's Cost Reduction Programme noting the challenges of operating within the initial timescales set nationally.

PG noted that work was progressing. News regarding the designate ICB Chair was expected later in the week. The Chief Executive interviews were also scheduled to take place during that week.

The Executive consultation period was due to commence that day and would be followed by consultation with all staff.

Outcome: The Committee NOTED the update on ICB Transition and Cost Reduction Programme.

6. Primary Care Estates Strategy

WG provided an update on the development of Primary Care Estates planning, advising a need for a more strategic approach to reflect the recently launched NHS 10 Year Plan and the left shift in service delivery.

Most Primary Care Networks (PCNs) were operating a significant space deficit which was up to 50% for some practices and would be stretched further by population growth from new housing developments and higher demand resulting from the left shift of services from acute care. This was compounded by restricted capital investment. A prioritisation tool had been developed to identify and prioritise shortfalls in estate within PCN areas.

WG advised that Section 106 (S106) funding was a key resource from property developers, however the funding was often location and purpose specific.

To manage and seek to resolve the issue, a primary care Medium Term Plan estates programme had been established comprising of four key aspects:

- Legacy Issues - resolve outstanding estate matters before ICB transition.
- Utilisation of Current Funds - maximise use of available capital (e.g., Primary Care Utilisation and Modernisation Fund (UMF) and S106 funding).
- Operational Oversight - improve processes for managing estate changes.
- Future Planning - develop a comprehensive, strategic estates plan around premises development to address left shift and population growth.

WG advised that a working group had been held to develop a future Primary Care Estates Strategy and would consider the critical issues cited above.

In response to SC, WG advised that the 10 Year Plan supported the maximisation of existing premises by tackling financial/contractual restraints on sharing spaces and maximising use outside of core service hours.

WG noted the issues of developers charging market rate rent for new surgeries and multiple developers phasing or splitting developments to impact on provision of surgeries. The ICB was looking to appropriately manage the need for new surgeries against the use of S106 funding to develop existing premises.

Members discussed the issues raised in relation to estates including:

- Comparisons to needs assessments in pharmacy.
- Suggesting an aggregation of smaller funding to the Local Authority.
- Better use of existing estate associated with the 10-year plans for neighbourhood health centres and therefore the need to finalise the principles of the Estates Strategy by the end of October.
- Historic S106 agreements restricting the use of funds that could be re-worded to facilitate operating at scale.
- Extended timescales for the completion of housing developments.
- The potential to lose S106 funding with the development of unitary authorities (as part of devolution where schemes had not been established).
- The impact of potential corporate models and the resulting need to engage with the GP Provider Collaborative (GPPC) when planning resources.

Outcome: The Committee NOTED the Primary Care Estates Strategy.

7. Neighbourhood Health and ICB Model Blueprint

PG welcomed RR and GJ from the NHS Confederation to stimulate discussion and reflection on the NHS 10 Year Plan and explore early insights and future considerations.

RR provided an update on the Neighbourhood Health strategies and ICB Model Blueprint.

The following points were discussed and noted:

- There was no detailed delivery plan for the 10 year plan.
- The Neighbourhood strategy and desire for a collaborative approach.
- The need for integrated patient health records to enable the neighbourhood health approach.
- The variation in primary care infrastructure.
- A neighbourhood health approach being led by primary care.
- An opportunity for the ICB to participate in the new financial flows mechanism pilot.
- Examples of primary care collaboratives from across the country.
- Challenges in Essex according to geographic considerations.
- The need for strengthened clinical leadership.

BB added that the fundamental purpose of moving care closer to home must not be lost and should be clearly understood and communicated by the new ICB. He stressed that the new ICB's strategic commissioning must reflect its intentions by supporting the shift of care out of acute settings, rather than continuing to direct the majority of resources into trusts.

Outcome: The Committee NOTED the Neighbourhood Health and ICB Model Blueprint.

8. Demand Management

PG shared a concept paper for the commissioning of activities associated with the demand management of referrals in the MSE system. The novel approach was in response to the Demand Management letter issued by NHS England, requesting a more clinically led approach to reduce demand on acute trusts.

The demand reduction target was 2% across all referral types. The aim was to reduce the total number of referrals and improve the quality of referrals across all specialities, ensure the appropriate use of referral types and reduce unwarranted variation between practices, geographies and trust sites.

The proposal was to keep primary care referral management embedded within practices, improve the referral interface, derive the most benefit from Advice and Guidance (A&G) and comply with the anticipated Red Tape Challenge document. The acute trust would be required to work differently with primary care who were the principal referrers to the trust.

It was agreed that a responsive cohort of specialists would be essential to support A&G effectively.

The paper highlighted the importance of supporting primary care providers to adopt new ways of working through commercially viable arrangements.

PW commented that several demand management schemes had been attempted, so lessons from previous efforts should be considered, including using the contractual relationship with the Trust to hold them to account.

PG confirmed that while providing A&G was now within consultant job plans the trust were prioritising waiting list management.

Outcome: The Committee NOTED the Demand Management update.

9. Integrated Neighbourhood Teams

DD presented an overview of the ongoing development of Integrated Neighbourhood Teams (INTs) across mid and south Essex (MSE).

INTs across MSE were asked to focus on frailty management and palliative end of life management as these areas could have the largest impact on patient care and acute care, resource, and improve patient outcomes and satisfaction.

Part of the focus was to create a neighbourhood teams resource guide, sharing examples of high impact, best practice interventions from work already taking place across MSE to improve the care provided to frail and end of life patients.

The paper highlighted challenges relating to information governance e.g., opening up access of the Business Intelligence platform for data sharing, risk stratification and patient identification.

AD noted the effectiveness of these schemes was dependent upon robust information sharing practices, and emphasised the professional duty to share information when in the best interests of patient care. DD agreed that the data sharing issues were resolvable.

The future aim was to have a neighbourhood level dashboard with metrics to demonstrate the impact of actions.

Outcome: The Committee NOTED the Integrated Neighbourhood Teams update.

10. Pharmaceutical Needs Assessment

PW provided an update on the tabled Pharmaceutical Needs Assessment paper detailing the assessments undertaken by the local authorities and requested any comments to be made to her by the end of July 2025.

Outcome: The Committee NOTED the Pharmaceutical Needs Assessment

11. Items to Escalate

No items were noted for escalation to the 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

1.00pm, Thursday 14 August 2025
Via Microsoft Teams

Minutes of MSE ICB Quality Committee Meeting

Held on 27 June 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.
- Ann Sheridan (AS), Executive Nurse, Essex Partnership University NHS Foundation Trust (EPUT).
- Diane Sarkar (DSa), Chief Nursing and Quality Officer, Mid and South Essex Foundation Trust (MSEFT) (present up to item 5).
- Dr Christine Blanshard (CB), Chief Medical Officer, MSEFT (present from item 6).

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience, MSE ICB (deputising for Dr G Thorpe).
- 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.
- Karen Flitton (KF), Patient Safety Specialist, MSE ICB (up to item 11).
- Anna Cheeseborough (AC), Interim Head of Midwifery, Southend Hospital, MSEFT (up to item 8).
- Lindsay Carpenter-Oliver, (LCO), Deputy Lead of MNVP, MSE ICB (up to item 8).
- Fiona Crump (FC), Patient Safety Partner, MSE ICB.
- Michelle Angell (MA), Director of Corporate Services, MSE ICB (for item 17.1 Patient Choice Policy)
- Angela Bell (AB), Principal Pharmacist, Quality, Patient Safety & Governance, MSE ICB.
- Frances Good (FG), Alliance Delivery & Engagement Officer, Thurrock Alliance, MSE ICB.
- Bridgette Beal (BB), Director of Nursing & Allied Health Professionals, Provide Community Interest Company (CIC).
- Sarah Paxman (SPa), Maternity and Neonatal Independent Senior Advocate, MSE ICB.
- Clare Angell (CA), Deputy Director of Babies, Children and Young People (BCYP) and Special Educational Needs and Disabilities (SEND), MSE ICB.

- Michelle Golder (MG), Quality Improvement Team, MSEFT (up to item 11).
- Dr Sarah Zaidi (SZ), System Clinical Lead, End of Life Care, MSE ICB (for item 13).

Apologies

- Deborah Goldsmith (DG), Director of Midwifery, MSEFT.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Viv Barker (VB), Director of Nursing for Patient Safety, MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, 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 25 April 2025 were reviewed and approved.

Resolved: The minutes of the Quality Committee meeting held on 25 April 2025 were approved.

4. Review of Action log

The action log was reviewed, and updates were noted.

Resolved: The Committee noted the Action Log.

5. Deep Dive – Maternity Services including Perinatal Mortality

NIB advised that the deep dive was an extension to the deep dive presented at the last meeting and was timely considering the national maternity investigation that was recently announced.

GH provided an update on the three main key areas of focus.

Perinatal Mortality related to deaths associated with maternity services, including stillbirths, early neonatal deaths and late miscarriages. The data sources were provided from the monthly reporting from Mid and South Essex NHS Hospitals Trust (MSEFT) and from external sources such as Mothers and Babies: Reducing Risks through Audits and

Confidential Enquiries (MBRRACE). Stillbirth and neonatal deaths when benchmarked against the MBRRACE data from 2023, identified no concerning trends of elevated levels, and numbers were below those benchmark levels. However, benchmark levels varied according to what was happening nationally and so the challenge was predicting any concerning trends.

In 2024 elevated stillbirth levels were identified and resulted in several activities being undertaken in conjunction with the Local Maternity and Neonatal System (LMNS) and ICB. There had been a deterioration in the neonatal death rate from 2022 to 2023 which triggered a neonatal death review of last year's cases. These steps taken by the LMNS provided assurance that when there was significant data variation, there was clear evidence of activity to address and identify opportunities for improvement.

The Maternity Safety Support Programme (MSSP) initiated in 2020/21 was reflective of a regulatory concern, raised initially at the Basildon site, and subsequently at Broomfield and Southend hospitals. Two maternity improvement advisors were working closely with MSEFT to address concerns raised on an operational and strategic basis. Four actions remained outstanding: alignment of diabetes pathway; action tracker for incidents to support governance process for learning and improvement; Section 31 conditions; and CQC actions. Unannounced inspections at all three sites last year led to a Section 31 Notice being served on the Broomfield site. This triggered further work, supported by the LMNS, ICB and maternity advisors, to ensure concerns were addressed diligently and confirm that assurance and oversight was being sought by peer support visits, and internal visits were being undertaken as part of the Trust's own internal compliance processes.

SP raised concern on the increase in preterm birth rate from October to December 2024 and requested further detail. GH explained that data for preterm births was reported differently than stillbirth or neonatal deaths. The crude stillbirth rate at MSE was 2.84% per 1,000 births. For neonatal deaths the rate was currently 0.82% per 1,000 births for May against a national parameter of 1.02% and was below the MBRRACE national standard. Assurances provided included the Saving Babies Lives Care Bundle (SBLCB), and Clinical Negligence Scheme for Trusts (CNST), where one requirement was that the Trust must demonstrate full compliance or in areas of non-compliance, evidence that steps had been taken. The perinatal mortality review panel reviewed all eligible cases of neonatal deaths and stillbirths to understand if there had been any service or care delivery problems and the actions being taken. GH was also involved in the oversight of serious incidents (SI) investigations.

MS highlighted that although the rating moved from green to amber for stillbirths, the Trust was still lower than average for the group. GH further explained that the rate moved from being more than 15% lower than average for the group to being up to 5% on either side of the average, so this could be an indication of a deterioration which would be closely monitored.

MS asked if neonatal reviews were separate from the Child Death Oversight Panel (CDOP). GH advised that the CDOP reviewed all neonatal death cases and child deaths across Essex. The neonatal review was held in March 2025 and the draft report had been shared with the Trust for comment and would be shared with the committee following completion of relevant governance processes.

SP asked if data was segregated into ethnicity and whether there was a higher risk in

Global Majority groups. GH confirmed that regional reporting undertaken by the Trust, since April 2024, focused on Global Majority Groups, due to being at greater risk of poorer outcomes as identified by MBRRACE. For stillbirths there was no significant variation, however, recently, more variation was noted for neonatal deaths. Language and communications were being reviewed to provide a greater understanding of when maternity services should be contacted for help and advice. SP requested inclusion of Global Majorities in the next report and also patients' maternal experiences.

For context AC explained that Southend Hospital maternity unit took babies from 32 weeks and above and Broomfield and Basildon took babies from 27 weeks if a singleton pregnancy and 28 weeks for multiple pregnancies. If a baby was not born in a tertiary unit under 27 weeks for a singleton, an investigation was held using an exception reporting tool to identify any missed opportunities, the optimisation in place, and what was not put in place before the baby was transferred. If a baby had been missed on optimisation, then improvements were considered. The part time preterm birth leads on each site led on investigations of all optimisations. Numbers of births across all sites were low, with 193 babies being born across MSE in total, from 24 weeks to 36 plus 6 weeks. The preterm midwives completed a comprehensive audit tool to identify issues and workstream meetings were held to review cases and discuss ways forward.

Neonatal conversations was a further area of focus. Admission to the neonatal unit was anticipated for delivery of babies up to 34 weeks and would be cared for by the neonatal team. Neonatal conversations were held with mums to ensure their understanding of the process, the baby's care plan and possible outcomes, including potential disabilities or complications.

Neonatal conversations in MSE for delivery of babies 36 weeks and 36 plus 6 weeks was a challenge due to transitional care. The transitional care team was responsible for the care of mother and babies transferred to a ward. There was set criteria to follow and depended on whether the transitional care nurse was able to speak to mothers. Ringfenced dedicated elective section days had been put in place, so there was an opportunity for that neonatal conversation to take place at the preoperative appointment. Some women fell into the foetal medicine category and needed to be delivered early for a particular reason, such as identical twins. A target setting trajectory meeting was scheduled for Quarter 1, and would consider splitting the metrics, so that areas of improvement could be celebrated and challenged areas could be targeted for improvement.

A further area of focus was the administration of intravenous (IV) antibiotics. When mothers were in preterm labour, IV antibiotics should be given to prevent infections being passed to the baby, except for planned elective caesareans. Compliance had recently deteriorated so a deep dive was completed to understand why. Compliance had increased from 26% in Quarter 1 (Q1) of 2024/25 to 88% in Q3, however, slipped slightly for Q4 but continued to meet Clinical Negligence Scheme Trust (CNST) requirements.

SPa highlighted the following key areas that her role of Maternity and Neonatal Independent Senior Advocate focussed upon:

The identification of themes, issues and family feedback supported the implementation of system level improvements. When a theme was identified or a significant impact made, the agreed escalation pathways highlighted issues urgently to the right people within the leadership framework for maternity and neonatal services. Feedback from families was

regularly discussed alongside the escalation pathways with senior leaders, so that the personalised needs of women and families could be met in a timely manner, and systems and processes could be improved.

Following feedback from bereaved families having experienced stillbirths or neonatal deaths, further work was required to improve Trust review processes which utilised the perinatal mortality review tool (PMRT). Several procedural issues had caused long delays before families were offered to meet with a consultant to discuss their care or findings of the review. This information should be received within six months from the date of death in line with Ockenden recommendations and MBRRACE. The Trust was implementing a Task and Finish (T&F) Group to review the whole pathway for PMRT reviews and had invited SPa as an independent person.

The role would cease at the end of March 2026, so referrals could only be taken up to October 2025. The Department of Health and Social Care were making recommendations to ICBs and providers on the future of the role. Positive feedback from the independent evaluation advised that families benefitted from this support and it should therefore continue. In light of the rapid national maternity investigation announcement, the role was important to ensure families had access to advocacy and continuing the service would demonstrate commitment to supporting families following adverse outcomes.

LC confirmed feedback provided at the last committee meeting on the bereavement survey was passed to relevant Trust teams. Actions were being developed, particularly with the Early Pregnancy Unit. The infant feeding workstream had been positive and further infant feeding support time was provided at Basildon to ensure equitable support across the three sites.

There had been successes across all workstreams, including meeting with the Traveller community to gain their views on access and representation of their culture. Similar meetings were being held with the Jewish Orthodox community. It had taken a considerable time to build trust with these communities to understand how to best support them to improve their experience.

SP asked if there was a timeline for the T&F Group to review the PMRT pathway. SPa explained this was being led by the Trust and a plan was already in place to review the pathway. GH confirmed the timeline would be confirmed in the next couple of weeks.

NIB asked if a recommendation to the national maternity investigation for this workstream to be protected and consolidated would be made. GH advised that it was a concern, as the ICB organisational change process suggested that oversight and assurance would transfer to regional colleagues. In MSE the focus on improvement was more urgent because of the nature of concerns around regulatory reporting. Also, moving from manual to digital processes could make processes more efficient. GH was working with the regional team and maternity improvement advisors to encourage MSEFT to consider who should be invited to participate in their processes and reviews to provide assurance.

MG highlighted that support provided from the improvement and change team at MSEFT would also be significantly reduced, so a significant amount of resource would be withdrawn from the management of the improvement system.

Resolved: The committee noted the Deep Dive on Maternity Services including

Perinatal Mortality.

Action: GH to include Global Majority Groups in the next maternity services report, with details of patients' maternal experiences.

6. Executive Chief Nurse Update

6.1 Safety Quality Group – Escalations

There were no escalations reported.

6.2 Emerging Safety Concerns/National Update

SM reiterated the paediatric thematic reviews being completed in MSEFT.

Other challenges related to changes to NHS England, ICBs and providers who were undergoing a non-frontline staff rebasing exercise. National guidance was awaited to support with the mitigation of any risks.

Outcome: The committee noted the verbal update on Emerging Concerns and National update.

6.3 ICB Board/SOAC concerns and actions

There were no escalations reported.

7. MSEFT/Acute Care Update

CB advised that MSEFT had developed focused quality improvements as part of an integrated improvement plan following its own assessment and patient feedback.

A significant number of Patient Advice and Liaison Service (PALS) contacts were related to waiting times and appointments. The communication pathway was under review to enable responses to be provided at the point of contact rather than logging as a PALs query to be responded to later. A divisional trajectory to reduce breaching PALS concerns was set to drive improvement.

All avoidable adult inpatient cardiac calls were reported. Not having a timely Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision or a treatment escalation plan in place were identified as the most common causes. Improvement work was ongoing with weekly audits of wards.

Within the integrated improvement plan, better patient experience was aligned with improving performance. Improvements had been made on the number of patients waiting more than four hours in Emergency Departments (EDs), 12-hour trolley waits and patients being cared for in a non-bedded area. However, cancer performance and the faster diagnosis standard required improvement.

A regulatory update was provided in the report and included the number of outstanding actions from the MSEFT Care Quality Commission (CQC) improvement plan and detail on the Section 29A for Children and Young People Services, for which an action plan had been developed across all sites. Mediation and cultural improvement work was completed at Broomfield, which made a dramatic difference in the way staff worked together and

interacted with patients and families. MSEFT was mentioned as one of the potential ten organisations to be included in the national maternity investigation. Consequently, it was anticipated the Section 31 notices would remain in place at Broomfield and Basildon. The remaining inspection reports would possibly not be published until after the review. Actions continued to be implemented for the Section 31 notice for ED in Basildon. A business case had been presented for a substantial increase in ED nursing staffing at Basildon, which could not be replicated across all sites due to financial constraints, so alternatives were being considered to ensure adequate nursing staff and patient safety.

An NHS England (NHSE) quality assurance visit reviewed several services. Concerns were raised regarding teaching and training within anaesthetics. Following feedback, trainees were transferred to other sites. An improvement programme was in place to improve culture and behaviour, particularly sexual safety in theatres, across MSEFT, focusing on Basildon.

The report on an external review of histopathology was awaited. The findings would support the trust to address poor turnaround times for diagnostic histopathology, which adversely impacted cancer services and general diagnostic services.

A risk summit was held following concerns raised on the safety of the inpatient pharmacy service due to low stock of medicines, reconciliation delays in 'to take out' medication and several incidents. Concern was also raised regarding Aseptic team staff capacity due to increased demand for chemotherapy. This was partly mitigated by increased outsourcing. There were also significant delays in planning and starting new patients on chemotherapy. An action plan was in place.

NIB asked if there was any rationale as to why the CQC did not agree that learning was sustainable. CB advised that the verbal feedback provided to-date was high level.

MS asked whether staff were able to complete Patient Safety Incident Investigations in a timely manner. CB confirmed that governance was good at high level and the quality of reports and discussion at the Trust Quality Governance Committee had improved. The challenge was at service and hospital level and ensuring that everyone understood accountability and responsibility. Support and training for some leaders and holding each individual service to account for the quality of the service delivered were required.

Resolved: The Committee noted the MSEFT / Acute Care update report.

8. Primary Care Update

VK took the report as read and highlighted the following key points.

There were no outstanding complaints for the primary care quality team. There had been two SIs that were being reviewed to ascertain whether they could be de-escalated to local level or if further investigation was required. Support was being provided to the wider primary care team with the complaints process.

Following CQC inspection, Balfour Medical Centre had improved their rating, resulting from the action planning implemented by their practice manager. The rating for Dr Bekas Medical Centre remained 'Inadequate' which was being closely monitored. Since the report was written, the Stock Surgery inspection report had been published and was rated 'Good'.

An explanation of the difference between the internal system practice risk review group versus CQC ratings was included in the report to enable a better understanding of the individual Alliance information.

A significant number of whistleblowing concerns all different in nature via external providers had been received. Support was being provided to the relevant practices.

SP asked if learning from 'outstanding' practices could be shared with practices with lower ratings. VK explained that those practices were rated outstanding under the previous framework, and it was now difficult to achieve outstanding under the current framework. However, if a practice gained an outstanding rating, themes and trends would be shared.

NIB asked if learning could be shared from Balfour Medical Centre which recently improved its rating. VK explained some practices embraced action planning processes and had consistent good governance, leadership and collaborative working. However, practices were rated for different elements, so there were no particular themes identified as a CQC issue. Good examples of primary care quality had been shared with Herts and West Essex (HWE) ICB and Suffolk and North East Essex (SNEE) ICB to identify any themes.

Resolved: The Committee noted the Primary Care update report.

9. Patient Experience Update

SM took the report as read and advised that the Patient Experience team continued to work under similar pressures as reported previously.

A new issue had emerged in relation to Attention Deficit Hyperactivity Disorder (ADHD) and the shared care right to choose policy, with GPs opting out of providing that provision, particularly when patients transferred from private providers, resulting in an increase in complaints.

Work was ongoing to address the backlog of primary care complaints and showed some improvement. Several outstanding complaints from 2024 were being addressed, with a particular focus on long-standing complaints.

The national submission portal for complaint data for 2024/25 was open and the deadline for submissions would be met.

Resolved: The Committee noted the Patient Experience update report.

10. Patient Safety Update, including Central Alerting System (CAS) Policy Update

KF took the report as read and advised that the paper focussed on the eight national priorities on patient safety.

All main providers were registered with the Learning from Patient Safety Events (LFPSE) service and the ICB's Datix system also now fed into LFPSE. Primary Care uptake of LFPSE remained slow, with a small upward trajectory. Engagement efforts continued.

All providers had transferred to the Patient Safety Incident Response Framework (PSIRF), apart from Primary Care, which was not mandated. Annual reviews with main providers

were undertaken. The number of overdue Patient Safety Incident Investigations (PSIIs) within MSEFT had been raised with the Trust as part of the annual review. Assurance was provided that the number should reduce as staff were getting used to the new framework and would be closely monitored.

There were eleven outstanding SI investigations currently being progressed. A good learning and engagement culture was in place across the system, including lunch and learn sessions and a learning forum.

There were four outstanding national patient safety alerts (NPSAs) related to East of England Ambulance Service Trust (EEAST). However, assurance had been provided by SNEE, the lead commissioner, that they were closed. The process to receive and cascade NPSAs was being reviewed to become centralised, however with the recent changes to ICBs that would be harder to navigate.

From April 2025, all Trusts should have two patient safety partners as mandated in the NHS Standard Contract. Peer support and ongoing development was provided by the regional support network.

All organisations were working well towards an upward trajectory for improving compliance in patient safety education. All main providers had been successful in training one person to levels 3 and 4, which supported development of patient safety expertise across the system.

An update was provided on safety improvement projects, including implementation of Martha's Rule, pressure ulcer improvement work, and the Prevention, Identification, Escalation, Response (PIER) project for patients with learning disabilities.

The Primary Care Patient Safety Strategy published by NHS England in September 2024, was not mandated, so implementation system wide was challenging. A questionnaire was issued to primary care providers with 22 responses received from 10 providers which would be utilised as pilot sites. A co-development approach would be used.

In response to a query from PW regarding sodium valproate, KF advised that discussions had been held regarding medication incidents and how lessons learned could be shared, linking medicines management with patient safety and bringing some of those issues to the learning forum. There was also a dependence on attendance at the learning forum becoming wider to enable more clinicians to join. NELFT were currently considering how clinicians could be released to attend and would report back to Patient Safety Collaborative.

MS commented that current systems in place made it difficult to track drugs prescribed and electronic prescribing and records could target interventions. CB commented that the ability to identify a cohort of patients who were prescribed a relevant drug would be easier with an electronic patient record as clinicians would be able to access the same record across primary, community and mental health and patients would be identified no matter where a drug was prescribed.

AS advised that EPUT held quarterly learning events, and everyone was welcome to attend.

Resolved: The Committee noted the Patient Safety update report.

11. Learning Disabilities, Autism and Neurodiversity

CA took the report as read, which focused on the work of the Medium-Term Plan (MTP).

Learning Disabilities (LD) and Autism Spectrum Disorder (ASD) was one of the seven improvement programmes that covered a 5-year period with a focus on improving outcomes. Objectives included strengthening the ability of the system to deliver timely assessment and care for those with LD and/or autism. The focus was on raising awareness of the needs of this patient group and ensuring that across health services for children and adults, reasonable adjustments were made and patient led care plans were in place, rather than increasing capacity and investment. The ambitious programme spanned from early intervention to crisis support. Essex was currently an outlier for the number of inpatient admissions and there was a high proportion of children and adults in LD beds due to their autism.

Four key workstream programmes, launched on 1 April 2025, were reviewing governance and commissioning arrangements; clinical transformation across NHS commissioned ASD and LD pathways; system transformation and being accountable and responsible collectively; and improvement of patient flow, by facilitating discharge and preventing admission / readmission for those children and adults at greater risk.

The report outlined expected key deliverables over the next 5 years, which would be adjusted as the ICB transitioned into the Greater Essex footprint. The primary aim was to ensure that the community support understood the needs and was able to respond across education, health and care.

ADHD was causing concern for families and patients following GPs' withdrawal from shared care arrangements. A pathway was in place for those patients under a specialist, but some patient groups were outside of the ICB policy. Work was ongoing to implement innovative commissioning arrangements. For adults, specialist capacity had been reviewed in the independent provider market and would be duplicated for children in the coming weeks.

SP asked whether commissioned funding would be provided for that group. CA explained there was inefficiency across the system on funding decision making and because of complexity of needs and lack of assertive commissioning approach with the provider market, it was the providers' decision whether they accepted the care of these young people and at their price. Since 2021, capacity had not been built into the market to respond to the current demand. There could be a requirement for new investment but equally an opportunity to review current spending habits.

MS queried support provided to clinicians for the change in culture from diagnosis to symptomology. CA explained that the needs led offer would not replace the requirement for diagnostics. Some children, young people and adults would be expedited through to clinical assessment and diagnosis because of the complex profile. A successful one-year pilot called 'Partnership for Inclusion of Neurodiversity in Schools' was near completion and focused on creating inclusive environments, being communication friendly across education, and using health experts to support education colleagues to deliver appropriate support. The aim was to shift away from diagnosis first but would not prevent people from accessing clinical assessment. The decision for the system would be whether it was better to invest collective money into services that could provide effective support, rather than what was being done currently, which was not improving outcomes for children, young people and adults.

PW commented that several patients with LDs had not been properly assessed under Stopping Over Medication of People (STOMP) and were still receiving antipsychotics as sedatives rather than addressing their needs via other means. Clinicians in primary care were not confident in stopping medication and there were not sufficient specialists to support this. NIB suggested a future deep dive into diagnosis, the pathway and use of medication.

Resolved: The Committee noted the update on Learning Disabilities, Autism and Neurodiversity.

12. Babies, Children and Young People (BCYP) Update

CA took the report as read.

The MSE ICB Board and Executives approved a funding plan to further strengthen Special Educational Needs and Disabilities (SEND) partnership arrangements, expand the asthma model across MSE and progress transformation activity.

The BCYP virtual views page had gone live, and parents had started to provide feedback on a range of services across the hospital, primary and community care.

Resolved: The Committee noted the Babies, Children and Young People update report.

13. Palliative and End of Life Care (PEoLC)

SZ took the report as read and highlighted the following key points.

Good data identified gaps of unwarranted variation across places in terms of early identification of patients. Early advanced care planning delivery was the key intervention that improved outcomes, and a provider's responsibility was to comply with the universal model of PEoLC.

Several PEoLC mapping exercises had been completed with providers to ascertain competencies with 24/7 capability delivery aligned to seven core functions that were essential to delivering end of life care in generalist or specialist services.

A PEoLC ambition self-assessment, Marie Curie lived experience survey and a staff educational needs assessment survey were completed which highlighted key challenges. The major theme was the shift in staff culture competencies and having confidence to expedite early conversations with the population about planning for end of life and incorporating their wishes into personalisation of care. Working groups were established to address these challenges and included the education and training group, which aimed to promote existing resources for education, consider bespoke training for specific teams and the expansion of roles for non-medical prescribing, nurse led advanced care planning and DNACPR competencies.

MS confirmed the PEoLC strategy was endorsed by the ICB Board and commented that datasets could track who received an intervention and identify areas of focus for the future requiring review and asked whether the tools would provide support with monitoring quality and improving outcomes. SZ explained that current datasets provided an understanding of the number of people living with a life limiting prognosis, which was nearly 3% of the local

population. To close the gap, data was utilised from the Population Health Management (PHM) system, which interrogated by place, neighbourhood, individual GP practice population, deprivation, age, and gender. The end-of-life performance dashboard identified the number of people being reached and the time it took to reach them, so timeliness of identification and delivery of best practice could be measured and enabled realisation of the benefits for the population outcomes in terms of how many people died in hospital and those having repeated admissions in the last 90 days of life. Areas that adopted the care delivery tools had improved identification and proactive care inputs.

Resolved: The Committee noted the Palliative and End of Life Care update report.

14. Medicines Management

AB advised the report highlighted three main risks.

MSEICB was comparable with other ICBs for the overall prescribing of opioids in general. However, for high doses, MSE ICB had maintained outlier status. The Prevention of Future Deaths Notice for the inquest mentioned in the report was being reviewed.

A programme to increase the number of 5-day prescriptions for antibiotics had been developed and showed signs of improvement. However, the target of the overarching number of antimicrobials prescribed was not being met. A new target of 27% or less for children 0-9 years old being prescribed an antibiotic in the last 12 months had been added to the national oversight framework. The ICB reported 40.9% which reflected the high number reported regionally.

Sodium valproate continued to be a challenge, due to the review waiting list of up to a year for women. Some completed risk assessments were not being sent back to the GP practice. This was recently raised with the Medicine Safety Officer for MSEFT, and it was suggested that the Trust should report these on Datix as incidents. However, the risk rating for the sodium valproate risk had been reduced, because women were being referred, but the risk of the delay and what could happen in that interim period remained.

Resolved: The Committee noted the Medicines Management Update.

15. Patient Safety & Quality Risks, including Risk Management Workshop Outcomes

SOC highlighted the following key points.

There were currently 27 risks within the remit of Quality Committee, of which, seven were currently rated red as detailed in the report.

No new risks had been opened since the last meeting.

One risk (Risk ID115: Compatibility of PEoLC register with the new electronic patient record (EPR) and shared care system) was recommended for closure as detailed in the report.

Several meetings were held with Board Members and Executive Directors to reframe the Board Assurance Framework, which would be available for the ICB Board meeting on 17 July 2025. Any quality related BAF risks would continue to be reported to the Quality Committee as per previous arrangements.

Two workshops had been undertaken to pilot the process for assessing and managing risks across systems. The first related to mental health patient flow and the second in relation to palliative and end of life care, which had resulted in several actions being agreed. The committee would receive an update on the pilot at a future meeting.

Work had also been undertaken to review the description of risks recorded on Datix and should be finalised by the next committee meeting.

MS provided assurance on the closure of Risk ID 115 which had been mitigated by going through data groups attended by clinical leadership, including the Deputy Medical Director. If any issues arose in the next year, once EPR goes online, a new risk would be opened.

NIB asked if ICB staff consultation risks were being identified. SOC advised that the ICB staff consultation had not yet been launched, but work was ongoing in this regard.

Resolved: The Committee noted the Patient Safety and Quality Risk report and approved closure of Risk ID115 (Compatibility of the palliative and end of life care (PEoLC) register with the new electronic patient record (EPR) and shared care system).

16. Provider Quality Accounts 2024/25

SM advised several provider quality accounts for 2024/25 had been received as detailed below:

- EPUT
- Provide CIC
- Havens Hospices
- Farleigh Hospice
- North East London Foundation Trust (NELFT)

The quality accounts had been scrutinised by relevant teams. For mental health there had been collaboration across the whole system and one standard report had been generated.

The committee was being asked to note the responses to the provider quality accounts. Remaining provider quality accounts would be circulated virtually for ratification by the committee.

Resolved: The committee ratified the provider quality accounts.

17. Nursing and Quality Policies

17.1 Review of Nursing and Quality Policies

005 Patient Choice Policy – MA advised that amendments requested at the previous committee meeting were made to the policy which was therefore being submitted for final approval.

PW requested that the word ‘policy’ needed to be amended on the operational guidance to ‘this guidance supports the implementation of the policy’.

Resolved: The Committee approved the Patient Choice Policy (005), subject to the amendment above being made to the operational guidance.

075 MSE Cross System Response Policy – KF advised that the policy had been circulated to all providers by the Patient Safety Collaborative. Under PSIRF, the ICB had a responsibility to coordinate complex PSIIs and learning responses. This policy outlined the process agreed across all partners.

Resolved: The Committee approved the MSE Cross System Response Policy (075)

17.2 Extension of Existing Policies

SM advised the extension to review deadline dates for the following policies was requested due to staff capacity within the teams and the requirement to standardise the process for the PHB Implementation Policy.

- 068 All Age Continuing Care Policy
- 069 PHB Implementation Policy

PW advised that there had been a version control issue with the Defining the Boundaries Policy (Ref No 080) approved at the December Quality Committee meeting. A further tracked version showing minor changes would be circulated virtually to Quality Committee members for approval.

SOC advised that work would shortly commence on reviewing all policies in preparation for the establishment of the new ICB covering the Greater Essex area.

Resolved: The Committee approved the extension of the review dates of the 068 All Age Continuing Care Policy and 069 PHB Implementation Policy.

18. Review of Committee Effectiveness Update

SOC explained that a review of all main ICB committees was an annual process.

A desktop review which summarised the work of the committee was completed and an online survey of committee members and regular attendees provided an opportunity for them to contribute their views against several questions and make suggestions for improvement. Following formal committee sign-off of the review, a summary of the review of all committees would be submitted to Audit Committee and the ICB Board.

NIB thanked HC for her work on the desktop review and collating the survey outcomes.

NIB also thanked those members who completed the survey noting that feedback would support committee effectiveness in the future. Feedback included that discussions were good, which at times were challenging which was supported and welcomed, and there was diversity of topics. It was noted that the paperwork had improved significantly.

SOC advised that following discussions with NIB and GT, the committee's workplan was revised to consolidate some reports and, in some cases, reduce frequency of reporting. NIB advised that committee members, attendees and report authors could further support by highlighting three key areas in their reports, to be focussed upon during meetings, and reducing the size of reports/presentations.

PW noted that the medicines management report was now required annually and queried if this should be increased to at last twice a year due to the numerous areas in which there were medicines related safety issues and risks, for example with controlled drugs and anti-microbial work. It was agreed that the report would be submitted twice a year, one of which would be submitted for information only.

MS, SP & JF confirmed that key areas should be highlighted at the beginning of a report. NIB commented that the Quality Committee would expect assurance via reports that an effective process was in place and being followed, what the outcome was and if that was sustainable. Other groups reporting into Quality Committee should under deep dives into particular processes within their own remit.

CA suggested highlighting that three key areas were required on the report template to steer authors. SOC advised that the board and committee report template included guidance on writing a report and provided several headings on the type of information that should be included, including summarising the key issues. However, Board report templates were currently being reviewed so this requirement would be taken into consideration. NIB suggested that presentations should be kept to one minute per slide with one minute for questions.

CA commented that when the focus was narrowed, the audience could be forced into making assumptions on what was being spoken about and there could be a lack of complexity so the level of risk could be misunderstood.

SOC advised that the draft revised terms of reference (ToR) for the committee had minor amendments, noting that no significant amendments had been made due to the proposed ICB transition. No further comments were made on the draft revised ToR, which were therefore approved.

Resolved: The committee:

- **Approved the desktop review of Committee Effectiveness 2024/25.**
- **Approved the draft revised terms of reference of the committee.**
- **Approved the draft workplan for 2025/26, subject to the amendment noted on Medicine Management.**
- **Noted the outcome of the online effectiveness survey.**

Action: HC to amend Medicines Management report to biannually on the committee workplan 2025/26.

19. Discussion, Escalations to ICB Board and agreement on next deep dive.

19.1 Escalations to or from other Forums:

- **Other ICB main committees (including SOAC)**

There were no escalations to or from other ICB main committees.

- **ICB Board**

There were no escalations to or from ICB Board.

- **Safety Quality Group**

There were no escalations from Safety Quality Group.

19.2 Agreement on next deep dive

SM confirmed that the next deep was Medicines Management and suggested a focus on the recent Regulation 28 and the prescribed opioid deprescribing services.

SOC clarified that the next scheduled deep dive was due to focus on Community Pharmacy and end of life care with a MTP focus was scheduled for October. SOC requested suggestions for future deep dives.

NIB suggested a future deep dive on autism diagnosis, linked with medicine optimisation and usage.

PW advised that the community pharmacy deep dive was linked to Pharmacy First and she would welcome the opportunity to present that at a future meeting particularly because of the range of services provided and to ensure integration across the system.

Resolved: The committee agreed that the next deep dive would focus on Medicines Management: Regulation 28 and Prescribed Opioid Deprescribing Services.

20. Any Other Business, including discussion on effectiveness of meeting

NIB noted that rich discussions took place. No other comments were received.

There were no further items of any other business raised.

21. Date of Next Meeting

Friday, 29 August 2025 at 10.00 am to 1.00 pm via MS Teams.

NB: This was subsequently amended to 10.30 am -12.30 pm on Friday, 5 September 2025.

Part I System Oversight & Assurance Committee (SOAC)

Minutes of Part I meeting held 27 June 2025 at 1.30 pm to 2.30 pm via Teams

Attendees

Members

- Tom Abell (TA), Chief Executive and Committee Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- 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).
- Paul Scott (PS), Chief Executive, Essex Partnership University NHS Trust (EPUT).

Other Attendees

- Will Guy (WG), Director of Primary Care, MSE ICB.
- James Wilson (JW), Collaborative Lead Director, Mid and South Essex Community Collaborative.
- Sharon Hall (SH), North East London NHS Foundation Trust.
- Pam Green (PG), Alliance Director, Basildon and Brentwood and ICB Primary Care Lead.
- Sara O'Connor (SO), Senior Manager Corporate Services, MSE ICB.

Apologies Received

- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB.
- Zoe Pietrzak, (ZP), Regional Director of Finance, NHS England (East of England).
- Simon Wood (SW), Regional Director for Strategy & Transformation, East of England, NHSE.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer Provide Community Interest Company.
- Sam Goldberg (SG), Executive Director of Performance and Planning, MSE ICB.

1. Welcome and Apologies (presented by T Abell)

TA welcomed everyone to the meeting. SO advised the meeting was not quorate as there was no representative from NHS England present.

Apologies were noted as above.

2. Declarations of Interest (presented by T Abell)

TA 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 T Abell)

The minutes of the last SOAC meeting held on 25 April 2025 were reviewed and approved by those present with no amendments requested. However, as the meeting was not quorate, SO advised she would request ZP and SW to confirm their approval of the minutes.

Outcome: The minutes of the committee meeting held on 25 April 2025 were approved by those present, subject to approval by ZP and SW.

Action 212: SO to seek approval of the minutes of the previous meeting held on 25 April 2025 from SW and ZP.

4. Action log and Matters Arising (presented by T Abell)

The following update was provided on the following outstanding action:

- **Action 194 – Progress of Investigation and Intervention (I&I) Actions:** JK advised that although this action had been open for some time, I&I had since become 'turnaround' and there wasn't a specific I&I closure report. However, a tracker was used by the Programme Management Office (PMO) to track delivery against actions which she would be happy to share with SOAC members. TA agreed this would be sufficient to close the action.

All other actions were noted as complete.

Outcome: Members noted the updates on the action log.

Action: JK to share PMO tracker regarding I&I / turnaround actions with SOAC members.

5. Financial Recovery (presented by J Kearton)

JK advised that at Month 2 (M2), the System presented a balanced position against plan, albeit the plan was £3 million deficit. During the most recent review meeting with ZP the key themes were that challenges in unlocking workforce trajectories and releasing efficiencies remained, although some benefits had been realised regarding bank and agency use.

The management of mental health patients was being reviewed across the system and, from a financial perspective, should be resolved by the time colleagues met with ZP to discuss the M3 position.

JK highlighted there was a higher level of non-recurrent savings propping up the position than normally expected during M2, so there was specific focus on addressing that by the end of Quarter 1 (Q1).

TA queried if some of the issues Elizabeth McEwan, NHS England, had exposed regarding efficiency and benchmarking should be discussed at SOAC because they required a system, as opposed to an organisational, response.

JK advised that she was expecting some more information to become available as there had been a challenge from the national team to help them understand triple lock arrangements, including with regard to the Mental Health Investment Standard. There was a general reset requirement coming from national finance leads who wished to share the information available

to them on the mid and south Essex (MSE) system, as well as comparators, which would be fed into future SOAC meetings.

MH advised that the cash regime was foremost in the mind of MSEFT and its Trust Board.

In response to a query from MH regarding a potential system follow-up meeting with Sir James Mackey and Dr Penny Dash, NHS England (NHSE), JK advised a further meeting had not been arranged. However, one might be required at the end of Q1. In the meantime, consideration was being given to I&I Mark II, National Oversight Framework Level 5 (NOF5) and new performance metrics, which might dictate if and when a further meeting was required.

Resolved: The committee noted the verbal finance update.

6. Deep Dive – Primary Care (presented by P Green)

PG shared a presentation on Primary Care focussing on key metrics, the primary care access recovery programme (PCARP), action plan for General Practice and Basildon Early Response Team (BERT) which connected out of hospital care with the hospital on a daily basis via Integrated Neighbourhood Teams (INT).

PG highlighted key metrics including that in April 2025, 860,546 appointments were delivered across the whole of Essex, of which 560,663 were seen face to face, with 42% of patients receiving a same day appointment. Seasonal spikes in the overall number of consultations year on year were mainly linked to flu / flu vaccination appointments.

WG advised that when compared with 2019/20, there were circa 1.2 million additional primary care consultations per annum in 2024/25. However, there was a general downward trend in the number of consultations undertaken by GPs due to the growth of Additional Roles Reimbursement Scheme (ARRS) staff, although this growth was beginning to plateau. There was a debate amongst primary care colleagues as to whether the quality of service had improved, or whether practices were just seeing individuals more times. Also, to facilitate 'left-shift' of services an increase in the number of GPs was required.

MSE was broadly in line with the national target to ensure patients accessed an appointment within two weeks of contacting their practice, with an aspiration to move to 85% meeting this metric. PG mentioned some practices allowed bookings beyond two weeks which changed the profile for this metric, and it was therefore being debated whether it was a valid indicator of good quality outcomes.

WG advised that the ICB Board approved the local PCARP action plan in 2023. National funds available to support this were invested into Connected Pathways Teams to implement the Modern General Practice (MGP) model. This meant trying to get into a position where all general practice demand was triaged via a single approach and managed within an appropriate setting, e.g. GPs, a Primary Care Network (PCN), another service or via self-management.

PG explained that models where Artificial Intelligence (AI) was being used across the country had been considered, with the aim of addressing the '8.00 am rush' for appointments by funnelling demand into more appropriate resources. This required effective leadership to implement as people needed to be taught to navigate systems differently to engender confidence they would receive a reply, even if later in the day.

The presentation highlighted several successes of the PCARP action plan locally, which included encouraging as many practices as possible to implement MGP. However, NHSE was now moving to a more targeted approach to implement MGP during 2025/26, including several requirements within this year's contracts requiring all practices to implement some aspects of

MGP, most of which came into force in October 22025. The ICB would need to monitor compliance and take contractual action to enforce mandated components.

PG explained that once practices implemented total triage via PCNs (which tended to have a registered population of circa 50,000) the ICB supported them via INT development to review the profile of disease origins of their demand. There had been significant work on frailty which, alongside younger/working age patients with mental health issues, tended to have high demand. Consequently, reviewing how teams were constructed could assist with addressing demand.

In relation to BERT, west Basildon had the foresight to co-locate teams in Laindon, one of the most deprived areas in MSE, with a much lower life expectancy (circa 10 years less than other wealthier areas). BERT was established in June 2024 and was starting to realise positive results, predominantly for older members of the population, those with a mental health condition, and those who were homeless or living in sheltered accommodation.

Initially, all over 75-year-olds who had not had a meaningful encounter with their GP practice in the previous six months were called in for reviews. The age criterion was subsequently dropped to 70. Other agencies supported discussions to mobilise people to help themselves to find support in communities rather than relying on a statutory / medical response, which helped to tackle health inequalities as people tended to remain engaged.

The team, which met three times a week, consists of representatives from charities, statutory agencies, housing, and GP practices to offer patients support. Co-location was an important part of the model as it enabled troubleshooting, thus reducing referrals.

BERT also linked daily into Transfer of Care Hub meetings to discuss those admitted overnight, with growing numbers of people being cared for through the process. The ICB was seeing a 50% reduction in relevant individuals attending primary care and a 30% reduction in attendance at Emergency Departments or contacting out of hospital emergency services, e.g. NHS111.

The process was also speeding up discharges. After each discharge there was a welfare check by primary care within seven days with any necessary changes to care packages made.

BERT had also resulted in high levels of staff satisfaction, reduced stress levels, and had supported solid relations to be built across teams.

In response to a query from TA, PG advised that an effective team with the ability to detect if people were engaging with health and social care services anywhere in the system was required. For example, an elderly/frail individual who had not seen their GP in six months was more likely to suddenly deteriorate and require intensive care and support, so having the ability to be proactive in supporting these individuals should start in primary care. However, there was variation across MSE and the ICB was looking at a commercial framework to support further implementation. In addition, the most recent changes to primary care contracts allowed variation to be addressed in a different way. Working across PCNs removed variation because stratification of the population addressed it by pulling patients into PCN offers. Also, the role of PCN Clinical Directors included using resources effectively, and consequently there was now less variation.

WG advised that through the GP action plan the primary care team was targeting the ten highest outliers in terms of metrics and developing action plans which were supportive or included reminding practices of their contractual obligations, which will be monitored.

In response to a request from MH, PG confirmed Cherry West at the Basilon hospital site was involved in this work and there were good models already in place at the Southend site. Managing Directors of each hospital site were engaged with the transformation work.
Dr Anna Davey and Christine Blanshard were considering how to attach consultants to each PCN, to ensure everything could be done in this space, including advice and guidance, demand management and co-ordination of frailty services. Frailty consultants who were interested had already reached out. One significant impact was that crisis management had reduced. PG was keen to achieve broad engagement with a wide range of colleagues to build relationships with primary care.

In response to a query from PS, PG advised that BERT was meant to increase access, which had occurred, but there was variability in terms of interactions and achieving the end result.

PS also asked whether there was anything to suggest our primary care offer was different from elsewhere and, in relation to BERT, was the whole population being looked at to identify its impact on secondary care.

In reply to PS's query regarding potential differences between primary care in MSE and other areas, PG responded there was a lack of GPs in some areas, and WG advised there was an ageing GP workforce with many working beyond normal retirement age, but that was probably the only material difference. WG also noted that the national trend was for practices to merge.

PG acknowledged identifying the impact of schemes was often challenging, but BERT was part of the strategic commissioning plan and had been demonstrated to work, including positive benefits for staff and a reduction in wasted time. ARRS roles needed leadership and without that a quantifiable benefit to the system would not be achieved. Therefore, GPs were needed to support a diverse workforce to case manage patients differently. This was the model the ICB was strategically working on to commission across MSE. PG noted that GP practices were independent businesses that could quickly reshape their workforce. Each time a patient returned to the practice, it was a cost to partners, so implementation of an efficient business model was beneficial and would have a larger impact as it was expanded.

TA advised there were now good examples of what worked well on a small scale which needed to be scaled up to operate consistently at whole population level to maximise benefits.

Resolved: The committee noted the Primary Care Services deep dive presentation.

Action 213: SO to share Primary Care Deep Dive presentation with SOAC members.

7. Update on Community Waiting Lists (Presented by S Hall and J Wilson)

JW advised that since the previous update, SH had worked hard to understand the available data and waiting lists. The report provided a summary of the current position in relation to autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD). However, due to high demand and limited capacity, it was acknowledged service models and pathways required significant redesign.

In response to a query from TA regarding the impact of actions, SH advised that considerable work had been undertaken with clinicians and operational managers on pathways. In relation to waiting lists, medication reviews would be focussed upon from September 2025 and it was anticipated the backlog should be addressed by the end of December 2025. Clear online information was available to sign post people to services, and a hotline was available for people to ask queries or raise concerns with most calls relating to individuals' place on the waiting list.

SH advised she was attending a conference looking at artificial intelligence and technology to enhance the front end of the pathways and was working closely with Clare Angell (Deputy Director Babies, Children and Young People, SEND & Specialised Commissioning and Senior Responsible Officer Learning Disabilities and Autism) at the ICB. SH confirmed that the data was now accurate, with southeast Essex having no 52-week breaches. However, backlogs remained in other locations.

It was agreed a further update would be provided in December 2025.

Resolved: The committee noted the update on community waiting lists.

8. Committee Escalations to SOAC / Triangulation (presented by T Abell)

8.1. ICB Main Committees

TA confirmed there were no escalations from ICB main committees to SOAC.

8.2 Other Committees/Forums

TA confirmed there were no escalations from other forums to SOAC.

Resolved: The committee noted that no escalations to SOAC had been received.

9. Escalations from SOAC (presented by T Abell)

9.1 SOAC to ICB / provider Boards

No escalations to the ICB or provider Boards were identified.

9.2 Provider Board escalations to ICB Board

No escalations from provider Boards were received.

9.3 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.

10. Review of Committee Effectiveness 2024/25 (presented by T Abell and S O'Connor)

As the meeting was not quorate, TA agreed that SO should recirculate the committee effectiveness review 2024/25, committee workplan for 2025/26 and revised Terms of Reference to members for virtual approval. If no comments were received within one week, all documents would be considered as approved.

Those present had no comments on these documents.

Resolved: The committee agreed that the committee effectiveness review 2024/25, revised workplan 2025/26 and revised Terms of Reference would be recirculated for virtual approval.

Action 214: SO to recirculate the committee effectiveness review 2024/25, workplan for 2025/26 and revised Terms of Reference to members for virtual approval with a covering note advising that of no comments are received within one week, all documents will be considered as approved.

11. Review of Effectiveness of this Meeting (presented by T Abell)

JK asked members for their views on the effectiveness of this meeting. No comments were received.

12. Any Other Business

No other business was discussed.

13. Date of Next Part I SOAC Meeting

Friday, 22 August 2025, 1.30 to 2.30 pm, via MS Teams.