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, 20 November 2025 at 3.30 pm – 5.00 pm

The Banqueting Suite, Tilbury Community Association, Civic Square, Tilbury, Essex, RM18 8AA

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	3.30 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	3.31 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	3.32 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	3.45 pm	Approval of minutes of previous Part I meetings held on: 4.1 18 September 2025 4.2 16 October 2025 (Extraordinary meeting)	Approve	Attached	Prof. M Thorne	 7 18
5.	3.50 pm	Matters arising (not on agenda)	Note	Verbal	Prof. M Thorne	-
6.	3.55 pm	Action Log: No outstanding actions	Note	Verbal	Prof. M Thorne	-
		Standing Items				
7.	4.00 pm	Chief Executive's Report	Note	Attached	T Abell	22
8.	4.10 pm	Quality Report	Note	Attached	Dr G Thorpe	27
9.	4.25 pm	Finance & Performance Report	Note	Attached	J Kearton	32
10.	4.40 pm	Primary Care and Alliance Report.	Note	Attached	E Hough	45
11.	4.55 pm	General Governance: 11.1 Board Assurance Framework 11.2 New and Revised Policies 11.3 Approved Committee minutes	 Note Note Note	 Attached Attached Attached	 T Abell Prof. M Thorne Prof. M Thorne	 52 67 69
12.	4.59 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-

No	Time	Title	Action	Papers	Lead / Presenter	Page No
13.	5.00 pm	Date and time of next Part I Board meeting: Thursday, 22 January 2026 at 3.30 pm - 5.00 pm*, in Function Room 1, Barleylands, Barleylands Road, Billericay, Essex CM11 2UD. *Time may be subject to change.	Note	Verbal	Prof. M Thorne	-

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - November 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
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 will declare my interest as necessary to ensure appropriate arrangements are implemented.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropraite arrangements can be made to manage any conflict of interest.
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.
Dawn	Scrafield	ICB Partner Member (Mid and South Essex Foundation Trust)	Mid and South Essex Foundation Trust	x			Direct	Interim Chief Executive Officer	01/11/25	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.
Dawn	Scrafield	ICB Partner Member (Mid and South Essex Foundation Trust)	Mid and South Essex Hospitals Charity		x		Direct	Chief Finance Officer of the Corporate Trustee	Apr 2020	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.
Dawn	Scrafield	ICB Partner Member (Mid and South Essex Foundation Trust)	Healthcare Finance Management Association (HFMA)		x		Direct	Member of the HFMA Trust Board	Nov 2021	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.
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.

Mid and South Essex Integrated Care Board
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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
Mike	Thorne	ICB Chair	Nil								N/A
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.

AGENDA ITEM 2

Mid and South Essex Integrated Care Board - Register of Interests of Regular Attendees at Board meetings - November 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.
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.
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.
Geoffrey	Ocen	Associate Non-Executive Member	The Bridge Renewal Trust; a health and wellbeing charity in North London		x		Direct	Employment	2013	Ongoing	The charity operates outside the ICB area. Interest to be recorded on the register of interest and declared, if and when necessary.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Professor and Director of the Vision and Eye Research Institute (Research and improvements in ophthalmology pathways and reducing eye related health inequality - employed by Anglia Ruskin University	31/03/23	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Director of Centre for inclusive community eye health. Lead for Grant to Anglia Ruskin University to improve eye health, prevent eye disease and reduce eye health inequality in mid and south Essex	01/05/23	01/04/27	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various Universities	x				PhD Examiner	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various grant awarding bodies UK and overseas		x		Direct	Grant reviewer	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Visionary (Charity)		x		Direct	Trustee	20/04/22	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	One World, One People - to support children in Third World countries to access eye operations		x		Direct	Chair Trustee	2021	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 an Optometrist	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.
Michael	Watson	Executive Director of Corporate Services	Nil								
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.

AGENDA ITEM 2

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

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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, 18 September 2025 at 2.00pm – 3.30pm

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

Attendance

Members

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

Other attendees

- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Mark Bailham (MB), 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.
- Pam Green (PG), Alliance Director (Basildon & Brentwood and Primary Care), MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Phil Read (PR), Associate Director Programme Management Office (PMO), MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.

- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Sarah Muckle (SMu), Partner Member, Essex County Council.
- Siobhan Morrison (SMo), Interim People Director, 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, and the recording of the livestream would also be available via the ICB website after the meeting.

Apologies were noted as listed above.

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

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

Declarations made by the Integrated Care Board (ICB) Board members and other attendees were in the Register of Interests within the meeting papers.

No other declarations were made.

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

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

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

Alberto Bonilla Miralles asked a question relating to details of patient numbers for mental health services which was referred to the Freedom of Information team.

Tricia Cowdrey asked a question relating to new housing developments and the ICB's capacity to keep up with demand**.** As the question did not relate to an item on the agenda, it would be responded to separately.

Clive Laing, PG Bradley and Marie Goldman asked what the ICB was doing to improve system performance, particularly non-urgent treatments, in light of recently published league tables. SG advised that the result of the league tables reflected pressures that the ICB were already aware of, and the priority remained on delivery. There was a focus on reducing long waits, extending diagnostic and surgical capacity and improving cancer and urgent care pathways. Patients should see progress over the next six to twelve months. The ICB was working with the hospital Trust on multi-faceted approaches to reduce waiting times for non-urgent treatments. Key actions included:

- Expanding clinical capacity through initiatives such as weekend working and increased utilisation of independent sector providers.
- Collaborating with neighbouring providers to establish mutual aid arrangements that supported patient flow and optimised available resources across the system.

- Streamlining care pathways to ensure patients progress more efficiently through treatment, reducing unnecessary delays.
- Prioritising patients with the longest waits to ensure equitable access and timely care.
- Focusing on high-demand specialties where waiting times were most acute, enabling targeted interventions that delivered the greatest impact.

The ICB recognised the challenges, and improvement work was underway, however significant challenges remained. Proven approaches from better-performing systems were being adopted, where appropriate, accelerating delivery within clinical teams.

Peter Lovett asked when the NHS was going to proceed with a new Health Centre in Ness Road, Shoebury, having already demolished the old hospital building.

PG explained that the ICB was committed to leading the development of primary care estate across Mid and South Essex (MSE). As part of the Medium-Term Plan (MTP), there was a dedicated programme focussed on maximising short-term opportunities for investing in the development of primary care premises alongside the development of strategic estates strategy. Through national utilisation and modernisation funding and local capital funding the ICB were committed to developing many primary care premises across all Alliance areas in 2025/26. The estates strategy not only ensured that primary care premises were fit for purpose but also that expansion of facilities was enabled to allow for the 'left shift' of care into communities. The ICB was working with stakeholders including local authority partners to optimise opportunities for the use of capital and revenue streams that enabled development of premises.

The ICB were aware of the long-term discussions around the provision of primary care premises in the Shoebury area and would ensure this was given full consideration.

Stuart Scrivener asked if the MSE Integrated Care Partnership (ICP) would continue under the 10-year plan roll out. EH advised that ICPs remained statutory bodies responsible for developing the joint strategy for improving the health, care and wellbeing of the local population. Going forward, the strategy would need to take account of the national 10-year health plan. This would be the case unless there was legislation to remove ICPs in the future.

Given the transition to the proposed Essex ICB, the ICB would be reviewing how the local ICP should evolve to support the health and care system in Essex. As part of that, the ICB recognised that Voluntary, Community, Faith and Social Enterprise (VCFSE) sector had a critical role in supporting neighbourhoods and addressing local health inequalities. The proposed new ICB and ICP would be committed to continue strengthening partnership working with the sector in planning and delivering health and care for the Essex population and was being considered as part of transition planning.

Peter Blackman referred to the ICB transition and queried the ongoing role of Alliances. TA advised that for the remainder of 2025/26, Alliances would continue to operate as key delivery vehicles for integrated care. Their role in supporting neighbourhood-level transformation, community engagement, and place-based commissioning remained unchanged. The ICB was committed to maintaining stability and continuity throughout this period, ensuring that local priorities, such as those in South Woodham Ferrers, were addressed effectively. The ICB would enter into arrangements with Suffolk and North East Essex (SNEE) and Hertfordshire and West Essex (HWE) ICBs to work collaboratively under

transitional arrangements on an 'Essex' footprint. While legal entities remained distinct during this phase, operational integration would commence.

Following Ministerial confirmation, the proposed Essex ICB would be created on 1 April 2026. From this point, a change in model and approach to Alliances was anticipated. As part of this, it was expected that the model of place-based delivery would evolve with more emphasis placed on provider led leadership at alliance and place, with the ICB moving to focus on the commissioning of those services. Alongside this, it was anticipated that the geographies of our place-based arrangements would be reviewed in light of any decision made around local government reform.

The ICB was committed to working with local communities to ensure the great work currently being delivered across MSE was maintained and would work with communities and partners on the evolving model over the coming months.

Kay Mitchell referred to recent reports from the NHS Confederation on ICB clustering and the expectation to reduce running and programme costs by 50% to become more efficient and reduce duplication by December 2025 and requested an explanation of where the duplication was and what this would mean for staff and service provision in Southend.

TA explained that the NHS Confederation's recent guidance confirmed that all ICBs, including MSE, were expected to reduce their running and programme costs by 50% by December 2025. This was part of a national effort to improve efficiency and reduce duplication across the system and to provide greater clarity on the roles and responsibilities of different parts of the NHS. An example of this duplication was given as overlapping assurance and performance management functions between ICBs, NHS England and other regulators such as the CQC. These changes aimed to address this and free up NHS resources for the front line.

Alongside this, there was an aim to transition ICBs to become 'strategic commissioners' which meant the organisation would focus on the design and purchase of health services which better met the needs of local residents, and supporting the delivery of commitments set out within the 10-year plan for health published by the Government. The ICB were working through the implications of this locally, and how to safely navigate this transition to minimise disruption to front line service delivery across MSE.

Caroline Donnison referred to the ICB communications strategy and services at St Peters Hospital and asked had the ICB written to local GPs in the Maldon (including the Witham surgery that Blackwater Medical Centre was linked with) and Dengie Peninsula. Furthermore, how could MSE ICB ensure communications were received by the wider population given it appeared that not even GP practices knew the percentage of patients who were successfully reached by email.

CH advised that the ICB were writing, or had written, to GP practices in the Maldon and Dengie area, including those linked with the Blackwater Medical Centre, to remind them of the services available at St Peter's Hospital and to ensure patients were being offered this option where appropriate. This formed part of the ICB's ongoing liaison with local practices and service providers about patient choice and the use of local facilities.

The ICB recognised the challenge of ensuring clear and consistent communication reached the wider population. Whilst a range of channels was used, including GP practice communications, local media, community groups, and digital channels, there was no single method that would reach everyone. The ICB continued to strengthen engagement with local

stakeholders, such as Save Maldon's Medical Services, to help reinforce messages within communities, as well as working with practices and the organisations providing services at St Peter's to ensure patients were informed of their choices when appointments were arranged.

The feedback from campaigns was valuable in highlighting the importance of ensuring residents were both aware of and confident in requesting care at St Peter's Hospital. The ICB would take this into account in any future communication and engagement activity.

Anonymous asked how was the ICB assured that there was sufficient capacity to support future campaigns, such as the 'high blood pressure' campaign. CH advised that when planning awareness campaigns, such as 'Know Your Numbers' (which focused on blood pressure and cardiovascular health), the ICB worked closely with clinical and operational colleagues to ensure that any potential increase in demand was considered as part of the campaign design. This included strong clinical input at the planning stage to ensure data and evidence was used to target the right audiences.

For 'Know Your Numbers', the ICB worked with system partners to ensure that additional checks could be delivered locally through a range of providers and locations, and that patients with high readings were referred to the most appropriate next step in their care pathway. This helped balance the benefits of prevention and early detection with the capacity available across services.

The ICB was grateful for the question, which highlighted the importance of linking communications and engagement activity to clinical planning and the need to work with colleagues across the system to ensure campaigns were effective and sustainable.

4. Minutes of the ICB Board Meeting held 17 July 2025 and matters arising (presented by Prof. M Thorne)

MT referred to the draft minutes of the ICB Board meeting held on 17 July 2025 and asked members if they had any comments or questions.

There were no further comments or amendments.

Resolved: The Board approved the minutes of the Part I ICB Board meeting held on 17 July 2025 as an accurate record.

5. Matters Arising (presented by Prof. M Thorne)

There were no matters arising.

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. Lampard Inquiry Update (presented by Dr M Sweeting)

MS advised that the Lampard Inquiry was a Statutory Inquiry into the deaths of mental health inpatients in Essex over recent decades. The ICB Board reaffirmed its commitment to openness, transparency and maintaining constructive relationships with the Inquiry team and partners. The ICB remained determined to learn from the findings to improve care for patients

and their families.

MS thanked PR for his leadership of the governance programme. The Board notes reassurance from robust governance structures, including sub-committees and joint working across SNEE and HWE ICBs. A clear safeguarding and escalation approach was in place, and proactive case reviews supporting the Inquiry within commissioning processes were positively received.

The Board noted that no new Rule 9 requests had been received and agreed that a further update would be provided at a future meeting.

PR confirmed that hearings scheduled for October would continue from July and would include witness statements from bereaved families. The Inquiry team emphasised that affected patients and families must remain central to its work and recommendations.

Resolved: The Board noted the Lampard Inquiry Update report.

8. Winter 2025/26 Assurance Framework (presented by S Goldberg)

SG presented the MSE Integrated Care System (ICS) winter plan for 2025/26, outlining the strategic and operational framework for managing seasonal pressures and ensuring safe, effective and timely care. The ICB led strategic coordination, supported by provider leads, with system leaders holding overall accountability. All Provider Boards had completed assurance processes and approved their plans, contributing to the wider system plan.

Operational delivery was led by the System Coordination Centre (SCC), co-located with the Integrated Care Transfer Hub (ICTH) team and the Unscheduled Care Coordination Hub (UCCH) teams to support patient flow and discharge. SCC operated seven days a week with out of hours cover by ICB and provider on-call directors. The SHREWD Resilience tool monitored real-time flow and capacity, enabling timely interventions. The Emergency Preparedness, Resilience and Response (EPRR) team managed incidents and oversaw the vaccination programme.

Seven priorities were noted:

- Governance, Leadership & Accountability
- Prevention, Vaccination and Community Care
- Urgent and Emergency Care Performance
- Mental Health Integration and Crisis Response
- Discharge, Admission Avoidance and Flow
- Digital and Data-Driven Improvement
- Workforce and Resource Management

System risks included demand, capacity, flow, and workforce. MSEFT's bed model indicated a winter bed deficit of 95-156, with mitigations underway across hospital sites, including Same Day Emergency Care (SDEC) centres and improved streaming. East of England Ambulance Services NHS Trust (EEAST) handover delays and NHS111 surge demand were noted as risks, with alternative pathways and hybrid rotas in place.

In response to JF, SG confirmed all actions were funded and explained SHREWD supported mutual aid and aligned to the OPEL framework. A system testing exercise was scheduled for 24 September 2025 with NHS England, East of England (EoE), followed by a regional and national review, on 7 October 2025.

In response to GO and MB, SG confirmed targeted vaccination strategies were in place to address health inequalities, with further work ongoing. A post-winter review would be undertaken and presented to Executive Committee and Board. The plan was described as a whole year approach, developed since spring and enhanced for winter.

MHar noted local authorities (LAs) would participate in the tabletop exercise; financial pressures were not specifically considered, but related risks were included. SHREWD historical data would validate assumptions and inform planning.

TA responded to GO highlighting low vaccine uptake among people with learning disabilities and recommended alternative approaches. SP suggested reviewing communication methods.

MHop noted improved system relationships and reduced delayed transfers, emphasising the need for urgent treatment centres at acute hospital front doors.

Resolved: The Board:

- **Noted the strategic approach outlined within the 2025/26 winter plan.**
- **Approved the 2025/26 Winter Plan and its implementation framework for deployment across the Mid and South Essex Integrated Care System.**
- **Endorsed submission of the ICB Winter Board Assurance Statement, acknowledging Provider Board approvals of individual winter plans.**

9. Quarterly Communications Performance Report (presented by T Abell and C Hankey)

CH reported that the Board quarter one (Q1) communications activity against the Communications Strategy. Campaigns on blood pressure checks within dentists and dental checks achieved strong media coverage. Targeted efforts increased spring COVID vaccination update by 15% in Southend and Thurrock Primary Care Networks (PCNs), and the 'Invincible Feeling, Invisible Danger' campaign, boosted pharmacy blood pressure checks.

Internal communications engagement rose during organisation transition, supported by the primary care bulletin and staff pulse surveys. External engagement grew, with higher website traffic, e-marketing subscriptions, and the virtual views platform reaching 1,000 subscribers. The vaccination survey achieved the highest response rate.

The Research Engagement Network (REN) expanded with new NHS England and the National Health Institute for Research (NIHR) funding, hosted successful community events, and piloted virtual Patient Participation Groups (PPGs) in seven practices with over 70 patients. CH confirmed the REN model focussed on building community relationships and funding local engagement programmes, overseen by Healthwatch Essex.

LW queried the absence of 'Choosing Well' in the winter plan; CH confirmed 'Help Us to Help You' remained the core message, supported by local campaigns such as 'Get the Care Quicker' and 'Pharmacy First'.

AD raised concerns about incidents of racial abuse directed at GP staff, particularly those from ethnic minority backgrounds. CH emphasised the importance of the NHS's diverse workforce and the need to reinforce this message. TA noted similar incidents were occurring across the NHS and confirmed that national messaging would be issued to address such behaviour. GT assured the Board that the matter had been escalated to NHS England and that a response was expected from the centre, emphasising collective responsibility to treat

all staff with compassion and respect. GW suggested a local campaign, referencing that of Barking, Havering and Redbridge University NHS Trust (BHRUT). GO highlighted that 'hate crime groups' were already in place. CH confirmed the issue would be raised with the Essex Communications Group and aligned with the British Medical Association (BMA) zero tolerance campaign.

Resolved: The Board:

- **Noted the strategic delivery and performance of communications and engagement activity during Q1 2025/26.**
- **Recognised 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.**
- **Endorsed 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**

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

TA presented the Chief Executive's report, which included an update on the ICB transition, with the proposed new Essex ICB scheduled for April 2026. NHS England's annual assessment of the ICB was noted, and an action plan would be developed to address areas for improvement. The NHS oversight framework and Q1 results highlighted performance challenges in Essex compared to other regions, and the organisation was asked to reflect on whether plans would deliver expected service improvements.

Cardiovascular disease prevention remained a priority. Published metrics showed significant improvement in hypertension treatment, with the ICB rising from 41st to 13th nationally, and achieving second highest performer in England atrial fibrillation (AF) treatment. MS reported that these improvements were projected to prevent at least 60 heart attacks, up to 100 strokes and 50 deaths over three years, generating system savings of over £2million.

MT acknowledged the considerable burden on the Chief Executive, Executive Team and staff during the transition and formally recognised their hard work and delivery of excellent services.

Resolved: The Board noted the Chief Executives Report.

11. Quality Report (presented by Dr G Thorpe)

GT presented the quality report**.** NHSE had deferred the Quality Summit, and the ICB would work with the regional team to arrange a new date. The CQC paediatric inspection report was published, and the ICB was working with MSEFT on the response and improvement plans.

The national Maternity and Neonatal Independent Senior Advocate (MNISA) pilot was closed following the launch of a new maternity and neonatal strategy and national investigation led by Baroness Amos. Families currently supported would transition back to the Trust with specialist support. The closure did not reflect on MNISA's work or pre-empt future decisions under the new strategy.

Several good practice documents were issued to support the Model ICB Blueprint for Continuing Healthcare (CHC), Special Educational Needs and Disabilities (SEND), statutory safeguarding and medicines optimisation. GT and MS were confirmed as Senior Responsible

Officers (SROs) to progress actions across this and the next financial year and support operational teams during consultation. In response to GO, GT confirmed close collaboration with LAs on SEND, noting statutory responsibilities remain under current legislation, with any changes requiring legislative reform. Broader collaboration across ICBs may be explored following government review. Strong partnerships with LAs and education providers were in place to support children with complex needs.

NIB reported opioid management was discussed at Quality Committee, noting national data showed usage 50% higher than expected. She welcomed current initiatives, including community pharmacy awareness, and suggested this as a future focus.

SP raised concern that health inequalities were not clearly reflected in the Model ICB Blueprint. EH confirmed addressing inequalities was a core commissioning ambition and should be embedded across all portfolios. A future Executive role was expected to include this responsibility. EH highlighted the need to strengthen analytics and population health management to target support effectively. Health inequalities would continue to be reported through the annual report, health inequalities report and specific reviews, including Trust waiting lists.

Resolved: The Board noted the Quality Report.

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

JK presented the joint Finance and Performance Report. At month 4, the ICB delivered to plan, with early indications of continuation into month 5. Risks had materialised, requiring mitigation. The most significant variance was in the acute setting due to higher activity, contributing to a £7million adverse movement, £6.5million of which arose from acute care. Regional escalation for MSEFT increased, and recovery actions were requested to support winter planning. The breakeven position remained the aim but was significantly challenged.

JF emphasised the importance of recovery, noting that failure to return to plan could impact future deficit funding. MHop reported Trust savings fell short, with pay and non-pay pressures and increased bank spend in medical staffing. Nursing costs improved, but medical staffing continued to drive the deficit. The turnaround team reallocated resources and implemented cost controls to improve the month 6 position, with phased withdrawal planned by March 2026. Their focus shifted to transformational change in theatres, outpatients and productivity, alongside embedding stronger controls. MHop stressed operating within budgets, noting that the Trust was a national outlier in bank doctor usage.

SG presented the performance updates. The Committee remained concerned about underperformance against national standards, though cancer pathways progress was noted. The ICB continued to support the acute trust through operational interventions, targeted funding, pathway redesign, and strengthened leadership. Capacity was expanded via independent sector partnerships and mutual aid, with Community Diagnostic Centres (CDCs) expected to improve diagnostics and reduce variation. Sustainable recurrent capacity was essential to address long waits.

JF noted fluctuating performance data and emerging negative trends. MHop confirmed NHS England's intensive support team focused on diagnostics and highlighted cultural change towards clinical ownership of waiting times. MT queried whether faster diagnosis could increase waiting lists; MHop responded this would indicate poor planning. MS referenced

CQC concerns on leadership and requested details of the Trusts cultural programme. MHop confirmed a Trust-wide organisational development programme was being launched with national funding to strengthen leadership capability and accountability.

Resolved: The Board noted the Finance and Performance Report.

13. Primary Care and Alliance Report (presented by P Green)

PG presented the Alliance report, focusing on South East Essex, and acknowledged the continued efforts of Alliance teams in delivering proactive care aligned with winter planning, quality priorities, and health inequalities. Highland Surgery was commended for achieving an outstanding CQC rating. Work continued on the medium-term financial plan for primary care, estates, and future commissioning, with alignment across Essex required.

Improvements in access and patient experience were noted, supported by pharmacy colleagues. The dental care home access project gained national recognition and informed future contract development. A pilot with schools engaged local dentists to improve children's oral health. The first dashboard outcomes for Integrated Neighbourhood Teams (INTs) were presented, with frailty mobilised in 17 of 24 INTs and case finder tools supporting proactive care. The ICB applied for the national Neighbourhood Health Implementation Programme; although unsuccessful, the work was positively recognised. Progress continued on the Sport England project in Canvey Island and the coastal community initiative, aligning investment plans to tackle health inequalities. The Better Care Fund underspend was redirected to support frailty and falls work.

AD queried the dental pilot's future; PG confirmed it was commissioned as business as usual and performing well against national targets. MS welcomed clear metrics and noted sustainable improvements in non-elective admissions and falls. PG highlighted progress outside the Electronic Frailty Care Coordination System (eFraCCS) tool and peer support for mid Essex INT mobilisation. GO commended securing £20m national funding for Canvey Island, building on successful work in Basildon. PG noted Sport England's focus on sustainable community development for wider health determinants.

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

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

14.1 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 discussed throughout the meeting.

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

14.2 Revised Constitution and Executive Committee Terms of Reference

The Board were presented with a revised ICB Constitution and Executive Committee Terms of Reference (ToR) following completion of the Executive Officer restructure for the proposed Essex ICB, which had resulted in a reduced number of Executive Officer positions.

The proposed changes to the ICB Constitution included removal of the position of Chief People Officer from both 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. The report highlighted that within the Constitution, the Director of Corporate Services, Director of Neighbourhood

Health and Director of Strategy were not members of the ICB Board. Those listed within the Constitution as 'attendees' at Board meetings had also been updated.

The membership within the revised Executive Committee ToR had also been updated to reflect the new Executive Officer structure, and its quorum reduced to three members.

MT confirmed that both documents had been supported through appropriate governance and asked if members had any comments on their content. There were no comments or questions raised.

Resolved: The Board approved the revised ICB Constitution, reflecting the revised Executive Officer structure for the proposed Essex ICB, and revised Terms of Reference for the Executive Committee.

14.3 Review of Board Effectiveness 2024/25

MT referred members to the report of the Board effectiveness review 2024/25 which was required to be undertaken annually. There were no comments or questions raised.

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

14.4 New/Revised Policies

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

- 021 Health & Safety Policy
- 026 Counter Fraud, Bribery and Corruption Policy
- 030 Business Continuity Policy
- 049 Maternity, Adoption and Paternity Policy.

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

14.5 Approved Committee Minutes

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

- Audit Committee, 15 April 2025, 23 April and 17 June 2025.
- Finance and Performance Committee, 1 July and 5 August 2025.
- People Board, 3 July 2025.
- Primary Care Commissioning Committee, 9 July 2025.
- Quality Committee, 27 June 2025.
- System Oversight and Assurance Committee, 27 June 2025.

Resolved: The Board noted the latest approved committee minutes.

15. Any Other Business

There were no items of any other business. MT thanked the members of the public for attending.

16. Date and Time of Next Board meeting:

The date and time of the next meeting was to be confirmed.

Minutes of the Part I Extraordinary ICB Board Meeting

Held on Thursday, 16 October 2025 at 12.30 pm – 1.15 pm

Via Microsoft Teams live webinar broadcast

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board.
- Tom Abell (TA), Chief Executive, MSE ICB.
- Jennifer Kearton (JK), Executive Director of Finance and Commercial, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Joe Fielder (JF), Non-Executive Member, MSE ICB.
- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Robert Persey (RP), Partner Member for Thurrock Council.
- Sarah Muckle (SM), Partner Member for Essex City Council.
- Dr Anna Davey (AD), Partner Member, Primary Care Services.

Other attendees

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSE ICB.
- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB.
- Samantha Goldberg (SG), Executive Director of Performance and Planning, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Viv Barker (VB), Director of Nursing, MSEICB, representing Giles Thorpe, Executive Chief Nursing Officer.
- Michael Watson (MW), Executive Director of Corporate Services, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Helen Chasney (HC), Corporate Services & Governance Support Officer, MSE ICB (minutes)

Apologies

- Dr Giles Thorpe (GT), Executive Director of Nursing, MSE ICB
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Siobhan Morrison (SM), Interim People Director, MSE ICB.

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

MT welcomed everyone to the meeting and explained that this was an extraordinary Board meeting required to consider for approval the transitional governance arrangements in preparation for the establishment of the proposed Essex Integrated Care Board (ICB) from 1 April 2026. MT noted his thanks to everyone who had been working to progress the new arrangements at pace.

The meeting was being livestreamed to enable transparent decision making; however, members of the public would be unable to interact with the Board during the meeting.

Apologies were noted as listed above.

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

MT noted the register of registers within the papers and advised there were no interests that would affect the proposals under discussion.

Those in attendance had an 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.

No further interests were declared.

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

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

There were no questions submitted by members of the public.

4. Transitional Governance (presented by Prof. M Thorne)

MT invited TA to outline the reasons for the proposed transitional governance arrangements.

Transitional joint working arrangements across Essex.

TA advised that establishment of the proposed Essex ICB as a statutory body from 1 April 2026 had been given national support. The proposed transitional governance arrangements would enable the current Mid and South Essex (MSE), Hertfordshire and West Essex (HWE) and Suffolk and North East Essex (SNEE) ICBs to work together to oversee the significant preparation work required to create the new ICB.

The proposals would support three key areas, these being:

- Governance arrangements, including the safe transfer of staff into the new organisation and an element of preparation for service harmonisation.
- Core planning across Essex, to agree how the new ICB would deliver the NHS 10 Year Plan and NHS England (NHSE) planning guidance, due to be published.
- Providing a mechanism to oversee commissioning decisions affecting the whole of Essex and to understand the impact these decisions could have on the new proposed ICB. There was also an opportunity for commissioning decisions to be harmonised across the three ICB areas.

The proposed transitional governance arrangements had previously been discussed with the Boards of all three ICBs. SNEE and HWE ICBs would formally consider the proposals for approval later in the month, following approval, the arrangements would create the Essex Joint Committee structure.

A draft Terms of Reference for a new Essex Joint Committee (EJC) had also been developed and shared with Board members to enable collective decisions to be taken forward until the proposed new ICB was established.

TA explained MSE, HWE and SNEE ICBs would continue to exist until 31 March 2026 but would delegate certain matters to the EJC. The EJC would be supported by three joint sub-committees being the Essex Executive Sub-committee, Essex Joint Finance and Performance Sub-committee and Essex Joint Quality Sub-committee. The ICBs' would not form joint committees for their Remuneration and Audit Committees, as would be contrary to legislation and their focus would remain on sovereign organisation matters, however there was a mechanism for them to meet in common if necessary.

The initial scope of the EJC included contract management, procurement, performance management, quality and safety, financial performance, mental health, leaning disabilities (LD), children and young people (CYP) and special educational needs and disabilities (SEND). TA noted there was a key opportunity for NHS and local authorities to improve the commissioning of LD, CYP and SEND services.

The membership of the EJC included five members of the new MSE ICB Executive Team, a representative from each of the three Essex local authorities, a primary care representative from each ICB, a Non-Executive Member from each ICB and Executive members from both HWE ICB and SNEE ICB.

Once the EJC was established, matters for future consideration would include how Place, Alliance and Health Care Partnership; planning and commissioning of neighbourhood health services; People and Digital Boards and their associated footprints interfaced with the EJC governance.

Regional collaborative working

NA advised that as well as working closely with HWE and SNEE colleagues, MSE ICB was working collaboratively with ICBs in the East of England region. A regional Memorandum of Understanding (MoU) setting out a collaborative working principles and a Data Sharing Agreement enabling data to be shared appropriately had been approved.

TA advised consideration was being given to common functions across geographies wider than Essex. Proposals were developing to create, within each NHS region in England, the Office of the ICBs to which regional commissioning responsibilities such as specialised commissioning and other services currently retained by NHSE, would transfer.

Due diligence in establishing the proposed new ICB

TA advised that MSE ICB was working with HWE and SNEE colleagues to identify roles that were 'Essex facing', determining staff who may transfer to the new ICB. Conversations with identified staff would commence in early November to prepare for the formal transfer.

MSE ICB continued to work with NHSE regarding running costs reduction and was considering a phased approach to organisational change over the remainder of the year.

TA summarised the four recommendations set out in the report. MT asked JK if she was confident the new arrangements would address financial requirements and asked MS if he was confident the quality and safety of services would be maintained.

JK advised that delivery of the financial control total continued to be the primary focus of MSE ICB. The new governance arrangements would not dilute this, and JK was therefore comfortable with the proposals.

MS confirmed Quality Committee would continue to meet, and GT had met with their counterparts from the other two ICBs.

GO asked to what extent the ICB was working with and supporting staff at this difficult time.

TA acknowledged that this was an incredibly uncertain time for all ICB colleagues. Staff members were kept informed via a variety of mechanisms including weekly staff briefings, which included an opportunity to ask questions; information on the ICBs' intranets. Several information sessions had been held on specific issues to support staff who were also made aware of the Employee Assistance Programme. The timeframe to complete reorganisation was still under discussion with NHSE.

MT noted that attendance at staff briefings was high at which TA responded to queries raised by staff in an open way.

Resolved: The Board:

- **Approved the terms of reference for the Essex Joint Committee and its associated sub-committee structure.**
- **Approved the revised Scheme of Reservation and Delegation.**
- **Delegated to the Chief Executive Officer the authority to approve the detailed terms of reference for the Essex Joint Committee sub-committees on behalf of the Board.**
- **Noted that further governance arrangements relating to People Board, Alliances, Digital and Data Committee and Primary Care Commissioning were being developed.**

5. Any Other Business

There were no items of any of business raised.

6. Date and Time of Next Board meeting:

The date and location of the next Part I Board meeting was to be confirmed.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, 20 November 2025

Agenda Number: 7

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 Integrated Care Board transition

Since the last meeting of the Board, we have appointed the following individuals to Executive Leadership roles for the proposed Essex Integrated Care Board (ICB):

- Dr Matthew Sweeting, Executive Medical Director
- Dr Giles Thorpe, Executive Director of Nursing
- Jennifer Kearton, Executive Director, Finance and Commercial
- Michael Watson, Executive Director, Corporate Services
- Emily Hough, Executive Director, Strategy

We have also concluded the appointments process for the role of Executive Director, Neighbourhood Health and I am pleased to report that Beverley Flowers will be joining us in December 2025 to take up this role. Between now and Beverley's starting date she will be working between us and the proposed Central East ICB to support transitional activities.

This has been a significant change for the organisation and unfortunately it has meant that some previous members of the Mid and South Essex ICB Executive Team have moved to alternative roles elsewhere within the region or have left the NHS, I would like to place on record my personal thanks for their contribution to Mid and South Essex and wish them all the very best for the future.

Board members are aware there had been a pause on further organisational change whilst negotiations continued nationally on the timeline and funding for the change process for teams below Executive Director level which are required to reshape the ICB to align with its changing duties and deliver the running cost reduction mandate. These negotiations have now concluded. I informed teams on 12 November 2025 that confirmation had been received that funding will be available to support the change process during this financial year. Consequently, we will now proceed with a consultation on the restructure of the teams that currently support Essex, which will be complemented by the launch of a voluntary redundancy scheme. We intend to commence this consultation next Wednesday, 19 November, and conclude in early January, subject to final Staff Side engagement and Renumeration Committee approval.

This clearly is going to be a difficult period for our people, particularly coming on the back of an extended period of uncertainty for all colleagues who work in ICBs. I therefore wish to place on record my appreciation for everyone's professionalism and commitment over the past nine months. We are committed to approaching the consultation process with transparency, compassion and fairness, ensuring everyone is kept informed at every step.

2.1 Medium term planning framework

"The Medium Term Planning Framework – delivering change together 2026/27 to 2028/29" was published by NHS England on 27 October 2025 and is intended to mark a shift away from some of the more recent planning practices of the NHS.

In particular, there is a focus on extending the planning horizon to a three-year period along with an ambition to empower local leadership and address some of the systemic issues facing the NHS. As part of the guidance, there is further clarity on the future operating model of the system, detailing the core ambitions of the NHS alongside steps required to begin to deliver on the ambition set out within the 10 Year Plan, such as building the neighbourhood health service.

The framework sets out ambitious improvements against a range of metrics including: achieving 92% of people waiting under 18 weeks for treatment by 2028/29; improving cancer 31 and 62-day standards to 96% and 85% respectively; reducing more than six-week diagnostic waits to 1%; achieving 85% of A&E attendances within four hours; and driving a sustained 2% year-on-year productivity improvement. The framework also prioritises strengthened neighbourhood teams, a digital-by-default care model via the NHS App, and a preventative shift in population health investment.

Some of the key implications for ICBs from this guidance are:

1. **Shift to multi-year planning:** ICBs must deliver three-year financial and operational plans aligned to national trajectories, moving away from annual bidding cycles.

2. **Local autonomy and accountability:** With changing roles within the NHS, ICBs can expect to gain greater control but also clearer accountability for productivity, outcomes, and financial balance.

3. **Neighbourhood health expansion:** ICBs must accelerate integrated neighbourhood teams and prevention-first models.

4. **Productivity and workforce:** ICBs are expected to take commissioning action to secure 2% annual productivity gains.

5. **Streamlined regulation:** A new operating model will reduce central bureaucracy, with performance oversight shifting toward outcome-based assurance at system level.

Work on our response to this has already commenced and we have issued draft commissioning intentions to providers across Essex which we will refine over the course of the next few months.

2.2 Strategic commissioning framework

We have also seen the publication of the Strategic Commissioning Framework on 4 November 2025 which positions strategic commissioning as the core role for ICBs in the future and defines it as *"a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term, with the aim of improving population health, reducing health inequalities and improving equitable access to consistently high-quality healthcare."*

The framework emphasises four sequential stages:

(1) understanding the context of the local population in depth
(2) developing a long-term population health strategy

(3) delivering the strategy through commissioning and resource-allocation functions
(4) evaluating impact and feeding the insights back into future commissioning decisions.

The framework also sets out a series of key enablers such as sophisticated analytics, strong partnerships with local government, provider collaboration and workforce capability to make this shift happen effectively.

In practical terms, the framework signals a move away from transactional, short-term contracting towards proactive, system-wide commissioning that spans prevention, community models, neighbourhood care and provider-led transformation.

ICBs are expected to adopt the approach from April 2026 onwards, supported by a Strategic Commissioning Development Programme, and begin baseline assessments and design of integrated needs assessments and five-year population health plans by early 2026.

2.3 Mid and South Essex NHS Foundation Trust – Care Quality Commission (CQC) well-led report

As Board members are aware, the CQC has published the findings of their 'well-led' inspection at Mid and South Essex NHS Foundation Trust (MSEFT) which rated the Trust as 'Inadequate'.

This is of significant concern to the ICB as the primary commissioner of services at the Trust. We are working alongside the Trust, and other regulators to seek assurance regarding improvement actions being put in place to resolve concerns identified by the CQC, alongside identifying support the ICB can provide to MSEFT in their improvement work.

2.4 The Hollies GP Surgery

Board members are aware that following the CQC taking immediate action at The Hollies GP Surgery in Hadleigh, there has been an interruption to normal services at this practice, which caused understandable frustration and uncertainty for patients registered at the practice.

I am very sorry for the disruption and have appreciated the patience of patients and stakeholders whilst we have worked hard, alongside other organisations, to restore services safely and sustainably.

At the time of writing, intense work was continuing with a new, temporary GP provider being in place with a partial restoration of services including:

- restoration of telephone lines and access
- provision of face-to-face appointments at alternative locations.
- commencement of non-urgent online consultations via the online consultation tool.
- processing of prescription requests.
- continuation of home visits.

Some significant practical challenges remain which have slowed progress, including difficulty accessing the building. These challenges are not the fault of the new provider who has been working tirelessly with our team and other partners to overcome these issues as quickly and safely as possible.

I would like to take this opportunity to remind patients who are registered at The Hollies that the latest verified information on the reopening of services and how to access care will always be published on the practice's website which is updated daily.

2.4 Other developments since my last report

There have been several other notable developments since my last report to the Board which include:

- The launch of a new partnership between the ICB, Thurrock Council and Impulse Leisure to provide two new programmes focused on Strength and Balance and Exercise on Referral – these are designed to help prevent falls and to support better outcomes for people living with a long-term condition.
- The launch of our new Cardiovascular Disease Detect and Prevent Programme which is an initiative to help GP practices across mid and south Essex to prevent cardiovascular disease, building on our previous programmes in this area.
- The opening of a new NHS dental location in Grays following additional dental commissioning undertaken by the ICB.
- The opening of the new Beaulieu Healthcare Centre, which is a new GP practice to support the population of Beaulieu and North Chelmsford.
- The opening of the new Thurrock Community Diagnostic Centre, which will provide thousands more tests and scans for the community of Thurrock and Basildon.

3. Executive Committee

Since the last report, there have been nine (9) weekly meetings (from 9 September 2025 to 4 November 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:

- Development of submission to National Frailty Improvement Programme
- Development and sign-off of the ICB's Commissioning Intentions for 2025/26
- Commissioned review of Community Eye Pathways for Essex.
- Commissioned 24/7 Crisis Text Service for all-ages across mid and south Essex.
- Review of the organisation's Talking Therapies services procurement.
- Approval of business case for development of an Unscheduled Care Coordination Hub (UCCH)
- Contract award for Community Dermatology and Teledermatology Services
- Contract award for Community Urology and Gynaecology Services
- Contract award for Specialist Fertility Services
- Review of the ICB's Decision Making Policy.
- Review of the ICB's Service Restriction Policies (SRPs).

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(s)

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

Part I ICB Board meeting, 20 November 2025

Agenda Number: 8

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 held on 7 November 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

- 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

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 updated date for the Quality Summit for Mid and South Essex NHS Foundation Trust
- Note the developments in relation to an updated National Quality Strategy, the National Quality Board's review of quality responsibilities, and the publication of a further good practice document, focussed on Infection Prevention and Control.

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 national updates in relation to the National Quality Board, Quality Strategy, Quality Responsibilities and an update in relation to a further good practice document focussed on Infection Prevention and Control.

2. Regulatory Update

Mid and South Essex NHS Foundation Trust

2.1. The Care Quality Commission (CQC) and NHS England (NHSE) have reconvened a Quality Summit for 12 December 2025, in relation to the ongoing quality issues raised in the Trust. It is expected that identification of further support required for the Trust to deliver a sustainable and systemic approach to quality improvement will be explored. The decision to move the date of the quality summit from 19 September to 12 December 2025 aligns to leadership changes which have occurred in the Trust, thereby allowing new executive members time to review and consider the concerns raised, so they are best able to respond fully and with due consideration to sustainability of action.

2.2. The Trust's Well Led Inspection report has now been published, and the ICB is working with the Trust to ensure that appropriate action is taken to respond to the recommendations and expectations outlined within the report. It is expected that the report findings will be discussed as part of the Quality Summit in December.

3. National Quality Board and National Quality Strategy

3.1. A renewed and rigorous focus on high quality care for all is one of the core themes of **Fit for the future: 10 Year Health Plan (10YHP) for England**. The 10YHP sets out a goal to universalise high quality care across the NHS through increased transparency and clearer accountability and by putting patient choice, voice and feedback at the heart of how we define and measure quality. It describes a revitalised role for the National Quality Board (NQB), which will oversee the implementation of a new national Quality Strategy to support this goal.

3.2. The Plan, together with the accompanying recommendations within Dr Penny Dash's Review of patient safety across the health and care landscape, also identifies a set of connected interventions designed to strengthen the system's collective capability to plan, assure, and improve care quality including:

- Creating the most transparent healthcare system in the world, where access to and use of data on care quality is dramatically increased and user voice and choice drives continuous feedback, learning and improvement.

- Setting clearer expectations and priorities - that reflect the principles of healthcare value - with the NQB providing a single and authoritative determination of quality.

- Clarifying accountability for quality and incentivising quality management and improvement, including through rewired financial flows.

- Increasing the use of technology to support quality management and improvement.

- Strengthening leadership and management of care delivery and quality throughout the healthcare system.

- Streamlining regulation, including a shift to a more intelligence-based regulatory approach.

3.3. The new NQB Quality Strategy will outline the approach that the NQB and its constituent organisations will take to deliver these shifts and serve as a call to action across the healthcare system to achieve the goal of high quality of care for all.

3.4. An Expert Reference Group has been convened to provide challenge, advice, and insight on the scope and content of the Quality Strategy. The Group will test the proposals for implementation and support wider engagement to ensure the strategy has credibility, ownership, and traction nationally. Positively, Mid and South Essex Integrated Care Board has been asked to form part of the Expert Reference Group.

Quality Responsibilities Mapping

3.5. In line with the ICB Model Blueprint and Regional Model Blueprint the National Quality Board is now consulting with stakeholders to more clearly define responsibilities at Provider, ICB, Regional and National levels; thereby offering clarity on the areas of focus that need to be delivered in 2026/27.

3.6. Currently in draft form, further consultation will take place with relevant leads for quality to finalise expectation of responsibilities moving forward, and these will subsequently be shared with the Essex ICB Joint Committee, as part of its delegated function, so that the proposed Essex ICB's quality functions can be developed and finalised.

4. Model ICB Blueprint – Good Practice Documents update – Infection Prevention and Control

4.1. A further ICB good practice document has been designed to provide greater clarity for ICBs on a fifth key functional area, namely Infection Prevention and Control (IPC). This is of particular importance given the time of year and expected prevalence of transmissible infections and system oversight and analysis required in the coming months.

4.2. As has been shared with the Board previously, 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. As with other areas identified within good practice documentation the ICB will work closely with 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.

4.4. The ICB's Executive Chief Nurse will be working with the IPC team to ensure that alignment with good practice document is achieved, and in line with other proposals, feedback will be offered to the wide Executive Team during Quarter 3, with the proposed Essex ICB Joint Committee appraised of plans to achieve expected deliverables in readiness for 2026/27, as part of its delegated function.

5. Recommendations

The Board is recommended to:

- Note the updated date for the Quality Summit for Mid and South Essex NHS Foundation Trust.
- Note the developments in relation to the proposed updated National Quality Strategy, the National Quality Board's review of quality responsibilities, and the publication of a further good practice document, focussed on Infection Prevention and Control.

Part I Board Meeting, 20 November 2025

Month 6 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 (Month 6, period ending 30 September 2025).

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

2. Executive Lead

Jennifer Kearton – Executive Director of Finance and Commercial
Sam Goldberg – Executive Director of Planning and Performance

Report Author

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

3. Committee involvement

The most recent finance and performance position was reviewed by the Finance & Performance Committee on 4 November 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 6. 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 (NHSE) provided deficit support funding of £106m as part of the planning process bringing the MSE System plan to breakeven. Deficit support funding, in cash terms, has been supplied for Q1 and Q2, but has been withheld for Q3 given the current financial position. The Q3 funding will be supplied with Q4 if the System position can be returned to plan by the end of Q3.

2. Key Points

2.1 Month 6 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB saw an increase of £2.37m between M5 and M6, £0.9m Cancer allocation, £0.6m Children and Young People Allocation and £0.6m additional allocations for Primary and Community uplift.

Table 1 – Allocation movements between month 5 and month 6

Allocations	Funding Stream	Current Month £m	Previous Month £m	Monthly Change £m
⊟ Recurrent	Programme	2,366.88	2,366.88	0.00
	Delegated - Specialised	300.23	300.23	0.00
	Co-Comm	258.44	258.44	0.00
	Delegated - DOP	117.37	116.80	0.57
	Running Costs	19.34	19.34	0.00
	Total	**3,062.26**	**3,061.69**	**0.57**
⊟ Non-Recurrent	Programme	218.10	216.29	1.81
	Delegated - Specialised	12.55	12.55	0.00
	Delegated - DOP	2.47	2.47	0.00
	Co-Comm	0.39	0.39	0.00
	Total	**233.51**	**231.71**	**1.81**
Total		**3,295.77**	**3,293.40**	**2.37**

The ICB position at M6 is in line with the planned position of a £3.0m year to date (YTD) deficit, (M6 £3.0m) driven by the profiling of planned efficiencies in-year. There are year to date (YTD) pressures in Acute (£1.5m), Continuing Care (£4.0m), Community Health Services (£3.4m) and Mental Health (£1.2m) 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 6.

Income/Expenditure	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m
⊟ Income	(1,671.96)	(1,671.96)	(0.00)	(3,295.77)	(3,295.77)	(0.00)
Allocation	(1,671.96)	(1,671.96)	(0.00)	(3,295.77)	(3,295.77)	(0.00)
⊟ Expenditure	1,675.04	1,675.04	0.00	3,295.77	3,295.77	0.00
Acute	798.33	799.81	(1.48)	1,542.65	1,542.88	(0.23)
Community Health Services	126.09	129.52	(3.43)	251.04	258.60	(7.57)
Continuing Care	90.37	94.39	(4.02)	190.34	198.53	(8.19)
Mental Health	155.72	156.90	(1.17)	307.15	310.01	(2.86)
Other Commissioned Services	8.00	(1.41)	9.41	15.56	(2.31)	17.87
Other Programme Services	7.26	7.01	0.24	15.86	15.91	(0.05)
Primary Care	318.98	318.56	0.43	636.92	636.31	0.60
Specialised Commissioning	158.74	158.74	0.00	312.75	312.75	(0.00)
Corporate	8.66	8.63	0.03	17.71	17.28	0.43
Hosted Services Admin	0.81	0.81	0.00	1.63	1.63	(0.00)
Hosted Services Programme	2.09	2.08	0.00	4.17	4.17	0.00
Total	3.09	3.09	0.00	(0.00)	(0.00)	0.00

2.2 M6 Efficiency Delivery

The M6 financial position includes delivery of £32.1m of YTD efficiencies, which is zero variance against plan. The ICB is forecasting to deliver the full £70.4m efficiencies in 25/26. The ICB efficiencies plan includes £66m of recurrent efficiencies

Tables 3 & 4 – summary of ICB efficiencies delivery for month 6.

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	15,447	15,380	(67)	31,809	31,366	(443)	(97)
All-age Continuing Care	1,497	879	(618)	4,676	2,200	(2,476)	(2,476)
Ambulance	822	822	0	1,643	1,643	0	1
Community Healthcare	3,696	3,510	(186)	8,030	7,751	(279)	(278)
Mental Health	3,351	3,351	0	7,318	7,318	0	2
Other Programme Services	942	3,476	2,534	2,290	5,861	3,571	4,236
Primary Care (inc. Primary Co-Commissioning)	4,356	4,230	(126)	9,769	9,258	(511)	(517)
Running Costs	252	452	200	500	2,700	2,200	504
Unidentified	1,737		(1,737)	4,349	2,287	(2,062)	(1,375)
Total	32,100	32,100	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	1,737	1,968	231	4,349	4,581	232
Recurrent	30,363	30,132	(231)	66,035	65,803	(232)
Total	32,100	32,100	0	70,384	70,384	0

2.3 ICB Risk

The ICB financial risk is reviewed as part of the month end closure and shows potential risk of £13.8m on the remainder of the year, with £11.9m of potential mitigations. The ICB assessment at M6 is in line with plan.

Category	Risk £m	Mitigations £m
Additional cost control or income (excl. ERF)		(1.45)
Additional cost risk (capacity, pressures, winter)	7.46	
Contract risk (excl. ERF)	2.57	
Non Recurrent Mitigations		(10.43)
Prescribing/CHC Risk	3.77	
Total	**13.79**	**(11.88)**

2.4 ICB Finance Report Conclusion

The ICB is delivering to plan at month 6 and forecasting 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 6 System Financial Performance

At month 6 the overall health system position was a deficit of £15.1m against plan. The deficit split is £0.7m EPUT and £14.4m MSEFT.

EPUT continue to face additional costs in year relating to servicing the current 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 have been developed and are being implemented.

With the significant movement from plan, our Provider organisations have been placed under additional scrutiny measures from our regional office of NHSE. Whilst neither organisation has formally changed their forecast outturn ambition for the 2025/26 financial year, the current run rate is frustrating ambitions to breakeven. Both organisations are working through their best, worst and most likely delivery for the end of the year, looking at recovery actions to support delivery to plan.

Table 5 – summary of the System position against the revenue resource limit for month 6.

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	(1,671,958)	(1,671,958)	0	(3,295,772)	(3,295,772)	0
Total ICB Net Expenditure	1,675,045	1,675,044	0	3,295,772	3,295,772	0
TOTAL ICB Surplus/(Deficit)	(3,087)	(3,087)	0	0	0	0
Income	(1,150,341)	(1,151,196)	(855)	(2,285,186)	(2,276,893)	8,293
Pay	717,579	734,246	16,667	1,412,015	1,413,725	1,710
Non-Pay	410,159	411,352	1,193	821,877	814,792	(7,085)
Non Operating Items	24,553	22,641	(1,912)	51,294	48,377	(2,917)
TOTAL Provider Surplus/(Deficit)	(1,950)	(17,043)	(15,093)	0	0	0
TOTAL ICS Revenue Resource Limit	(1,671,958)	(1,671,958)	0	(3,295,772)	(3,295,772)	0
TOTAL ICS Net Expenditure	1,676,995	1,692,087	15,093	3,295,772	3,295,772	0
TOTAL ICS Surplus/(Deficit)	(5,037)	(20,130)	(15,093)	0	0	0
Less Non-Recurrent Deficit Support Funding	(61,603)	(61,603)	0	(106,000)	(106,000)	0
ICS Surplus/(Deficit) excluding Non-Recurrent Deficit Support Funding	(66,640)	(81,733)	(15,093)	(106,000)	(106,000)	0

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 6 the system has delivered £77.5m of efficiencies against a plan of £91.8m, 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	32,100	32,100	0	70,384	70,384	0
EPUT	13,795	13,592	(203)	31,335	31,335	(0)
MSEFT	45,926	31,801	(14,125)	117,487	117,490	3
SYSTEM	**91,821**	**77,492**	**(14,328)**	**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 M6 position shows the system is £14.8m behind on the £54.0m plan submitted to NHSE, but forecasting to spend £0.6m more than the planned total by yearend.

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	29.46	10.85	18.61	79.33	81.42	(2.09)
EPUT	2.51	2.26	0.26	18.94	19.02	(0.07)
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Total	31.97	13.10	18.87	98.27	100.44	(2.17)
Internally Financed/System CDEL						
MSEFT	21.31	23.51	(2.20)	46.53	46.53	0.00
EPUT	0.47	2.70	(2.22)	17.19	6.32	10.87
ICB	0.31	0.00	0.31	2.41	2.67	(0.26)
Total	22.09	26.20	(4.11)	66.14	55.53	10.61
Total	54.07	39.30	14.77	164.41	155.96	8.44

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	0.00	0.00	0.00
Total	0.00	0.00	0.00	0.00	0.00	0.00

2.8 System Finance Report Conclusion

At month 6 the System needs to deliver significant recovery to deliver the breakeven outturn position. The System forecast outturn position for 2025/26 excluding deficit support funding totals £106m deficit.

Deficit Support Funding for Q3 cash has currently been withdrawn by NHS England. Should the System return to plan by the end of Q3, deficit support funding for Q3 and Q4 will be provided.

Despite the System continuing to forecast a breakeven outturn position at year end, the ICB Finance and Performance Committee have highlighted concern at month 6 that the overall health system position had deteriorated to £15.1m, a position that could be considered irretrievable by the year end. Financial recovery plans and actions are in train and we will continue to work closely as partners to deliver a view on the best, worst and most likely outcomes and consequences for the end of this year.

2.9 Urgent and Emergency Care (UEC) Performance

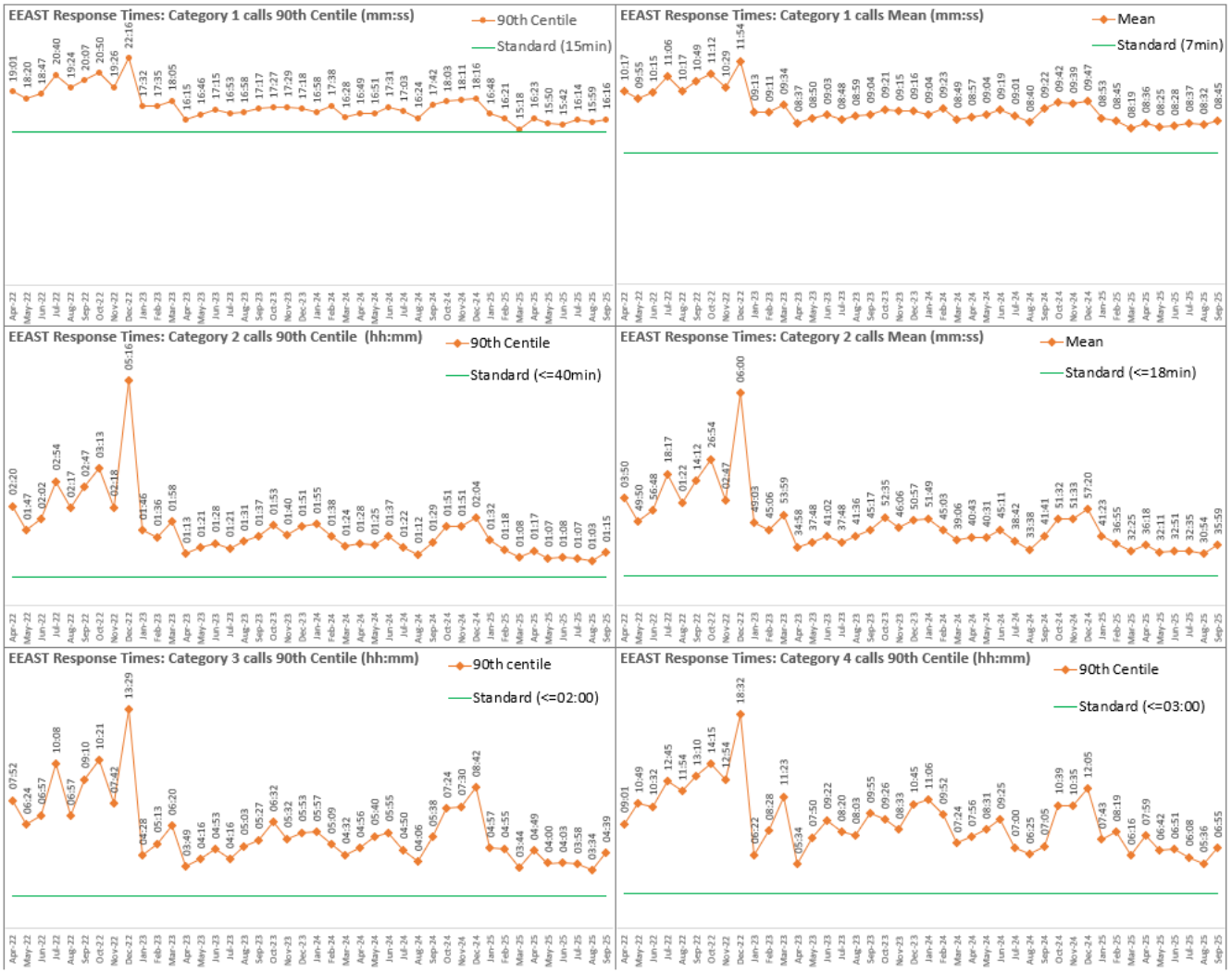
The Urgency Emergency Care (UEC) Oversight & Assurance Board oversees performance and planning for all UEC services (East of England Ambulance Service (EEAST), NHS111, A&E, Urgent Community Response Team (UCRT), Virtual Wards, Mental Health Emergency Department (ED) and has members from both health and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

Ambulance Response Times

Standards:

- Category 1 (life-threatening calls)**:**
  – Average response time: 7 minutes
  – 90th percentile: within 15 minutes
- Category 2 (serious/emergency calls)**:**
  – Average response time: 18 minutes
  – 90th percentile: within 40 minutes
- Category 3 (urgent but not life-threatening)**:**
  – 90% of calls responded to within 120 minutes (2 hours)
- Category 4 (less urgent)**:**
  – 90% of calls responded to within 180 minutes (3 hours)

The response times standards for EEAST listed above have not been met as shown in the following graphs.



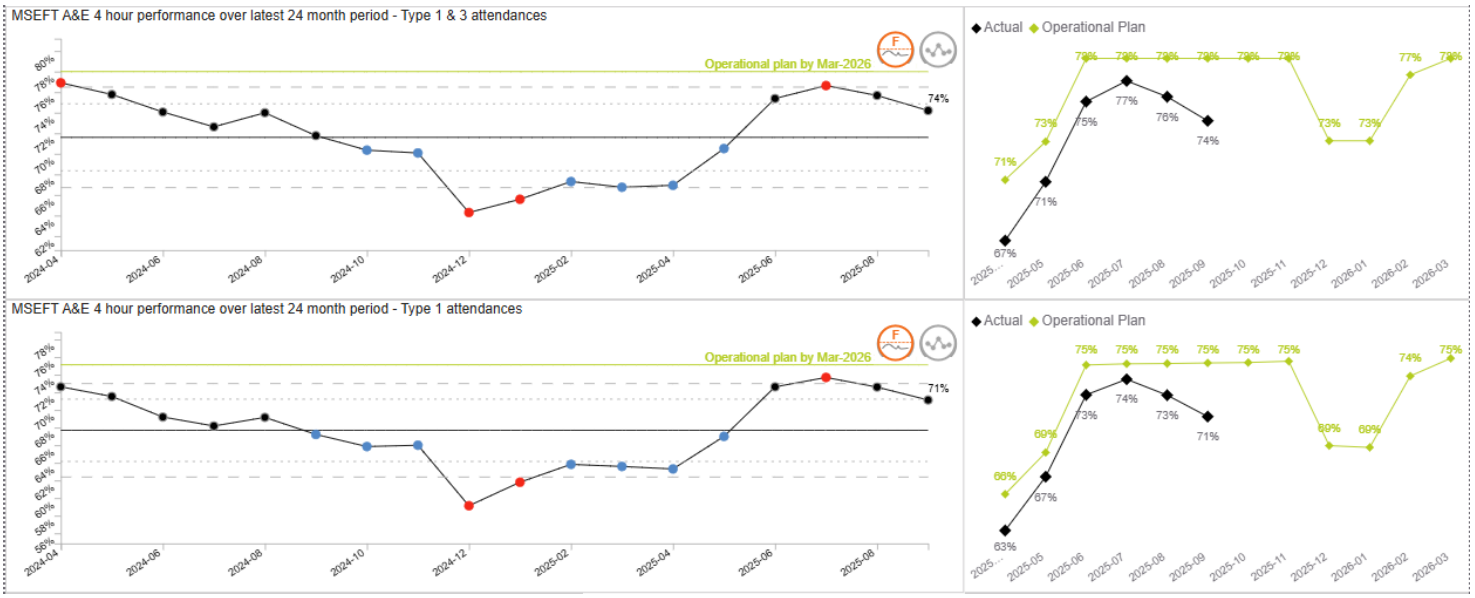
Emergency Department – waiting times

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 year to date

(graph below top right). Overall performance (type 1 & type 3 attendances) for September was 74% with common cause variation (graph top left). 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.

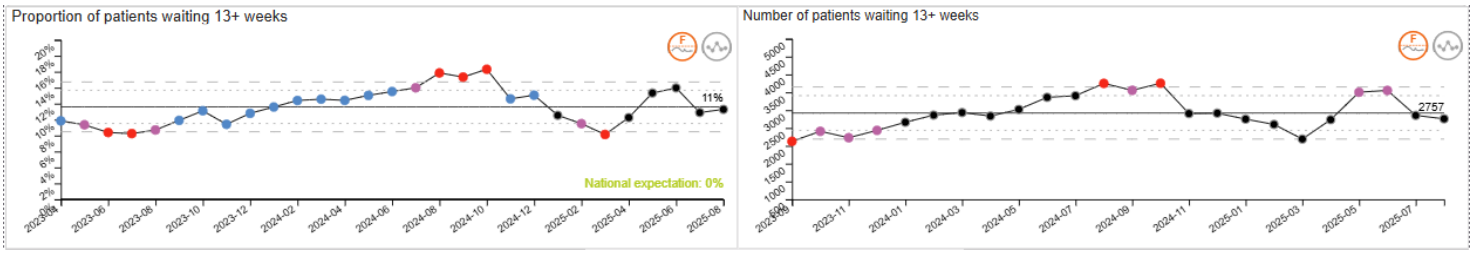
Diagnostics Waiting Times

Standards:

- 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) and vary between 8% and 15% (between 2,190 and 3650 patients).



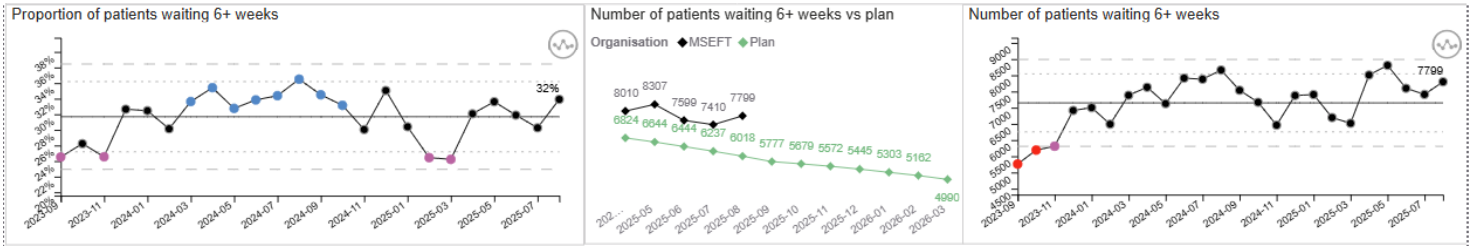
The following table shows the number and proportion of patents waiting 13+ weeks by diagnostic test (August-2025).

13+ weeks

Test	Number	Proportion	
CYSTOSCOPY	81	43%	
FLEXI_SIGMOIDOSCOPY	159	39%	
SLEEP_STUDIES	169	38%	
PERIPHERAL_NEUROPHYS	175	34%	
GASTROSCOPY	365	32%	
COLONOSCOPY	500	32%	
NON_OBSTETRIC_ULTRASOUND	981	17%	
URODYNAMICS	4	15%	
ECHOCARDIOGRAPHY	234	7%	
DEXA_SCAN	51	5%	
AUDIOLOGY_ASSESSMENTS	12	1%	
MRI	25	0%	
CT	1	0%	
Total	**2,757**	**11%**	**11%**

Diagnostics waiting 6+ weeks

There has been no significant change in the proportion of patients waiting over six weeks with August position at 32%. The proportion can be expected to be around 30% (mean) varying between 23% and 36% (graph below left). The reduction in 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 (August 2025).

6+ weeks

Test	Number	Proportion	
PERIPHERAL_NEUROPHYS	395	77%	
SLEEP_STUDIES	276	62%	
CYSTOSCOPY	101	53%	
FLEXI_SIGMOIDOSCOPY	217	53%	
DEXA_SCAN	471	50%	
COLONOSCOPY	711	46%	
GASTROSCOPY	508	45%	
ECHOCARDIOGRAPHY	1,346	41%	
NON_OBSTETRIC_ULTRASOUND	1,944	33%	
URODYNAMICS	8	31%	
MRI	1,612	22%	
AUDIOLOGY_ASSESSMENTS	92	10%	
CT	118	6%	
Total	**7,799**	**32%**	**32%**

Cancer Waiting Times

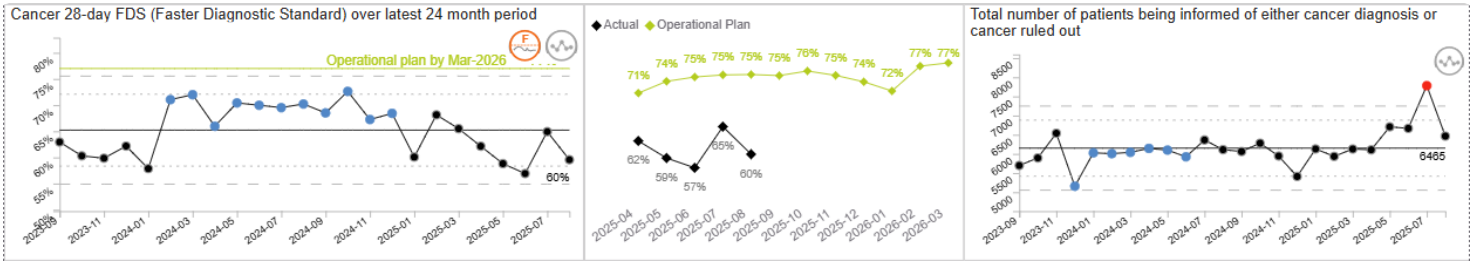
Standards: For people with suspected cancer:

- 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 show the MSEFT monthly performance for the 28-day Faster Diagnosis Standard. Performance YTD has not met the operational plan (graph below middle) with no significant change (graph below left). The number of patients being informed of either cancer diagnosis or cancer ruled out is back in line with historic average after the significant increase experience in July (graph below right).

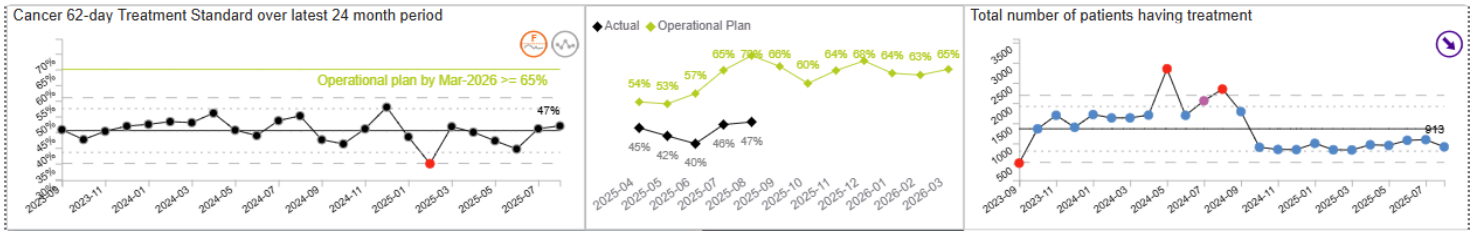


The following table shows the number informed, and proportion informed within 28 days by tumour site pathway (August-2025).

By tumour site			
Metric_Description	Total	Within 28 days	Proportion
Suspected haematological malignancies (excluding acute leukaemia)	25	5	20%
Suspected head & neck cancer	420	178	42%
Suspected gynaecological cancer	656	320	49%
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	47	24	51%
Suspected breast cancer	1,022	531	52%
Suspected cancer - non-specific symptoms	33	18	55%
Suspected skin cancer	2,216	1,383	62%
Suspected urological malignancies (excluding testicular)	417	265	64%
Suspected children's cancer	29	19	66%
Suspected testicular cancer	9	6	67%
Suspected lower gastrointestinal cancer	1,120	750	67%
Suspected upper gastrointestinal cancer	346	250	72%
Suspected lung cancer	123	100	81%
Suspected sarcoma	2	2	100%
Total	**6,465**	**3,851**	**60%**

Cancer waiting times – 62 day general standard

The following graphs show the MSEFT 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
Head & Neck	31	9	29%
Breast	154	50	32%
Gynaecological	37	13	35%
Other (a)	33	13	39%
Lung	86	34	40%
Urological - Other (a)	57	24	42%
Haematological - Lymphoma	30	14	47%
Upper Gastrointestinal - Oesophagus & Stomach	24	12	50%
Lower Gastrointestinal	99	51	52%
Urological - Prostate	133	72	54%
Skin	193	109	56%
Upper Gastrointestinal - Hepatobiliary	23	17	74%
Haematological - Other (a)	13	11	85%
Total	**913**	**429**	**47%**

The Trust is in national oversight Tier 1 for cancer performance, with recovery trajectories and schemes to return to trajectory in January 2026.

Referral to Treatment (RTT) Waiting Times

Standards:

- The constitutional standard is starting consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. Since the significant increase in waiting times following the global pandemic the NHS is working to eliminate waits of over 65 weeks by September 2024 as outlined in the 2024/25 Operational Planning guidance.

The national expectation to have zero patients waiting over 65 weeks has not been achieved (graphs below top left and right) and increased to a significant number of patients in August-2025.

The number of patients waiting 52+ weeks is not meeting operational plan and increased significantly (graphs below bottom left and right).

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

Number and proportion of patients waiting 65+ weeks

Specialty	65+ weeks	Proportion
Trauma and Orthopaedic Service	906	5%
Ear Nose and Throat Service	330	2%
General Surgery Service	188	2%
Other - Paediatric Services	170	4%
Oral Surgery Service	138	2%
Other - Medical Services	127	1%
Gastroenterology Service	113	1%
Urology Service	101	1%
Dermatology Service	78	1%
Other - Surgical Services	55	1%
Gynaecology Service	51	0%
Plastic Surgery Service	51	1%
Neurology Service	38	1%
Other - Other Services	22	1%
Ophthalmology Service	20	0%
Rheumatology Service	6	0%
Neurosurgical Service	2	2%
General Internal Medicine Service	1	0%
Cardiology Service	0	0%
Elderly Medicine Service	0	0%
Other - Mental Health Services	0	0%
Respiratory Medicine Service	0	0%
Total	**2,397**	**1%**

Number and proportion of patients waiting 52+ weeks

Specialty	52+ weeks	Proportion
Trauma and Orthopaedic Service	2,841	16%
Ear Nose and Throat Service	1,734	11%
Dermatology Service	1,684	11%
Gastroenterology Service	900	8%
Oral Surgery Service	853	14%
Other - Medical Services	804	5%
General Surgery Service	791	8%
Gynaecology Service	743	5%
Other - Paediatric Services	655	14%
Urology Service	610	6%
Ophthalmology Service	499	4%
Plastic Surgery Service	446	7%
Other - Surgical Services	366	6%
Neurology Service	312	5%
Rheumatology Service	255	9%
Other - Other Services	193	5%
General Internal Medicine Service	64	3%
Neurosurgical Service	15	15%
Cardiology Service	12	0%
Elderly Medicine Service	4	0%
Respiratory Medicine Service	3	0%
Other - Mental Health Services	0	0%
Total	**13,784**	**8%**

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 Psychological Therapies (IAPT)

Standards include:

- 75% of people referred to the improving access to psychological 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 Mid and South Essex (latest position: August 2025).

Early Intervention in Psychosis (EIP) access

Standard:

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

The EIP access standard is being sustainably met across Mid and South Essex (latest position: August 2025).

3.0 System Performance Report Conclusion

The System has in place oversight groups whose core concern is the delivery of the constitutional targets or Operational Plan delivery. Performance is reviewed and progress monitored with escalation to the MSE ICB Finance and Performance Committee as required.

Across the System there remains a challenge in achieving delivery of the Constitutional Standards in 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.

4.0 Recommendations

The Board is asked to receive this report for information

Part I ICB Board Meeting, 20 November 2025

Agenda Number: 10

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

Emily Hough, Executive Director, Strategy

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

Access

The ICB has been working closely with practices to ensure that GP practices are compliant with the new contractual requirements that came into effect on 1 October 2025. This includes access to online consultations during the full working day. Work continues to support practices that have relatively recently implemented total triage systems and other aspects of Modern General Practice.

With the exception of one practice, all practices in Mid and South Essex have online consultation systems on offer. There is a technical issue in relation to this practice. This is expected to be fully resolved by end of November.

A key national metric is the percentage of appointments offered within 14 days of contacting the practice. As of September 2025 (latest reported data):

Nationally 81.8% of consultations were undertaken within 14 days
Within Mid and South Essex ICB, 82.2% of consultation were undertaken within 14 days.

The Hollies Surgery, Hadleigh

On 30 October 2025, the Care Quality Commission (CQC), which regulates health and care services, issued an urgent notice under Section 31 of the Health and Social Care Act 2008 to temporarily suspend the registration of the practice as a service provider for up to six months.

This action was linked to issues raised in previous CQC inspections and resulted in the temporary closure of the practice on Friday, 31 October 2025.

A new temporary GP provider is now in place to ensure continuity of care for patients at The Hollies.

However, there have been significant practical challenges which have slowed progress, including difficulties accessing the building.

The ICB's website contains further information on the position and a verbal update can be provided to the Board.

New Beaulieu Health Centre Opens

Residents in North Chelmsford are to benefit from enhanced access to GP and other clinical appointments as the new Beaulieu Healthcare Centre officially opened its doors on Monday, 10 November 2025.

Located in Beaulieu Square, the new-build healthcare centre will operate as a branch surgery of nearby North Chelmsford Healthcare Centre. It is open to the practice's existing patients as well as new patients wishing to register

Learning Disability Friendly Practice

Audley Mills Surgery in Rayleigh is the first GP practice in mid and south Essex (MSE) to be accredited Learning Disability Friendly. The practice has been recognised for its efforts to better support patients with learning disabilities after successfully completing the accreditation process. The Learning Disability Friendly GP Accreditation Scheme aims to encourage more practices to review and enhance care delivered to learning disability patients. The aim is to ensure services are equitable for those accessing them, minimising barriers into healthcare via a supportive approach.

Primary Care – Pharmacy

Pharmacies have fulfilled a greater role in the ICB's winter vaccination programme than previous years. Pharmacies continue to provide COVID and flu vaccinations but a greater number are also delivering Respiratory Syncytial Virus (RSV) vaccinations and 2-3 year old flu vaccinations.

The ICB has been working with community pharmacies on local campaign programmes as part of their national framework obligations.

Primary Care – Dentistry

National 700K appointments target: MSE ICB's target is an additional 6,098 Urgent band 1.2 Units of Dental Activity (UDAs) in 2025/26. We are on track to deliver more than that figure.

As part of the National Dental Care Incentive Scheme, 55 of our 117 dental practices have expressed an interest. If all 55 contracts deliver the required number of 1.2 UDA it will deliver 12,969 additional 1.2 UDA appointments by 31 March 2026. If practices deliver to the 70% requirement and receive a 50% payment this will deliver 9,105 additional 1.2 UDA appointments. Consequently, we expect that between November 2025 and March 2026 we will overdeliver against our portion of the 700K national target.

2024/2025 Commissioned UDA outturn:

- Commissioned UDAs 1,806,844.00
- Delivered UDAs 1,823,013.64
- Percentage achieved 100.9 %

A new dental practice was opened on Monday 3 November 2025, Grays Dental Practice on Milton Road, as part of the Harunani Group that also operates the nearby St Clements Dental Care practice. A key feature of the new practice is a bariatric dental chair, which is used to support heavier patients who may struggle to access standard dental facilities. Two new dentists have been recruited, and team members from St Clements Dental Care will also work from the new site to support continuity of care for local patients.

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 have continued the work to support at-scale delivery of frailty and improved end of life care via Integrated Neighbourhood Teams (INTs) to support the MTP.

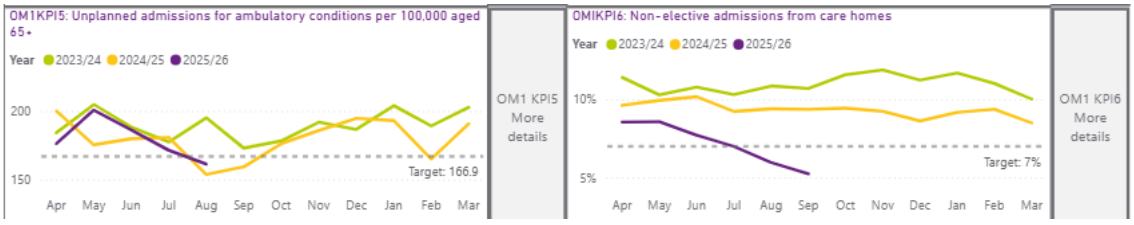
Progress so far is as follows:

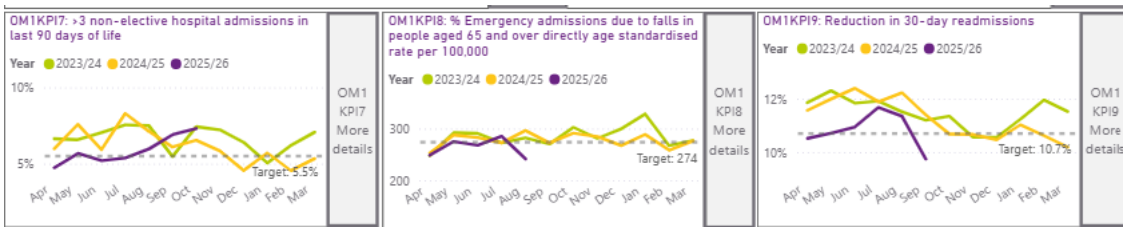
- 18 out of our 24 INTs already have a full or partial focus on frailty and end of life (EoL) care within their model. The remaining teams are working to implement the frailty and EoL framework as the focus for 2025/26
- Our INT Cohort Finder and Case Finder tools are now live on Athena to support INTs to identify residents who would benefit from an INT model approach. Training has been delivered to INT teams to support use with 20 out of 25 Primary Care Networks (PCNs) now having signed up to access Athena.
- Peer support between PCN Clinical Directors who have implemented INTs and those that have not, have remained a way of sharing learning.

We continue 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.

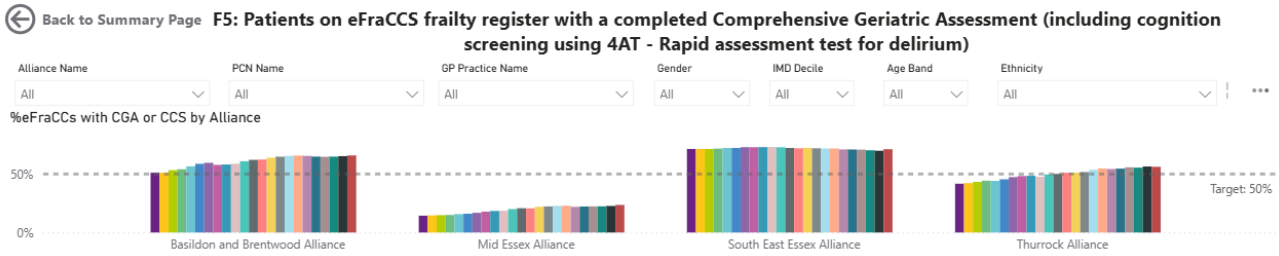
Across our key performance indicators (KPIs) we are showing an improved trajectory from the pattern last year for:

- 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
- 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, Mid Essex have made modest improvements, and have been working with primary care and community health teams to build upon this as part of future working



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 (NNHIP)

This programme has now commenced across the 43 wave one neighbourhood pilot sites, and whilst we do not have any pilot sites across MSE, we are working closely with colleagues from West Essex and North Essex who are part of the wave one programme. This includes sharing of successful bids and best practice from all areas. There is a robust programme structure in place, directed by the national team, and MSE is following the same workplan by shadowing colleagues in West and North Essex. This includes establishing a baseline of current information such as data availability, existing partnerships, local assets, risk stratification tools, current delivery models and local leadership.

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. Importantly, this is not an ICB or health only programme. The national narrative is explicit that social care and wider partners within the place have a role and accountability to embed this new way of working.

Aligned to this we are expecting the publication of a ‘Model Neighbourhood’ and a ‘National Framework for Neighbourhood Health’ in November, which will describe the key actions ICBs need to take, working with partners, between now and April 2026 and during 2026/27. In advance of this, each Alliance is currently working with partners to develop thinking and ideas relating to future Neighbourhood Health services and engaging on neighbourhood footprints. Neighbourhoods are expected to cover populations of approximately 50,000, be geographically aligned and, importantly, meaningful to people and partners. This work will be carried out during November with the intention of collating all feedback in December.

Pride in Place

The Pride in Place Programme is a decade-long national initiative aimed at revitalising up to 339 of the UK's most deprived neighbourhoods. It focuses on hyper-local areas with high deprivation and weak social infrastructure. The programme empowers communities by placing decision-making in the hands of local residents, businesses, and organisations, supported by local authorities. Available funding will support improvements to high streets, parks, public spaces, and community hubs, with a strong emphasis on social cohesion, local empowerment, and long-term transformation.

Previously part of the Towns Fund under the former administration and more recently known as the Plan for Neighbourhoods, the programme has now been rebranded as 'Pride in Place'.

This is also a significant opportunity to improve the health and wellbeing of our local populations. By investing in the physical environment and creating spaces that support social connection, physical activity, and access to services, the programme will help foster healthier, more active communities.

Canvey Island was awarded funding as part of the original launch and in the most recent phase of the programme three further areas in Mid and South Essex have been selected to benefit from the initiative, Shoebury in Southend and Chalvedon and Laindon in Basildon. Each area will receive up to £20 million over a 10-year period to support long-term, community-led regeneration. The Alliances will work closely with local leaders to shape and influence the place-based plans, ensuring an embedded focus on improved health and wellbeing.

South East Essex Alliance – Coastal Navigators Network

The South East Essex Alliance has made significant progress in establishing the Coastal Navigators Network for Canvey and Southend. An inception workshop was successfully held at the end of September 2025, bringing together key stakeholders to shape the network's purpose and priorities. We are pleased to confirm the appointment of a Senior Responsible Officer (SRO) from Castle Point Borough Council to provide strategic leadership for this initiative.

Following the network's launch event in mid-October, SROs agreed that our collaborative efforts will focus on supporting the delivery of **Integrated Neighbourhood Teams**, with a clear emphasis on **Frailty**, **Dementia**, **End of Life care**, and **Care Technology**. This alignment ensures that our work directly addresses the needs of residents in coastal communities, improving health outcomes and quality of life.

The Alliance is committed to working with partners across the network to define shared ambitions and measurable outcomes, ensuring that this initiative delivers meaningful impact for our population.

Better Care Fund

The Better Care Fund (BCF) teams have completed the quarter 2 (Q2) submission to the national team, including refreshing the BCF metrics and updating and confirming the financial allocations and spend in Q2.

Financial spend is on track for delivery in all three local authority (LA) areas for Q3 with the majority of metrics on track for delivery. We are working with colleagues in Mid and South Essex NHS Foundation Trust (MSEFT) to improve the national reporting of the discharge ready date data as the quality of this is not currently meeting the national reporting requirements. This is being led by the Integrated Transfer Care Hub team.

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, which is now fully live across MSE, with new providers being mobilised in October and November.

In September, Trust Links launched a new mental health and wellbeing app, funded through the Castle Point and Rochford BCF. The app is designed to provide accessible, community-based support for mental health, offering tools, resources, and signposting to local services. It supports users in managing their wellbeing through self-help content, peer support features, and connections to Trust Links' wider network of services. Since its launch, the app has already attracted over 500 subscribers, demonstrating strong early engagement and demand. This digital initiative complements existing face-to-face services and forms part of a broader strategy to improve mental health outcomes across the area.

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, a strategic review of the overall expenditure from Thurrock BCF is subject to an 'all system' meeting later in November, in response to the developments around neighbourhood health.

There is recognition that LA re-organisation and devolution, and changes to ICB boundaries and responsibilities might affect funding flow and the work undertaken in the BCF space. Pre-planning has therefore commenced with LA colleagues within the realms of information currently available.

2. Recommendation

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

Part I ICB Board meeting, 20 November 2025

Agenda Number:

Board Assurance Framework (BAF)

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.
Michael Watson, Executive Director of Corporate Services

3. Report Author

Sara O'Connor, Senior Corporate Services Manager
Executives have updated BAF slides within their remit.

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 assurance 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 includes seven strategic risks all of which are currently rated red, with their scores (red risks are those scored between 15 and 25):

- Workforce (16)
- Primary Care (16)
- Primary Care Estates (Capital) (16)
- Quality Assurance of Services (reduced from 20 to 16)
- Access to Services (16)
- System Financial Performance (16)
- ICB Transition (16)

Members are asked to note that BAF risks scores are decided by Executive Leads - they are not aggregate / average scores of the associated individual risks recorded on Datix (and listed on the BAF slides).

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

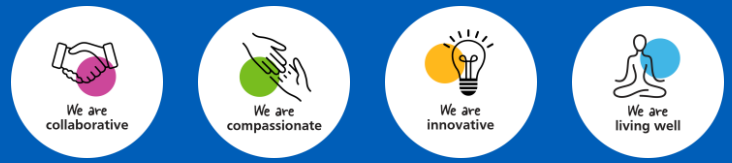
Appendix 1 - Board Assurance Framework, November 2025.

NHS
Mid and South Essex

Appendix 1

Board Assurance Framework

November 2025



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.	M Watson / 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'.	Exec Director of Neighbourhood Health	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 / Exec Director of Neighbourhood Health	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.	Dr G Thorpe	Quality Committee / Quality report	**4 x 4 = 16** ⟺
5.	**ACCESS TO SERVICES** There is a risk that patients experience poor access to services (health inequality), a lack of timely intervention (according to constitutional standards), deconditioning, poor experience and outcomes or harm. | This is caused by waiting list backlogs, non-delivery of operational planning requirements, lack of capacity in service delivery and supporting services such as diagnostics and poor data. | This could lead to reputational damage, regulatory scrutiny, increase demand on ICB functions and increased financial pressure.	S Goldberg	Finance & Performance Committee (FPC)/ Finance and Performance Monthly update report.	**4 x 4 = 16** ⟺
6.	**SYSTEM FINANCIAL PERFORMANCE** There is a risk that organisations within the system control total do not deliver the required financial plans / efficiency savings. | This is caused by grip and control, capacity to manage, unforeseen cost pressures and lack of join up across all functions within the organisations. | This could lead to increased scrutiny by regulators, reputational damage and a potential changes to service delivery.	J Kearton	FPC / Finance and Performance Monthly update report.	**4 x 4 = 16** ⟺
7.	**ICB TRANSITION** There is a risk that the creation of a new ICB geography and organisation at reduced cost will not be able to deliver core functions and transformational changes required by the MTP. | This is caused by an expected reduction in capacity, at a rapid pace that will detract staff from delivery as they engage in workforce redesign and consultation during a period of significant national change and cost saving requirements across the NHS. | This could lead to disengagement of staff, a failure to maintain strategic commissioning functions that could ultimately result in potential harm to residents, poor experience and reputation damage, with resulting increased regulatory scrutiny.	T Abell	Transition Committee / Chief Executive Report	**4 x 4 = 16** ⟺

BAF

Risks recorded on Datix that make up our BAF and their scores (Impact x Likelihood)

	Workforce	4 x 4=16
21	Primary Care (PC) Workforce Recruitment and Retention (R&R)	4 x 3=12
145	System Workforce Sustainability	4 x 4=16
150	ICB Safeguarding Staff Capacity	4 x 4=16
	Primary Care	**4 x 4=16**
3	PC Demand & Capacity	4 x 3=12
21	Primary Care 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	All Age Continuing Care (AACC)	4 x 3=12
15	Acute quality assurance	4 x 4=16
17	Maternity	4 x 4=16
127	AACC Care Quality Commission	4 x 2=8

	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 2=8
	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 2 = 6
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.	**Current Risk Score: (impact x likelihood)** **Target Score** **Risk Appetite Category**	**4 x 4 = 16** **4 x 1 = 4 (Yellow)** **People (4 - Seek)**
Risk Owner/Lead:	Michael Watson, Executive Director of Corporate Services 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 21, 145 and 150

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)

- Ongoing compliance and control tracking within provider organisations.
- 2025/26 operational plan submission provides appropriate staffing levels and there is commitment to manage to that workforce plan.
- People Board to take a greater role in assurance of workforce plans.
- Opportunities for system working (eg workforce analyitics) will be picked up via the system efficiency programme of the MTP.
- Following confirmation of national funding for redundancies, MSE ICB to consult on proposed new structure for Essex ICB (commences 19 November 2025) to meet mandated running costs reduction.

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

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)** **Target Score:** **Risk Appetite Category:**	**4 x 4 = 16** **4 x 1 = 4 (Yellow)** **People – 4 (Seek) and Quality – 4 (Seek)**
Risk Owner/Lead:	Executive Director of Neighbourhood Health	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.
- Work being undertaken to ensure practices are compliant with new contractual requirements from 1st October 2025.
- Continue engagement with Essex Local Medical Committee and Primary Care Networks.
- 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)** **Target Score:** **Risk Appetite Category:**	**4 x 4 = 16** **4 x 1 = 4 (Yellow)** **Financial – 3 (Open)**
Risk Owner/Lead:	Jen Kearton, Executive Chief Finance Officer. Executive Director of Neighbourhood Health.	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.
- Maximising use of developer contributions where available for general practice improvements.
- Progressing number of schemes funded via Utilisation & Modernisation Funding made available in 2025/26.
- Prioritisation & Pipeline development for schemes to progress in 2026/27.

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.
- Continue to progress opportunity through PC Estate Utilisation & Modernisation Fund and Plan for 26/27.
- 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)** **Target Score:** **Risk Appetite Category:**	**4 x 4 = 16** **4 x 1 = 4 (Yellow)** **Quality – 4 (Seek)**
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.
- 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 concluded, report published and Quality Summit planned for 12 December 2026.
- Partnership work ongoing to improve psychiatric liaison/flow/escalation across MSEFT/EPUT
- Clarity on ICB/Regional roles finalised and work underway to agree model for transition

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?

- 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)** **Target Score:** **Risk Appetite Category:**	**4 x 4 = 16** **4 x 1 = 4 (Yellow)** **Quality 4 (Seek)**
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 and other NHSE 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 supporting attendance avoidance/reducing discharge delays.
- Ongoing monitoring of CDC delivery
- Monitoring the delivery of the additional NHSE and Cancer Alliance funds to support Elective and Cancer, ensuing delivery of schemes against funds and translating into performance.

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

•Faster Diagnostics Standards (FDS): Return to trajectory forecasted for December, with performance expected to reach 74%
•31 Day Performance Standard: No risk to performance not being delivered against trajectory
•62 Day Performance Standard: Return to trajectory is expected by January 2026, with performance projected to reach 64%.
•Leadership Support: Operational and clinical leadership resources seconded from NHSE and the Cancer Alliance to drive task force groups improving patient access and pathways.
•Targeted Funding from NHSE and Cancer Alliance (£2.024m): Strengthen leadership within cancer teams to improve/redesign pathways. Increase clinical capacity in key areas: Breast, Radiotherapy, Therapeutic Radiography & Physics, Histopathology and Thoracic Outpatients and Surgical Capacity
•Capacity Expansion (2025/26): Commissioned additional clinical capacity worth approx. £75m, including: Independent sector providers for 7,830 patients, Mutual aid with local providers (ESEOC) for 304 cases.
•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 MDT led services to reduce first outpatient appointments and procedures, scheduled for deployment in Q2-Q4.

Risk Narrative:	**System Financial Performance**: There is a risk that organisations within the system control total do not deliver the required financial plans / efficiency savings. This is caused by a lack of management capacity and capability and ineffective collaborative working. This could lead to increased scrutiny by regulators, reputational damage and a potential changes to service delivery.	**Risk Score: (impact x likelihood)** **Target Score:** **Risk Appetite Category:**	**4 x 4 = 16** **4 x 1 = 4 (Yellow)** **Financial – 3 (Open)**
Risk Owner/Lead:	Jen Kearton, Executive Chief Finance Officer	Directorate: Board Committee:	Finance Directorate Finance & Performance Committee
Impact on Strategic Objectives/	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 delivery 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 2025/26.
- Medium Term Plan delivery and alignment to Planning Framework.

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)** **Target Score:** **Risk Appetite Category:**	**4 x 4 = 16** **4 x 1 = 4 (Yellow)** **Financial – 3(Open)**
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)

- The appointment process for Chief Executive and Executive Team has concluded to provide leadership stability during the transition.
- Establishment of Essex Executive Committee to oversee transition related activity.
- Redundancy funding arrangements now in place – draft structures complete and staff consultation to commence imminently.
- Engagement plan in place, including weekly staff updates, engagement with partners and provision of staff support offer.
- Plans for Essex Joint Committee and relevant sub-committees now agreed. Essex Joint Committee meetings to be held bi-monthly.
- Central Programme Management Office (CPMO) continues to oversee, support and report key programmes to the Executive Committee via due diligence workstream and the MTP Delivery Boards.

Barriers (Gaps)

- Staff consultation required to run across all six current ICBs concurrently (plans in place to mitigate any risks arising from this arrangement)

Next Steps (Actions)

- Launch staff consultation on agreed timelines.
- Continue staff engagement (pan-Essex and via directorates)
- Run VR process in line with national guidance.

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

- Successful delivery of staff consultation in Q3 and outcome in Q4.
- Staff are supported throughout the process.

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

- Staff consultation will take place over the remainder of Q3 – this may cause distraction from priorities as staff consider the proposals.

Partner self-identified Red Risks (and scores)

MSEFT - 12 Red Risks (as per BAF report to Trust Board, 9 October 2025

- Financial Sustainability (25)
- Constrained Capital Funding Programme (25)
- Workforce Instability (20)
- Capacity and Patient Flow (20)
- Estate Infrastructure (20)
- Planned Care and Cancer Capacity (20)
- Quality and Patient Safety (20)
- Cyber Security (15)
- Organisational Culture, Engagement and Wellbeing (16)
- Clinical and Operational Systems (16)
- Nova Programme (16)
- Realising Clinical Integration (20)

Partner self-identified Red Risks (and scores)

EPUT red risks, as per risk dashboard reported to Trust Board on 1 October 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, 20 November 2025

Agenda Number: 11.2

Revised Policies

Summary Report

1. Purpose of Report

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

2. Executive Leads

Jennifer Kearton, Chief Finance Officer
Michael Watson, Executive Director of Corporate Services

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Finance & Performance Committee and
Remuneration Committee (both Chaired by Jo Fielder, Non-Executive Member)

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.

- 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

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
Finance & Performance Committee 4 November 2025	The committee approved the revised Decision-Making Policy and Procedure (Ref 088). The committee also agreed to extend the review date of the ICB's Standing Financial Instructions (SFIs), Ref 093, until 31 March 2026 to give sufficient time for new SFIs to be developed for the proposed Essex ICB.
Remuneration Committee 5 November 2025	The committee approved final drafts of the following revised policies: • Ref 023: Freedom to Speak Up (Whistleblowing) Policy • Ref 042: Grievance Policy • Ref 045: Disciplinary Policy • Ref 055: Organisational Change Policy. The committee also agreed to extend the review dates of the following policies to 31 March 2026, to give sufficient time for new policies to developed for the proposed Essex ICB. • Ref 033: Equality in Employment Policy • Ref 034: Recruitment & Selection Policy • Ref 043: Managing Performance Policy • Ref 046: Hybrid Working Policy • Ref 054: Appraisal Policy • Ref 058: Management of Leavers Policy • Ref 091: Menopause at Work Policy

2. Findings/Conclusion

The above policies ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities. Approved policies are 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, 20 November 2025

Agenda Number: 11.3

Approved Committee Minutes

Summary Report

1. Purpose of Report

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

- Finance & Performance Committee (FPC) – 2 September and 7 October 2025.
- Primary Care Commissioning Committee (PCCC): 14 August, 11 September and 9 October 2025.
- Quality Committee (QC): 5 September 2025.
- Clinical and Multi-Professional Congress (CliMPC), 25 June and 24 September 2025.
- System Oversight and Assurance Committee (SOAC): 22 August 2025.

2. Chair of each Committee

- Joe Fielder, Chair of FPC.
- Prof. Sanjiv Ahluwalia, Chair of PCCC.
- Dr Neha Issar-Brown, Chair of QC.
- Dr M Sweeting, Chair of CliMPC
- 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.

Finance and Performance Committee, 2 September 2025

The following items of business were considered:

- Month 4 system finance and performance report.
- Capital update.
- Deep dive on cancer performance.
- Medium Term Plan update.
- Review of risks within the remit of the committee.

Finance and Performance Committee, 7 October 2025

The following items of business were considered:

- Month 5 system finance and performance report.
- Deep dive on Urgent and Emergency Care.
- Planning update.
- Transitional governance arrangements.
- Contracting policies and procedures.
- The minutes of the System Finance Leaders Group (SFLG) held on 21 July 2025 and minutes of the System Investment Group (SIG) held on 28 July 2025 were presented for information.

Primary Care Commissioning Committee, 14 August 2025

The following items of business were considered:

- ICB transition and cost reduction programme.
- Medium Term Plan update.
- Practice relocation application.
- Primary Medical Services contracts.
- Approval of Community Pharmacy Commissioning and Transformation Group Terms of Reference.
- Update on action plan for General Practice.
- Primary care risk management.
- Primary care quality update.
- Community pharmacy update.
- Primary care optometry update.
- Minutes of the Dental Commissioning and Transformation Group meeting held on 2 July 2025.

Primary Care Commissioning Committee, 11 September 2025

The following items of business were considered:

- ICB transition and cost reduction programme update.
- Development of Integrated Neighbourhood Teams update.
- Training Hub/Workforce update.
- Primary care demand & capacity Risk.
- Future Local Enhanced Services.

Primary Care Commissioning Committee, 9 October 2025

The following items of business were considered:

- ICB transition and cost reduction programme update.
- Medium Term Plan update
- Primary Medical Services update
- Primary care performance reporting
- Winter access scheme
- Changes to core practice membership
- Quarterly finance report
- Dental research proposal.
- Update on primary care risks.

Quality Committee, 5 September 2025

The following items of business were considered:

- A deep dive relating to medicines management.
- Executive Chief Nurse's update.
- Essex Partnership University Foundation Trust / Mental Health update.
- Safeguarding (Adults).
- Equality and Health Inequalities Update, including the Patient Safety Healthcare Inequalities Reduction Framework.
- Patient Safety and Quality risks.
- Provider Quality Accounts 2024/25.
- The committee approved extensions to the review dates of five policies within its remit until 31 March 2026.
- The committee agreed that the next deep dive would relate to Community Optometry Services.

Clinical and Multi-Professional Congress, 25 June 2025

The following items of business were considered:

- Approach to National Institute for Health and Care Excellence (NICE) Technology Appraisals.
- Adoption of Evidence-Based Interventions – Sinusitis
- Horizon Scanning – the committee noted that obesity, weight management and bariatric surgery would be reviewed.

Clinical and Multi-Professional Congress, 24 September 2025

The following items of business were considered:

- Outcome of commissioning discussions since last meeting.
- Upper Gastrointestinal (GI) Endoscopy Service Restriction Policy (SRP)
- Spinal Injection SRO
- Specialist Obesity Services – Bariatric Surgery SRP
- Horizon Scanning

System Oversight and Assurance Committee, 22 August 2025

The following items of business were considered:

- The Executive Director of Finance provided an update on the Month 4 financial recovery position.
- A deep dive on All Age Continuing Care and Discharge to Assess was presented.
- An update was given on the Treatment of Disease, Disorder and Injury Registration issue and action being taken to address issues identified.

3. Recommendation

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

Minutes of the ICB Finance and Performance Committee

Held on 2 September 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**
- 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
- 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, Executive Medical Director, MSE ICB.
- Matt Williamson (MW) Senior Finance Business Partner, Essex County Council (ECC) (attending on behalf of Laura Davis-Hughes)

Other attendees

- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Sam Goldberg (SG) Executive Director of Performance and Planning, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB
- Emily Hughes (EHu) Deputy Director of Delivery, MSE ICB (agenda item 5)
- Aidan Quinn (AQ) Deputy Chief Finance Officer, MSEFT (agenda item 6)
- Jenny Davis (JD) Director of Finance - Strategy & Commercial, EPUT (agenda item 6)
- Fiona Ryan (FR) Managing Director Southend Hospital, MSEFT (agenda item 8)

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 ECC, noting Matt Williamson was attending on her behalf, Diane Leacock, Non-Executive Director EPUT and Tom Abell (TA) Chief Executive Officer, MSE ICB.

2. Declarations of interest

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

JP declared a potential interest for agenda item 5) GP Direct Access Endoscopy (Diagnostic) Service Procurement in her role as Non-Executive Director (NED) for MSEFT and would leave the meeting at

the point the agenda item was discussed. It was noted that JP had not received the papers relating to the item.

Outcome: The Register of Interests and declaration from JP was noted.

3. Minutes of previous meetings

The minutes of 5 August 2025 were agreed as an accurate record.

Outcome: The minutes of 5 August 2025 were approved.

4. Action Log / Matters arising

The action log was noted.

Following a query from JP on how well the ICB secured Section 106 (S106) funding, AK clarified the ICB respond as appropriate to secure funding and were actively engaging in large scale developments. A paper was being presented to the Executive Committee on changes to the scope of S106 funding and would be shared with the Finance and Performance Committee.

Matters arising

The Committee noted the correction to the Deep Dive on Performance – Referral to Treatment (RTT) presentation provided to the Committee on 5 August 2025. It was clarified additional booking resource was effective from 16 June with capacity for the outpatient referral and communications team (ORC) to book an additional 6,300 appointments per month (as a minimum) ensuring MSEFT returned to the activity plan for first outpatient attendances.

Action: Executive Committee paper on Section 106 funding to be shared at a future Finance and Performance Committee.

Business Cases

5. This item has been minuted confidentially.

Assurance

6. System Finance and Performance Report: Month 4

JK reported a £7.1m year-to-date deficit for the System at Month 4. Key drivers for MSEFT included medical staffing cost pressures, underperformance in the cost improvement programmes, and increased drug and consumable costs.

EPUT's position had worsened by £0.5m in Month 4, attributed to the impact of the Mental Health Inquiry. JK noted that temporary staffing levels had remained stable and acceptable.

For the ICB, activity for quarter one exceeded planned levels, and validation work was underway. All Age Continuing Care (AACC) remained volatile, consistent with national trends. Redundancy funding linked to ICB changes was identified as a further uncertainty.

AQ confirmed that MSEFT had implemented internal measures to recover its financial position, with a recovery action plan due to NHS England by the end of September.

In response to MSEFT's financial deterioration, NHS England would attend future Trust Finance and Investment Committee and Audit Committee meetings. A deep dive into the Trusts improving value programme was in progress.

The Committee discussed workforce related triple lock requests. JF welcomed clearer reporting on whether the posts were within plan.

JP raised concerns about the impact of Month 4 figures on cash flow. JK explained the wider implications for System partners when an organisation was off plan, noting that deficit support funding was not guaranteed, and a system-first approach was needed.

Given the scale of MSEFTs variance, the Committee agreed to escalate the matter to the September ICB Board.

Performance

SG provided an overview of performance against constitutional standards at Month 4. July data showed cancer waiting time performance for the 28-day Faster Diagnosis Standard (FDS) was 64.9%, below the trajectory of 76%. MSEFT had increased Radiology capacity and administrative support, with improvements expected by November.

The Trust had secured national cancer alliance funding to support additional Histopathology capacity. It had consistently met the 31-day treatment standard for the past three months.

However, performance against the 62-day cancer treatment standard was 45% in July, significantly below trajectory. A deep dive with NHS England was scheduled for 7 October to review MSEFT actions.

The Committee noted a deterioration in the number of patients waiting over 65 weeks for Referral to Treatment (RTT). All Elective Care specialities, except Trauma and Orthopaedics, remained on track to meet year-end targets.

MSEFT did not meet the A&E 4-hour standard of 78%, reporting 76.4% in July. The ICB and NHS England were supporting redesign efforts at the front door.

Concerns were raised about the size of the RTT waiting list and the number of patients waiting over 18 weeks. MSEFT had met the NHS outpatient standard of 56.8% for four consecutive months.

Following discussion, the Committee agreed to escalate concerns to the ICB Board regarding performance against constitutional standards, particularly in Emergency Department, RTT, and cancer pathway waiting times.

JF thanked SG for the clear presentation and emphasised the need for Providers to give assurance on timelines for improvement.

Outcome: The Committee noted the Month 4 Finance and Performance report.

Action: The Committee agreed to escalate concerns on financial and service delivery performance at month 4 to the ICB Board. It was recommended that the Board formally request a report outlining in-year financial and performance recovery for consideration at a future Board meeting.

7. Capital update

JD reported that the System Capital Programme at Month 4 was £0.8m behind plan year-to-date. Internal local programmes were £8.4m ahead of plan, with EPUT £4.8m ahead due to a lease renegotiation (technical adjustment), and MSEFT ahead due to accelerated progress on its ICT programme.

External funded schemes were £9.2m behind plan. MSEFT accounted for £8.2m, with £6m linked to schemes awaiting NHS England approval for constitutional standards funding. EPUT was progressing £5.5m worth of schemes for approval.

In line with the Estates Strategy, EPUT planned to dispose of five properties no longer required for health service use.

Primary Care had reported no spend to date. The Committee discussed challenges in utilising funding within year, including time constraints and contractor availability. It was agreed that greater

flexibility across years was needed to optimise use of Primary Care funding. A pipeline of schemes had been developed for future funding releases.

Outcome: The Capital update was noted.

8. Deep Dive on Performance – Cancer

FR presented an update on cancer performance against constitutional standards, with a focus on priority areas including skin, breast, urology and histopathology. The service continued to respond to rising demand, with efforts to strengthen core capacity and explore pathway transformation through Taskforce support and left shift opportunities.

National funding had been secured to increase capacity within Breast services to address the treatment backlog.

Following a query from JP regarding increased teledermatology referrals, it was confirmed that additional activity had been commissioned in the independent sector.

MB queried the fluctuations in the FDS trajectory. FR explained that seasonal factors contributed to the variation.

To support assurance, JF requested future Finance and Performance reports include a clear overview of progress against recovery trajectories. SG and FR agreed to review how this would be reported.

Outcome: The Finance and Performance Committee noted the Deep Dive on Performance for Cancer.

Action: An overview to show progress to recover cancer waiting time standards to be included in future Finance and Performance reports.

9. Medium Term Plan (MTP)

JC reported that meetings were underway with each Programme Delivery Board to discuss the ambitions set out in the MTP and the associated business case process. A key challenge was translating these ambitions into commissioning intentions for 2026/27, supporting a whole-Essex approach as planning progressed.

Planning Framework

It was noted that MSE had received the NHS Planning Framework, which signalled a shift from system-level to organisational-level planning. It was clarified that MSE would continue to plan on an Essex footprint.

An Essex-wide working group had been established to explore the detailed governance requirements needed to support transition to a new ICB from 1 April 2026.

Outcome: The Finance and Performance Committee noted the update on the Medium-Term Plan and Planning Framework.

10. Finance Risk Register and Report on Trends

The Committee noted the finance and performance risks, along with the trend report previously requested. A discussion took place on the current risk ratings for key risks.

MB highlighted that several risk ratings had remained static and questioned whether the existing mitigations were effective. He also noted some assurance details on the Risk Register appeared outdated and suggested including completion dates for actions.

EH assured the Committee that risks were regularly reviewed and confirmed that Risk Owners had

recently been asked to assess risks against the organisation's corporate objectives.

Outcome: The Committee

- **noted the recent updates on risks within the remit of the committee**
- **noted there are 9 risks rated red**
- **noted no risks had been closed or opened since the last report to the committee**
- **approved the draft finance and performance related risks on the Board Assurance Framework prior to submission to Board**
- **noted the risk rating trend report**

Triple lock ratification

No items presented for this meeting.

11. Feedback from System groups

JK advised a refresh of the System Finance Leaders Group and System Control Total Delivery Group would take place considering the new Essex footprint.

12. Any other Business

There were no items raised.

13. Items for Escalation

The Committee agreed an escalation was made to the ICB Board on financial performance and service delivery performance at month 4. It was recommended that the Board formally request a report on in-year financial and performance recovery actions to be shared with the ICB Board.

14. Date of Next Meeting

Tuesday 7 October 2025
2.00pm - 4.30pm
Microsoft Teams Meeting

Minutes of the ICB Finance and Performance Committee

Held on 7 October 2025 at 2.00pm

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
- Ralph Jackman (RJ) Non-Executive Director, Mid and South Essex NHS Foundation Trust (MSEFT) (attending on behalf of Julie Parker)
- Matt Sweeting (MS), Executive Medical Director, MSE ICB

Other attendees

- Jo Fletcher (JFl) Associate Director of Cancer and Elective, MSE ICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB
- Cherry West (CW) Hospital Managing Director, MSEFT (agenda item 6)
- Vicky Sawtell (VS) Director of Commercial, MSE ICB (agenda item 9)

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate.

Apologies were received from Julie Parker (noting RJ was attending on her behalf), Diane Leacock, Non-Executive Director EPUT and Sam Goldberg (SG) Executive Director of Performance and Planning, MSE ICB.

2. Declarations of interest

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

Due to the sensitivity of agenda item 10 (Provider Selection Regime (PSR) Review Group – update) the paper had not been shared with Provider leads. In his role as Non-Executive Director (NED) for MSEFT, RJ would leave the meeting at the point the agenda item was discussed.

MB advised of a new declaration of interest following his appointment as NED at Cambridgeshire and Peterborough Foundation Trust. MB was Chair of their Audit and Assurance Committee and a member of the Business and Performance Committee.

Outcome: The Register of Interests and new declaration from MB was noted.

Action: The updated Register of Interests would be presented at the November Finance and Performance Committee.

3. Minutes of previous meetings

The minutes of 2 September 2025 were agreed as an accurate record.

Outcome: The minutes of 2 September 2025 were approved.

4. Action Log / Matters arising

The action log was noted, there were no matters arising.

Assurance

5. System Finance and Performance Report: Month 5

JK reported the year-to-date (YTD) position showed a System deficit of £11.8m against plan, although the forecast outturn remained on track to deliver breakeven. Due to the Month 5 variance, System deficit cash funding support would be withheld for quarter 3. NHS England would attend future Trust Finance and Performance Committees and Audit Committees.

Two supplementary papers were circulated outlining the underlying cash positions for MSEFT and EPUT and the mitigation actions in place. The ICB was analysing activity data to identify opportunities to shift activity into the most appropriate setting.

LDH noted EPUT's WTE position and welcomed improved visibility of MSEFTs workforce data. JK advised NHS England was supporting MSEFT with workforce reporting and the reconciliation between monthly planned and actual workforce returns. MB highlighted an increase in the headcount for bank staff since month 1. Although nursing temporary staffing had reduced, this was offset by increased spend in medical staffing, and MSEFT had not realised expected benefits from its improving value programme.

Following the movement on Indicative Activity Plans highlighted in Month 4, JK assured the Committee, the position had been corrected. The ICB continued to monitor the position. All Age Continuing Care and ADHD/ASD assessments continued to flag as areas of pressure within the ICB.

In response to a question from JF on the utilisation of capital funding, JK explained capital spending was monitored closely across the System and remained in line with the plan.

Performance

The ICB maintained strengthened governance oversight across Urgent and Emergency Care, Cancer, and Elective services in its support to MSEFT. This was underpinned by the ICB led System Medium Term Plan (MTP), and efforts on pathway redesign and optimisation of out-of-hospital urgent care capacity.

JFl reported achievement of the 31-day decision-to-treat cancer target and improvements in outpatient waiting times and Emergency Department 12 hours breaches. Despite improvements in performance against the 18-week trajectory, it remained below plan.

The Faster Diagnosis Standard (28 days) showed improvement but remained 12% below the national trajectory. The 62-Day and 31-Day cancer standards were also below trajectory. Early indication of reporting for August, showed a decline in performance against the three cancer trajectories, consistent with national trends. A dedicated taskforce and targeted investment were in place to support recovery in urology, breast and skin cancer services.

In urgent and emergency care, ambulance handover times improved across sites except Basildon.

MB asked what actions were taking place to recover RTT performance. JFl advised the ICB had commissioned a regional peer review and national missed opportunity review across the three acute hospitals, this has informed Emergency Department redesign, including patient redirection to Pharmacy First and direct streaming to acute service.

JFl left the meeting.

Outcome: The Committee noted the Month 5 Finance and Performance report.

6. Deep Dive on Performance – Urgent and Emergency Care

CW provided an update on the Urgent and Emergency Care (UEC) work following the launch of the Simplify Access to Fast and Efficient Urgent and Emergency Care (SAFE) programme, aimed at improving performance against the constitutional standards.

CW highlighted:

- MSE ED attendances increased by 6% from April 2022 to March 2025; with Southend showing the highest rise at 13%.
- Ambulance arrivals rose by 37% from March 2023 to March 2025: with Southend seeing the largest increase at 65%.
- Ambulance handovers under 15 mins remained challenged, though handovers under 30 minutes had improved since January 2025.
- ED conversion rates declined from 28% to 18-19%.
- ED admissions reduced by 8%, with admissions between April 2025 and August 2025 down 21% compared to the same period in 2024.

A regional peer review and missed opportunities audit identified four priority workstreams for phase 2 of the SAFE programme: ED process and alternative to admission, length of stay reduction, simple discharge and complex discharge.

Following a decline in ED 4-hour performance in August, Basildon, Broomfield and Southend hospital were asked to submit recovery plans to support MSEFT in returning to trajectory by the end of November 2025.

In response to a query from JF, CW noted that while each site faced unique challenges and population needs, best practice was shared where feasible.

Outcome: The deep dive on Urgent and Emergency Care was noted.

Following the request at the September ICB Board, it was noted that the requested report on in-year financial and performance recovery from MSEFT would be presented to the Committee when available.

7. Planning update

JC reported that meetings with Programme Delivery Boards regarding the ambitions set out in the MTP had concluded. Work commenced to assess the impact of programmes for 2026/27.

Planning progressed on a proposed Essex footprint, with commissioning intentions for 2026/27 and beyond being developed in collaboration with Suffolk and North East Essex and Hertfordshire and west Essex ICBs.

Once commissioning intentions were finalised, a triangulation exercise would be undertaken across finance, workforce, performance and quality to inform a collective plan.

EH outlined the requirement for a five-year commissioning strategy to underpin Neighbourhood health plans.

JK noted that financial allocations for the proposed Essex footprint and the technical planning guidance had not been released. Despite this, planning continued. The ICB was informed that revenue allocations would be issued over three years and Capital allocations over four years; making a shift from NHS England's previous annual allocation approach.

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

8. Transitional Governance

JC advised the development of a staffing structure was underway for the proposed Essex ICB for April 2025. MSE would continue to perform its statutory duties until such time.

Transitional governance was being developed to establish a joint Committee for Essex with several key sub-Committees reporting to the Essex Joint Committee. It was proposed the Finance and Performance Committee would alternate on a bimonthly basis between MSE business and a focus on Essex and broader plans on planning, strategy development and performance.

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

9. Contracting Policies and Procedures

Following a recent audit, the ICB was advised to implement a Standard Operating Procedure (SOP) for due diligence checks when appointing new suppliers, based on national Counter Fraud guidance.

VS summarised the SOP, noting it formally documented existing practices. Conflicts of interest were added to core checks to reinforce the importance of regularly reviewing supplier status and maintaining contract integrity.

JF recommended the SOP include a provision of additional risk assessments where significant concerns were identified during due diligence, to clarify expectations around contract award decisions.

In response to RJ's query on the depth of Supplier Reputation Assessments, VS confirmed further checks would be undertaken if initial assessments indicated a need, with cases considered individually.

TA queried implementation of the checks; VS confirmed they would be conducted periodically and upon changes in supplier ownership. A timetable for review periods was recommended.

The Procurement and Contracting Policy was updated to reflect statutory changes introduced by the Procurement Act 2023. The policy outlined guiding principles, legal compliance, and operational procedures, including approaches under both the Procurement Act 2023 and the Provider Selection Regime (PSR).

Contracting principles were revised to align with the relevant procurement objectives under each regime. In response to MB's query, VS confirmed the policy incorporated learning and best practice from PSR Representation Panels.

The updated policy would be submitted to the Audit Committee.

Outcome: The Committee approved the Procurement and Contracting Due Diligence Checks Standard Operating Procedure (SOP) and Procurement and Contracting Policy.

10. This item has been minuted confidentially.

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 21 July and minutes of the System Investment Group (SIG) held on 28 July 2025 were presented for information, there were no comments.

12. Any other Business

ICB letter of support

As EPUT are within the MSE System Control Total, the ICB was asked to provide a letter of support for EPUT to apply for Mental Health urgent treatment capital funding from NHS England for premises to be developed on Harlow and Colchester sites.

The Mental Health Urgent Care Centre's would support patients being triaged and assessed in the most appropriate setting, improving admission avoidance.

The value of the associated business case was £5.3m, there was no incremental revenue consequence to the ICB. The letter of support would stipulate the need for Hertfordshire and West Essex ICB and Suffolk and North East Essex ICB to form part of the approval process.

MS asked if the establishment of the Mental Health Urgent Care Units formed part of the strategic plan and queried if there were any restrictions placed upon the capital funding. JK took an action to check.

Outcome: The Finance and Performance Committee supported the ICB letter of support and asked the letter reflected the requirement for Hertfordshire and West Essex ICB and Suffolk and North East Essex ICB to form part of the approval process. Chairs approval of the letter would be sought outside of the meeting.

Action: JK to clarify if the Mental Health Urgent Care Units were within the strategic plan and if there are any restrictions on the remit of the capital funding.

Action: Chairs approval of the ICB letter of support for the Mental Health Urgent Care Centre's in Harlow and Colchester to be sought outside of the meeting.

13. Items for Escalation

No items raised for escalation.

14. Date of Next Meeting

Tuesday 4 November 2025
2.00pm - 4.30pm

Minutes of ICB Primary Care Commissioning Committee Meeting

Thursday, 14 August 2025, 1.00pm–3.00pm

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dr James Hickling (JH), Deputy Medical Director.
- 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).
- Kate Butcher (KB), Deputy Alliance Director Mid Essex (nominated deputy for Dan Doherty).
- Michelle Cleary (MC), Alliance Delivery & Engagement Lead, South East Essex (nominated deputy for Rebecca Jarvis)

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Deputy Director of Commissioning.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Jane King (JKi), Corporate Services and Governance support Manager.
- Sarah Cansell (SC), Contracting Manager.
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Sheila Purser (SP), Chair, Local Optical Committee.
- Emma Spofforth (ES), Clinical Lead, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.

Apologies

- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Margaret Allen (MA), Deputy Alliance Director for Thurrock.
- Ali Birch (AB), Head of Connected Pathways Programme.
- Viv Barker (VB), Director of Nursing.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Nicola Adams (NA), Associate Director of Corporate Services.

- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.

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 9 July 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 9 July 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was agreed that action ref 9 (mid-point Committee effectiveness review) would be paused until the future state of the ICB was known.

Under Matters Arising, in relation to action ref 13, ES highlighted that the correct reference was to Optometry Services, not Ophthalmology Services. These were distinct services provided by different professionals.

Outcome: The updates on actions and matters arising were noted.

5. ICB Transition and Cost Reduction Programme

WG provided an update on the ICB's Cost Reduction Programme. The Executive consultation had concluded, and the selection process would take place. Outcomes were expected by mid-September. The CEO and Chair appointments remained pending, awaiting sign-off by the Secretary of State.

Outcome: The Committee NOTED the update on the ICB Transition and Cost Reduction Programme.

6. Medium-Term Plan

WG presented an update on the progression of the Primary Care workstream within the Medium Term Plan (MTP), confirming that progress had been made across all schemes. Monthly Primary Care Delivery Board meetings were in place and supported by the Central Programme Management Office (CPMO).

Project Initiation Documents (PIDs) were largely complete, with no issues escalated by the CPMO. The Alliance Primary Care Clinical Leads Group had met regularly and was actively supporting scheme implementation. Guidance was awaited on the scope of the national 'Red Tape Challenge 2025/26', part of the UK Government's Plan for Change.

The Primary Care workstream was collaborating with other workstreams to strengthen the organisation-wide understanding of 'left shift' priorities, although ongoing refinement of these priorities was affecting progress in several areas, including the Strategic Commissioning Framework, the Left Shift Scheme, and the Primary Care Estates Programme. The ICB was reviewing the Neighbourhood Health Programme to ensure alignment with national priorities, protect resources for MTP delivery, and assess implications for estates planning.

ES expressed concerns about the lack of reference to Optometry services in the MTP and their potential contribution to shifting services into primary care and supporting acute care. JS acknowledged that the absence of primary care services in early-stage scoping of other MTP programmes had been flagged as a risk and agreed to follow up with ES. KSS emphasised the importance of involving all Pharmacy, Optometry and Dental (POD) groups in the discussion. WG suggested that the concerns could be addressed through CPMO-led work on defining 'Left Shift' across workstreams, presenting an opportunity to integrate the POD perspective. SA added that the ongoing reshaping of the ICB provided an opportunity to strengthen strategic commissioning and highlighted the importance of early provider involvement.

Outcome: The Committee NOTED the Medium Term Plan update.

7. Practice Relocation Application

SC presented an application from a Thurrock Alliance practice seeking formal approval for premises relocation, effective 1 September 2025, following a landlord-issued notice to vacate. The practice had completed patient engagement and provided assurance of continued service delivery from the new site, along with plans to mitigate any operational impacts. Following the submission of the Equality and Health Inequalities Impact Assessment (EHIIA) and Quality Impact Assessment (QIA), feedback was provided to the practice. A revised EHIIA was received, addressing all previously raised concerns. The revised QIA remained under review, with no significant outstanding issues.

It was noted that this was the third landlord-issued notice within a year, and the issue had been flagged to the Primary Care Estates Programme. The ICB was working to mitigate the risk and had added the broader estates concerns to the risk register, mapped to the Primary Care Commissioning Committee. JH enquired about minimum lease notice periods, and JS confirmed that NHSE recommended standard lease terms including notice periods, although the practice did not have an agreed lease. A six-month notice period had been given, which was considered acceptable from a business perspective.

Further concerns were raised about other practices facing similar lease expiry positions, which would be reviewed through the Primary Care Estates Programme, with support offered to affected practices. JH and SA both expressed support for the relocation, subject to satisfactory risk assessments being in place, and requested that the EHIIA and QIA be shared with the Committee. JS reported that a recent overview of estates-related issues had been presented to the GP Provider Collaborative (GPPC), and AD noted that the

GPPC acknowledged the importance of contributing to a future Primary Care Strategy and welcomed continued engagement.

Outcome: The Committee APPROVED the relocation of the Thurrock Alliance based surgery effective 1 September 2025, subject to satisfactory risk assessments being in place.

8. Primary Medical Services Contracts

JS provided an update on primary medical service contract activity for assurance and information. Between April to May 2025, 83% of non-prebooked GP appointments were delivered within 14 days, with the Connected Pathways Team addressing data quality and performance variation.

A contract change from Individual to Partnership (in South East Essex) was approved for another practice, effective 31 August 2025, subject to completion of contractual documentation and changes to the lease and rent charges. As a new provider, the practice would be placed on a 'to be assessed' list by the Care Quality Commission (CQC).

Additional potential changes under review included a surgery relocation, opening of branch surgeries, boundary changes, and merger requests. Several discretionary funding applications from practices had been received and were under review. Furthermore, around 20 primary care estates funding schemes and allocations were expected to progress in 2025/26.

The ICB Operational Group supported the development of a new approach for commissioning Enhanced Services for 2026/27.

Three live remedial action plans related to Mid and South Essex Foundation Trust (MSEFT) were impacting primary care.

An update was provided on the work of the Connected Pathways Team, noting that all outstanding projects remained on track.

KSS commented that the positive community pharmacy results from the GP patient survey had not been reflected in the Connected Pathways update. JS and PG acknowledged the work, but also that limited resources impacted the ability to share and promote such feedback more widely.

ACTION: JS to liaise with the Communications Team to support the promotion of positive patient feedback relating to the Pharmacy First service.

ES informed the Committee of changes made by MSEFT to the Community Optometry commissioned enhanced services. PG confirmed there had been recent discussion with MSEFT regarding the commissioning of the eye care pathways and reported positive developments which would be communicated to the Local Optical Committee.

Outcome: The Committee NOTED the Primary Medical Services update.

9. Community Pharmacy Commissioning and Transformation Group Terms of Reference

WG presented the Terms of Reference (ToR) for the newly established Community Pharmacy Commissioning and Transformation Group, a sub-group of the Primary Care

Commissioning Committee (PCCC). The group would focus on advancing the strategic development of community pharmacy services. It would operate collaboratively with the Pharmaceutical Services Regulations Committee, hosted by Hertfordshire and West Essex (HWE) Integrated Care Board. The meetings would be held bi-monthly, and minutes submitted to PCCC for review.

ES clarified that the Mid and South Essex Primary Care Governance chart within the ToR, correctly included the Mid and South Essex Ophthalmology Transformation Board, which was primarily focused on acute care. However, ES noted that this Board differed from an Optometry Transformation Board and was therefore not equivalent to the Dental Commissioning or Community Pharmacy Commissioning Transformation Group.

WG proposed that consideration would be given to this during the delayed mid-point Committee review to determine whether an alternative governance arrangement for Optometry Services was required. SA agreed with the proposal.

ACTION: Consider during the mid-point Committee review whether an alternative governance arrangement was required for Optometry Services.

Outcome: The Committee APPROVED the Community Pharmacy Commissioning and Transformation Group Terms of Reference.

10. Action Plan for General Practice update

WG presented the ICB's response to the NHS England Planning requirement to submit an Action Plan for General Practice. The aim of the Action Plan was to enable patients to access general practice in a timely way and improve patient experience.

The ICB's plan would be a continuation of the Primary Care Access Recovery Programme, with a targeted plan for 2025/26 to reduce variation across practices, support practice development, and improve performance through enhanced oversight and commissioning.

The plan included detailed information on the actions the ICB would undertake to strengthen each area of focus, along with the expected outcomes and performance metrics. It also outlined the key risks associated with these actions and the corresponding mitigation strategies.

There were no comments or concerns raised.

Outcome: The Committee NOTED the Action Plan for General Practice update.

11. Primary Care Risk Management

An overview of the primary care risks included on the ICB's risk register and Board Assurance Framework was presented to the Committee. There were 11 active risks, one of which was rated red (Primary Care Demand and Capacity) and 6 rated amber. Since the last meeting, the risk rating score for the 'Management of prescribing costs and medicines improvement programmes' had increased to amber.

No additional risks had been opened, and none had been closed. There were three risk updates still outstanding at the time of issuing the paper.

An exercise was underway to assess the risks associated with the reorganisation of the ICB; the implications for primary care would be reported in the next update.

SA noted that the Workforce Hub funding risks previously discussed were not reflected in the register. PG acknowledged the ongoing risk around workforce development, advising that she recently met with NHS England and neighbouring ICB Training Hubs to develop a coordinated approach to address these challenges. NHS England had confirmed funding for the NHSE-funded components of the hub through the 2026/27 financial year. However, a sustainable, long-term funding solution was still required to ensure the hub's viability, it was suggested this be considered at the next Committee meeting.

ACTION: Funding arrangements for the ICB Training Hub be re-considered at the next meeting to fully understand funding arrangements beyond 2026/27.

JH enquired when the Primary Care Demand and Capacity risk should be formally reassessed and downgraded. WG proposed to bring a paper to the September meeting to facilitate a review of the Primary Care Demand and Capacity risk, including consideration of current evidence for downgrading.

ACTION: Present paper at September meeting supporting a review of the red-rated Primary Care Demand and Capacity risk.

SA enquired whether the workforce issues should be added to the risk register. PG commented that a fair resolution was being sought, however if this could not be achieved, the issue would formally be classified as a risk and added to the register.

Outcome: The Committee NOTED the Primary Care Risk Management update.

12. Primary Care Quality update

The ICB Quality Committee was responsible for oversight of primary care quality issues and received a report on a quarterly basis for Primary Medical Services, and bi-annual basis for Pharmacy, Optometry and Dental Services. The Primary Care Quality Committee papers were provided to the Committee for information. There were no escalations to the PCCC from the Quality Committee.

Outcome: The Committee NOTED the Primary Care Quality update.

13. Community Pharmacy

The Q1 2025/26 Pharmacy Services Regulations Committee (PSRC) paper for mid and south Essex was presented to the Committee, providing an update of the contractual activities in relation to community pharmacy services. The PSRC oversaw formal regulation activities for community pharmacy providers on behalf of all six East of England ICBs and was hosted by NHS Hertfordshire and West Essex (HWE) ICB.

Outcome: The Committee NOTED the Community Pharmacy Regulatory update.

14. Primary Care Optometry

The Q1 2025/26 Community Optometry update was presented to the Committee which provided an update of the contractual activities and local development issues in relation to primary care optometry services. The management of the General Ophthalmic Service (GOS) was hosted by HWE ICB on behalf of the six ICBs in the East of England.

Outcome: The Committee NOTED the General Optometry Services update.

15. Minutes of the Dental Commissioning and Transformation Group

The minutes for the Dental Commissioning and Transformation Group meeting held on 2 July 2025 were received.

16. Items to Escalate

There were no items to escalate to Board or Board Assurance Framework.

17. Any Other Business

PG advised that discussions had taken place with the Executive regarding the future provision of Local Enhanced Services (LES) and review of existing schemes. Further work was required to support a clearer understanding of the associated risks and opportunities within the LES framework. PG indicated an intention to present a paper at the next PCCC to inform the development of a strategic response on the future direction of LES. SA supported.

ACTION: Paper setting out the development of a strategic response on the future direction of Local Enhanced Services to be presented at next meeting.

18. Effectiveness of meeting

The Chair thanked attendees and the Primary Care team for their professionalism in the quality of papers and discussion taking place.

PG advised that the Executive consultation process was underway, and until its conclusion, the identity of the responsible officer for primary care remained undetermined. PG took the opportunity to express that it had been a privilege to lead the Primary Care and POD teams over the past 18 months, and extended thanks to colleagues, acknowledging their expertise and contributions.

19. Date of Next Meeting

9.30am to 11.30am, Thursday 9 October 2025, Via Microsoft Teams.

Minutes of ICB Primary Care Commissioning Committee Meeting

Thursday, 11 September 2025, 1.00pm–3.00pm

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Ashley King (AK), Director of Finance and Estates (nominated deputy for Jennifer Kearton).
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality (nominated deputy for Viv Barker).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Head of Commissioning.
- Michelle Cleary (MC), South East Essex Alliance Delivery & Engagement Lead.
- Nicola Adams (NA), Associate Director of Corporate Services. For part.
- Jane King (JKi), Corporate Services and Governance Support Manager (Minutes).
- Dr Sarah Crane (SC), Training Hub Senior Responsible Officer Clinical Lead.
- Kathryn Perry (KP), Head of Primary Care Workforce.
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Sheila Purser (SP), Chair, Local Optical Committee.
- Emma Spofforth (ES), Clinical Lead, Local Optical Committee.

Apologies

- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Margaret Allen (MA), Deputy Alliance Director for Thurrock.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Sarah Cansell (SC), Contract Manager.
- Dr Matt Sweeting (MS), Executive Medical Director.

- Viv Barker (VB), Director of Nursing.
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.
- 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 14 August 2025 were received.

Item 8 was amended to include revised wording as follows: 'KSS commented that the positive community pharmacy results from the GP patient survey had not been reflected in the Connected Pathways update. JS and PG acknowledged the work of community pharmacy, but also that limited resources impacted the ability to share and promote such feedback more widely.'

Outcome: The minutes of the ICB PCCC meeting on 14 August 2025 were approved, subject to amendment, as discussed.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly.

ES highlighted that it was agreed at the last meeting that Pharmacy, Optometry and Dental groups should be involved in Medium Term Plan discussions, however this was not picked up on the action log.

ACTION: DB to facilitate a meeting with Pharmacy, Optometry and Dental colleagues to discuss the Medium Term Plan.

It was noted that action reference 9 (to undertake a mid-point committee effectiveness review) had been paused pending greater clarity on the future state of the ICB. Outstanding actions 19 and 20 were within timescales for completion.

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, highlighting that progress to date had been slower than anticipated. This was largely due to the financial impact of workforce reductions, causing ongoing uncertainty surrounding the timeline of the ICB's

wider staff restructure. Additionally, the announcement of CEO appointments had been postponed pending confirmation of appointments across other regions. The statutory responsibilities of the ICB remained unchanged, and the work of the committee should continue until otherwise directed.

SA stressed that the strategic view of the PCCC should remain a priority on the ICB's agenda, given its critical role in shaping primary care delivery across the system.

Outcome: The Committee NOTED the update on ICB Transition and Cost Reduction Programme.

6. Integrated Neighbourhood Teams

PG reported continued development of Integrated Neighbourhood Teams (INTs) across mid and south Essex (MSE), with performance improvements across key indicators compared to last year. Focus areas such as frailty and end of life care contributed to reductions in hospital admissions, falls-related emergency admissions, 30-day readmissions, and unplanned ambulatory admissions.

JH praised the progress made and queried the sustainability of improvements. PG confirmed ongoing analysis of service variation, enhanced service payments, and additional roles to inform targeted reinvestment and support commissioning reform.

SA asked if commissioning would shift to outcome-based models. PG confirmed a move toward integrated, outcome-focussed commissioning, requiring long-term contracts to support workforce development and a "left shift" in care. Primary care must be a proactive partner in neighbourhood collaboratives.

KSS highlighted that the Ambulatory Blood Pressure Monitoring (ABPM) Locally Enhanced Service (LES) could be discontinued, as community pharmacies were contractually required to provide it from October 2025. A review of Direct Enhanced Services (DES) was recommended to free up GP capacity.

SA expressed concerns about shifting responsibility to providers without sufficient support, risking limited change. A cultural shift would require investment in development of organisational transformation. PG agreed and highlighted the GP Provider Collaborative (GPPC) as key to driving change. A provider maturity assessment would identify suitable integrators; if none identified, alternative strategies would be considered.

WG emphasised the importance of embedding change management as a core commissioning function as the ICB transitioned to strategic commissioning.

Outcome: The Committee NOTED the Integrated Neighbourhood Update

7. Training Hub/Workforce update

KP provided a verbal update on the Training Hub and workforce developments since the last report to the committee in June 2025. NHS England had confirmed that Primary Care Training Hub contracts had been extended until 31 March 2027. Under the new executive structure, the responsibility for the Training Hub would fall under the remit of the Executive Director of Neighbourhood Health.

All Clinical Lead roles, originally set to expire at the end of October 2025, had been extended until 31 March 2026. System Development Funding had been approved, and initiatives aimed at supporting the retention and development of primary care staff were underway.

SC provided a summary of the regional NHS England (NHSE) meeting held in August, involving representatives from Mid and South Essex (MSE), Hertfordshire and West Essex (HWE), and Suffolk and North East Essex (SNEE). The meeting focused on the ongoing uncertainty surrounding primary care training hubs. Currently, three training hubs operated across the newly defined ICB footprint. While all hubs were aligned with national KPIs for their respective programmes, each operated slightly differently with different funding arrangements.

A follow-up meeting was scheduled for late November or early December, by which time greater clarity was expected regarding the future role of ICBs and whether they would assume responsibility for the training hubs.

PG expressed a desire for the GPPC to play an active and influential role in the development and oversight of the training hubs. SC added that the GPPC currently held a non-voting position on the training hub Board. This arrangement enabled a closer working relationship with primary care and ensures visibility throughout the transition period.

PW remarked that a more inclusive primary care collaborative approach was required to ensure that all professional groups in primary care were effectively engaged and represented within the training hub framework.

SA highlighted the critical importance of aligning the work of the training hubs with the delivery of the NHS 10-Year Plan. The capacity, capability, and expertise within the hubs was seen as essential to supporting the required 'left shift' in care delivery. SA emphasised the need for the commissioning function to develop a clearer and more precise understanding of this alignment, and to ensure that the associated messaging is made explicit

Outcome: The Committee NOTED the Training Hub/Workforce update.

8. Primary Care Demand & Capacity Risk

WG presented a paper addressing a long-standing risk added to the ICB risk register in 2021, highlighting the gap between primary care demand and available capacity. Despite increased consultation volumes post-pandemic, demand continued to exceed capacity, affecting patient experience, quality of care, and workforce morale.

Significant work over three years, including implementation of NHSE's Primary Care Access Recovery Plan and expansion through the Additional Roles Reimbursement Scheme (ARRS), had reduced the likelihood of the risk. The committee agreed to reduce the risk rating from 16 to 12.

SA welcomed the review and stressed the need to ensure mitigating actions were effective.

ES raised the potential to improve referral pathways to community optometry services. PG confirmed a meeting with acute care leads would be arranged to review the eyecare pathway.

JH noted that the rating change reflected the extensive work undertaken.

SA questioned whether provider failure risks were sufficiently considered. WG acknowledged some contracts remained vulnerable but confirmed that contract hand-back risks were at their lowest across MSE

SA requested an addendum outlining current challenges and mitigating actions to provide a holistic view. WG confirmed ongoing reporting progress against the risk and mitigating actions.

The committee supported the rating reduction, with the risk remaining on the register.

Outcome: The Committee SUPPORTED the reduction of the primary care demand and capacity risk.

9. Future Local Enhanced Services

WG presented a strategic approach to strengthen commissioning of Enhanced Services. The proposed framework aimed to improve effectiveness, align with national and local priorities, and support the priorities of the ICB, including the delivery of the 10-year Health Plan and promoting care closer to home.

A review of commissioning arrangements across Essex was underway to ensure consistency, particularly with West and North East Essex. Financial pressures, required robust, resource-aligned business cases, with no additional funding available for pilots. Future proposals must demonstrate value, sustainability, and alignment with system priorities.

Annual commissioning cycles for Locally Enhanced Services (LES) had limited certainty for providers and minimal incentive for long-term investment. Provider feedback supported longer-term commissioning to enable workforce investment and improve capacity. Outcome-based funding and scalable service models to support both practice-level and PCN-level development were encouraged.

The ICB was exploring HWE's 'basket commissioning model', which combined services and annual payments per registered patient. A comparison exercise with HWE and SNEE, and engagement with the Local Medical Committee (LMC), would inform the 2026/27 commissioning model.

SA welcomed the framework but raised concerns about provider suitability and service variation. WG confirmed these issues were being addressed within the commissioning framework. JS cited a GP-in-ED service commissioned by the acute Trust and stressed the need for collaborative service design and a market management strategy.

SA emphasised the importance of coordinated commissioning to improve quality, access, and cost effectiveness, and requested market management to be considered in future planning.

Outcome: The Committee NOTED the Future Local Enhanced Service paper.

10. Items to Escalate

No items were noted for escalation to the Board.

11. Any Other Business

ES advised that the Local Optical Committee (LOC) had been asked to support work in West Essex and North East Essex regarding sight testing in special schools. ES enquired about the process and plans for Mid and South Essex (MSE), and how this work might be expanded into the Essex footprint.

PG suggested that this matter be considered separately and discussed at a future meeting.

ACTION: DB to present paper at future meeting outlining MSE plans for sight testing in special schools.

12. Effectiveness of meeting

The Chair expressed sincere thanks to all committee members and attendees for their valuable contributions and the depth of discussion, acknowledging that the committee continued to play a vital role in supporting and shaping primary care.

Considering the forthcoming changes to the Executive structure and committee leadership, SA formally acknowledged PG's significant contributions to the committee's work and her advocacy for primary care at Board level. Her efforts had ensured that primary care was not only visible but also meaningfully heard.

13. Date of Next Meeting

1.00pm, Thursday 9 October 2025
Via Microsoft Teams

Minutes of ICB Primary Care Commissioning Committee Meeting

Thursday, 9 October 2025, 1.00pm–3.00pm

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- 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).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleks Mecan).
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex (nominated deputy for Dan Doherty).
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.

Other attendees

- David Barter (DBa), Head of Commissioning.
- Sarah Cansell (SC), Contract Manager.
- Jane King (JKi), Corporate Services and Governance Support Manager (Minutes).
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.

Apologies

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Viv Barker (VB), Director of Nursing.
- 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.

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. It was noted that the meeting was quorate.

2. Declarations of Interest

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

Members noted the register of interests. For Item 9 (Winter Access Scheme) it was noted that Dr Anna Davey was a GMS contract holder within Colne Valley Primary Care Network. The PCN would be eligible for the Winter Access Scheme and benefit from it. The conflict, however, was not considered to be significant and therefore AD was not excluded from the discussion.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 11 September 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 11 September 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly.

All actions were complete, and action ref. 9 (Mid-Point Committee Effectiveness Review) remained paused.

Outcome: The updates on actions were noted.

5. ICB Transition and Cost Reduction Programme

WG updated the Committee on the Cost Reduction Programme. The Executive Director of Neighbourhood Health role remained vacant, with interim leadership assumed by the Executive Director of Strategy who intended to attend meetings regularly during the vacancy.

A Joint Committee was being established across the Essex footprint in preparation for the proposed single Integrated Care Board (ICB) for Essex from April 2026. Primary Care was excluded from the Joint Committee's remit at this stage; transitional arrangements for Primary Care would be presented to a future meeting.

Work continued with West Essex and North Essex colleagues to develop a shared understanding of contractual matters and related issues ahead of the transition to the proposed Essex ICB.

The timeline and details of the wider ICB restructure remained undetermined.

AD reported ongoing discussions with Primary Care Board members in West Essex and North Essex regarding the formation of an all-Essex GP Provider Collaborative to replace the MSE GPPC ahead of the proposed Essex ICB launch. SA welcomed this as a positive development and emphasised the importance of retaining primary care quality assessment and queried whether this had been considered. WG noted uncertainty around the future structure and function of the proposed Essex ICB, but expected greater clarity on primary care commissioning by late autumn/early winter.

Outcome: The Committee NOTED the update on ICB Transition and Cost Reduction Programme.

6. Medium Term Plan Update

WG reported progress across all scheme within the Primary Care workstream of the Medium Term Plan (MTP). A risk had been escalated to the MTP Programme Board regarding the expiry of the Connected Pathways Team's fixed-term contract at the end of December 2025, creating potential uncertainty for certain areas of primary care transformation work. Mitigation options were being explored.

Scrutiny of GP contract performance and metrics from NHS England had increased and was expected to continue. A significant proportion of the Connected Pathways team's time was spent supporting outlier practices, making it challenging to meet national expectations while also progressing local ambitions without the full team.

The risk of not retaining the team was that practices could lose access to supportive guidance, potentially leading to a more enforcement-driven approach to contract management.

North East Essex and West Essex were both part of Wave 1 of the National Neighbourhood Health Programme, and learning from these areas would be used to inform future planning across the Essex footprint.

PW requested greater integration of community pharmacy within the MTP programme. WG confirmed this would be addressed through the Community Pharmacy Transformation Group.

Outcome: The Committee NOTED the Medium Term Plan update.

7. Primary Medical Services

WG provided an update on primary medical service contract activity for assurance and information. Between April to July 2025, 83% of non-prebooked GP appointments were delivered within 14 days. The Connected Pathways Team continued to address data quality and performance variation.

Support was ongoing for a South East Essex Alliance practice following a Care Quality Commission (CQC) rating of 'Requires Improvement'. Potential changes under review included two new branch surgery applications, boundary changes and PCN changes.

The Committee noted that GPs in England had voted to re-enter a dispute with the Government over patient safety concerns linked to unlimited online consultation requests. Regulatory changes were due to take effect from 1 October 2025.

The ICB was working with three practices nearing formal debt recovery proceedings to prevent escalation. NHS England issued guidance on 2 October 2025 for ICBs to adopt the national 'Freedom to Speak Up' policy and ensure Guardian access for primary care staff. The ICB's proposed implementation was presented to the Executive Committee, with regional collaboration under consideration. The ICB had taken a lead role in developing the approach for dental providers.

An update was provided on Connected Pathway's Team transformation work, confirming all outstanding projects remained on track. VK noted all practices referenced had received support from the Primary Care Quality team.

This section has been minuted confidentially.

SA queried whether contractual and estates issues had been recognised as a formal risk. WG confirmed mitigation work was underway and agreed to outline the actions taken and plans in the next risk update, including implications for patient care.

ACTION: WG to include an update in the next committee risk report detailing actions taken to address contractual and estates issues and their impact on patient care.

Outcome: The Committee NOTED the Primary Medical Services update.

8. Primary Care Performance Reporting

WG provided an update on the development of the NHS England GP Primary Care Dashboard, designed to support ICBs in effective commissioning of Primary Medical Care services, focussing on GP access, workforce, clinical outcomes, care quality, medicines management, screening and vaccinations.

PW highlighted the dashboard's GP specific focus. WG confirmed separate dashboards existed for Community Pharmacy and Dental services, though options for Optometry were limited. SA requested inclusion of Dentistry and Pharmacy performance in the next update.

ACTION: Dentistry and Pharmacy performance to be included in the next performance reporting update.

SA queried how data would be used to monitor performance, stressing that insights were more valuable than raw data. WG explained the dashboard a national tool to identify outliers and prompt discussions, helping correct data issues and assess whether concerns were performance-related or due to other factors. He cautioned against unnecessary bureaucracy.

JH acknowledged limitations but noted the dashboard provided consistent data across practices, enabling a balanced view and targeted support for outliers.

Outcome: The Committee NOTED the Primary Care Performance Reporting update.

9. Winter Access Scheme

WG presented the proposed 2025/26 Winter Access Scheme, recommending continuation of the previous models to increase capacity for respiratory care and expand to include frailty and end-of-life support in line with Integrated Neighbourhood Teams (INT) priorities. The ICB allocated £500k for the scheme, reduced from £600k last year due budget pressures. The scheme would run from December 2025 to March 2026, funding services beyond core

capacity, such as additional PCNs staff hours. Practices were required to meet set parameters but had retained flexibility in delivery, with payments made in arrears upon submission of evidence

PW and KSS proposed making increased Pharmacy First referrals a funding condition. WG agreed and confirmed this could be incorporated. PW suggested a minimum referral threshold, supported by KSS, to encourage patient behaviour change and reduce GP pressure. JH recommended prioritising children and young people with respiratory conditions, ensuring self-care plans and medication updates aligned with November 2024 NICE guidance. AD emphasised the scheme's role in admission avoidance and proactive care, welcoming its extension to frailty and end-of-life support. SA suggested rebranding the scheme to better reflect its focus on proactive care. VK proposed evaluating patient experience to measure outcomes such as reduced hospital visits, lower reliance on NHS 111, and improved satisfaction. SA supported formal evaluation given the investment. WG confirmed data capture would be included in the current cycle.

The committee supported the proposal subject to caveats: clarifying the scheme's purpose beyond winter access, developing an evaluation framework, and defining general practice's interface with the wider system. SA agreed to take a Chair's action on a revised paper to expedite communication to primary care, allowing time for planning and PCN governance processes.

ACTION: WG to clarify the scheme's purpose beyond winter access, develop an evaluation framework to assess its impact, and define how general practice interfaced with the wider system.

Outcome: The Committee SUPPORTED the proposed 2025/26 Winter Access Scheme, subject to the caveats discussed, and receiving Chair's support in between meetings.

Outcome post-meeting:

Following comprehensive discussions within the Committee, the Chair subsequently took Chairs action to approve the recommendation subject to the following caveats being included in the final scheme:

1. **PCNs to demonstrate increased Pharmacy First referrals.**
2. **Scope to include children and young people with respiratory problems (particularly asthma).**
3. **Scheme rebranded as a "enhanced proactive care scheme".**
4. **Data capture to enable an impact review post winter.**

10. Changes to Core Practice Membership

WG reported a change in membership within a Primary Care Network (PCN) following a formal request to remove a core member practice. Governance procedures under the Network Directed Enhanced Services (DES) were followed, and both parties agreed to the cessation.

As a result, the practice ceased participation in the Network DES, becoming the only practice within the ICB without DES status. This created a temporary lack of access to DES services for its patients. The ICB and the practice were engaging with other PCNs in the

Alliance to identify alternative arrangements, with a proposed solution to be presented in a future paper.

In response to SA, WG clarified that participation in Network DES was optional; however, under the General Medical Services (GMS) contract, practices must ensure patient access to DES services if they opt out. Short-term risk to patients was minimal, though concern was noted regarding care home provision due to the practice's significant number of care home beds. A separate discussion confirmed access to alternative services for enhanced care in care homes. WG emphasised this was an exceptional arrangement, applicable only to the care home element of the DES. SA stressed the need to document the exceptional nature of this arrangement.

SW anticipated an alternative arrangement would be in place by 1 December 2025. VK recommended that a Quality Impact Assessment be undertaken to identify current issues and assess the potential future impact on the population.

ACTION: Quality Impact Assessment to be undertaken by practice temporarily without Network DES status to identify current issues and assess the potential future impact on the population.

Outcome: The Committee NOTED the changes to Core Practice Membership in Central Basildon PCN.

11. Quarterly Finance Report

AK presented the finance report, providing an overview of the financial performance of the ICB in respect of its investments in, and directly influenced by, primary care as of Month 5 2025/26. The ICB reported a year to date forecast breakeven position. Approximately £265.26m was spent across the Primary Care portfolio during the first five months, £0.16m below available resources.

The report highlighted ongoing risks related to prescribing and premises costs, including potential claims for unaccounted premises reimbursements and support for legacy debts. GP prescribing remained the main area of volatility, though less so than in previous years. A cross-portfolio risk was noted between the GP Prescribing Budget and the delegated Community Pharmacy fund, due to national contractual obligations and retained margin commitments, which may impact drug pricing.

PW noted a reduction in referrals to Community Pharmacy services, leading to underutilised delegated funding and queried whether the underspend could be redirected to commission additional services. AK confirmed there was flexibility within the pharmacy budgets and agreed to discuss options with PW outside the meeting.

SA queried the overspend on premises costs and PCN budget variances. AK explained budgets were based on previous years, which may have underestimated contractual exposure, including potential rent increases. AK agreed to investigate and report back in the next Finance Report.

SA also queried whether the same applied to Local Enhanced Services (LES). AK clarified that the LES position was offset by a £5m underspend in local incentive schemes due to a reporting anomaly. He confirmed that future reports would explain anomalies in core allocations.

SA further queried the reason for a £0.14m underspend in prescribing and dispensing. AK agreed to investigate and provide an update in the next finance report.

ACTION: AK to investigate the premises cost overspend, PCN budget variances, and the £0.14m prescribing/dispensing underspend, and provide an update in the next Finance Report.

The Committee NOTED the Finance Report as at Month 5 2025/26.

12. Dental Research proposal

DB presented a research proposal from the University of Essex (UoE) on Dental Hygienists (DHs) and Dental Therapists (DThs). The study aimed to examine work patterns, identify barriers to the full utilisation of DHs and DThs, and explore better integration of these roles into NHS dental service delivery. Optimising the dental team was noted as essential to support future General Dental Services (GDS) and maximise NHS dental care provision.

Funding would be drawn from NHS England grant monies allocated by MSE ICB to the UoE in April 2023. DB confirmed the grant supported multiple workstreams, including research. In response to SA, DB confirmed the research would be national in scope, with a specific focus on MSE and its alignment to the national picture.

AK noted that the original grant included proposals to improve access to dentistry, particularly in areas of high deprivation. Subject to committee agreement, the research was intended to generate insights from the national context to inform and improve local service delivery, aligning with the grant's scope. AK recommended PCCC scrutiny of the broader grant and its use to date.

ACTION: Paper to be presented to PCCC outlining how the grant paid to the University of Essex was being utilised.

SA requested that the paper be reframed to reflect the proposal as an ICB investment in education and research aimed at optimising the dental workforce across Essex, improving retention and working patterns. BH noted the research could offer valuable regional insights and enhance the ICB's understanding of local needs.

ACTION: DB to bring an updated Dental Research paper to next PCCC meeting clearly articulating the intended use of the resource and to include details of the original grant agreement.

Outcome: The Committee NOTED the Dental Research proposal and that a further iteration would be presented at the next PCCC for consideration.

13. Risk Management

WG presented an overview of the primary care risks included on the ICB's risk register and Board Assurance Framework.

There were 11 active risks, with no risks rated red and 6 rated amber. Following discussion at the last meeting, the risk rating score for the 'Capacity and Demand' risk had decreased to amber. Additionally, LD Health Checks decreased to yellow.

No additional risks had been opened, and none closed. One risk update was still outstanding at the time of issuing the paper.

Risks linked to the ICB reorganisation and its potential impact on primary care, including transition-related risks, were noted in the update.

Outcome: The Committee NOTED the Risk Management update.

14. Items to Escalate

No items were noted for escalation to the Board.

15. Any Other Business

No other business.

16. Effectiveness of meeting

SA thanked ICB colleagues for their professionalism and rigour during a period of significant uncertainty, commending their impressive capabilities and collaborative approach under pressure.

17. Date of Next Meeting

1.00pm, Thursday 13 November 2025
Via Microsoft Teams

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 25 June 2025 at 9.30 am – 11.30 am

Via MS Teams

Members

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Simon Griffiths (SG), Social Care.
- Owen Richards (OR), Resident Engagement.
- Ronan Fenton (RF), Acute Care
- Feena Sebastian (FS), Mental Health.
- Nisha Thakrar (NT), Senior Clinical Fellow.

Attendees

- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- Helen Chasney (HC), Corporate Services & Governance Support Officer (Minutes).

Non-Attendees

- Olugbenga Odutola (OO), Primary Care.
- Babafemi Salako (BS), Primary Care.
- Holly Middleditch (HM), Senior Clinical Fellow, MSE ICB.
- Rachael Marchant (RM), Primary Care.
- Sarah Zaidi (SZ), Primary Care.
- Fatemah Leedham (FL), Pharmacy.

Apologies

- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Krishna Ramkhelawon (KR), Public Health

1. Welcome and Apologies

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

2. Declarations of Interest

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

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

3. Minutes

The minutes of the last Clinical and Multi-Professional Congress (CliMPC) meetings held on 28 May 2025 were presented for comment due to the meeting not being quorate.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 28 May 2025 would be presented for approval at the next CliMPC meeting on 27 August 2025.

4. Matters Arising/Action Log

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

MS explained that a high number of Service Restriction Policies (SRP's) had been presented to Congress over the last six months due to the requirement to align with neighbouring Integrated Care Boards (ICBs) and ensure that good commissioning documents were in place.

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

5. Approach to NICE Technology Appraisals

PW took the report as read and highlighted the following key points.

There was an increased focus on National Institute for Health and Care Excellence (NICE) Technology Appraisals (TAs), due to the increased number of disruptor NICE TAs. PW provided the background information for committee members on NICE TAs and disruptor NICE TAs, which included Hybrid Closed Loop (Type 1 diabetics) and Tirzepatide (weight management drug), and a business case was developed for both.

The NICE appraisal summary document would be presented to Mid and South Essex Medicines Optimisation Committee on 25 June 2025.

An example was provided for the underutilisation of a drug on formulary which was endometriosis. Specialists could now prescribe the drugs initially and then passed to primary care where the patient could continue on the medication for symptom control until the menopause. However, some patients may choose to have medication as opposed to an operation, which could deal with the symptoms, however this was a short-term, high-cost approach. The implementation of medication on NICE TAs provided savings in the system, but not savings within the prescribing budget.

The report recommended that the management of TAs should be brought into the business-as-usual process, including the prioritisation, the business case approach and how the funding would be defined, as no new funding would be received. The options for the NICE delay would be ensuring that a proper business case approach was followed, however, the ICB would be less likely to meet the 90-day implementation phase unless they were picked up early in the scoping phase.

PW advised that whilst NICE ensured access to clinically and cost-effective treatments, the increasing number of high-cost approvals could strain ICB budgets, requiring difficult prioritisation decisions. Although NHS England can negotiate phased introductions for

expensive therapies, ICBs must still absorb the financial impact locally. Operationally, implementation demands rapid updates to formularies, pathway redesign, and clinical engagement, often without sufficient infrastructure or workforce capacity. Additionally, NICE's streamlined cost-comparison appraisals may not align with local clinical pathways, complicating adoption. Despite legal funding mandates, regional variation in uptake persists, raising equity concerns.

OR suggested that there should be consideration on the approach that the ICB took to support the public to understand the complexities of the pathways, how their expectations would be managed. and how people with the living experience of a particular condition were engaged in the pathway design and how their experience could be used as advocates of what the ICB was doing as strategic commissioners. MS advised that the patient engagement element should be considered for all Service Restriction Policies (SRPs) and pathways.

SG commented that if the proposed medication was fundamental to improving people's lives and was more advanced than what was already in place, could something else be taken off the formulary to support budget management.

RF commented that this was not about individual drugs, it was about how they were managed in a national and local context. The Secretary of State for Health and NICE mandated ICBs to enact NICE TAs within 90 days. The timeline and funding were not suitable and the protocol was not yet in place to deal with this locally that recognised the local and system pressures within the ICB. The ICB needed to be in a position where the population understood the rationale for not enacting a TA within 90 days and would be a communication and engagement challenge.

OR asked how NICE TAs would fit in with the new ICBs strategic commissioning role, particularly if the concern was regarding communication and engagement, as following the transition, the new organisation would not have that resource in Essex. MS agreed and advised that all work completed on SRPs to date required a level of consultation and was becoming a pressure for individual teams.

PW advised that PS had suggested ensuring that the new ICB identified capability and capacity to carry out the process and develop the governance framework. Future NICE TAs should be assessed by one or more of the four strategic commissioning approaches and the ICB would have to agree to accept the risk of legal challenge and reputational damage of not meeting the 90-day implementation timeframe. PW advised caution on the approach to communication and engagement around the 90-day time frame, as that could provide visibility that the organisation was not meeting their legal requirements and the approach should focus on prioritisation and where the funding was spent. The recommendations were amended slightly to reflect PS comments.

In response to a suggestion from RF, PW confirmed that the requirement for a communication and engagement process would be included as an additional recommendation.

MS commented that communication and engagement should be highlighted as a risk.

OR asked whether Health Overview Scrutiny Committees (HOSCs) would be included in the governance process, which would highlight the process in the public domain. MS agreed and added that it would be helpful to provide the rationale to them for their oversight and challenge. OR commented whether this would possibly be a component of the Medium-Term Plan (MTP).

MS asked whether other ICBs in the area were working through their approach to SRPs and NICE TAs. PW confirmed that similar conversations were being held nationally on the challenges of taking these forward. MSE ICB was possibly further ahead by focusing on the business case approach.

MS suggested that when the report was presented to commissioning board, one area should be focused on to demonstrate where this approach has already been taken. ie. Hybrid Closed Loop, and that the risks should be articulated on legal challenge and reputational damage and include comments made by RF, OR and SG.

6. Adoption of Evidence-Based Interventions – Sinusitis

NT took the report as read and highlighted the key areas.

Sinusitis was an intervention listed within the national Evidence Based Intervention (EBI) programme where there was currently no commissioning position and an SRP had therefore been developed.

The SRP was essentially for surgical intervention for chronic sinusitis, where there was evidence to support surgery for a selected cohort of patients. For first line management there was good evidence for medical management which involved steroids or nasal saline irrigation. However, for selected patients, the national guideline supported secondary care assessment and consideration of surgery once medical therapy failed. There was good evidence of clinical and cost effectiveness to support surgery for these patients and could lead to improvement of symptoms, reduction in health care utilisation and could be more cost effective than continued ongoing medical management.

The policy was developed with clinical leads within the system and was based on national guidelines. Neighbouring ICBs do not currently have any specific policies in place.

MS asked why the cash and activity for endoscopic surgery had significantly increased from 2023/24 to 2024/25. PW explained that levels for endoscopic sinus surgery were possibly returning to pre-covid levels. A Trust ENT Lead had highlighted the requirements for this policy so that people were not referred for surgery who had not tried the alternatives for a reasonable length of time.

RF commented that the reason for the increase could be because there were more people that could do it, but also that the criteria was not being adhered to, as opposed to an increase in sinusitis in the population.

MS asked if medical therapy continued after surgery or would that need be eliminated. NT confirmed that some patients would continue with medical therapy. PW explained that sinusitis was classed as a chronic disease and the surgery would be given when the medication was not as effective, however, the medication would then be continued to avoid the worst-case scenario.

MS asked if compliance audits would be undertaken. PW explained that it would be proposed as an individual prior approval process, so GPs would confirm that relevant action had been undertaken beforehand. The next step would be to ensure the development of a robust prior approval proforma. Following the coding process being developed, activity could then be monitored.

OR asked if pharmacies were following the same first line approach and there were no

implications for a change in a practice. PW suggested checking the sinusitis pathways with community pharmacies, which wouldn't impact the SRP. One of the challenges would be when seeking evidence that a patient has tried certain things before a referral, because currently Pharmacy First consultation was not recorded in the GP records in the same way.

Outcome: The Committee supported the recommendation to adopt the Sinusitis Service Restriction Policy, subject to comments made from those not in attendance.

7. Horizon Scanning

MS advised that the SRPs for kidney stones and enlarged prostrate were both approved at commissioning board. All SRPs that had been approved at commissioning board required consultation, and a meeting was being held to discuss this further.

The committee discussed possible areas of work for discussion at future meetings. The following was noted.

- Obesity, weight management and bariatric surgery would be reviewed together at a future meeting.

MS advised that difficult decommissioning decisions continued to be made within the system because of the financial challenges, which could come be presented to Congress as and when they arise.

8. Escalation to SOAC/ICB Board

There were no escalations.

9. Any other Business

There were no items of any other business raised.

10. Date of Next Meeting

It was confirmed that the meeting on Wednesday 30 July 2025 at 9.30am would be cancelled and consideration would be given on whether the meeting on 27 August 2025 would be held due to the holiday period. Any reports that require urgent consideration could be sent to committee members virtually and noted at their next meeting.

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 24 September 2025 at 9.30 am – 11.30 am

Via MS Teams

Members

- James Hickling (JH), Deputy Medical Director, MSE ICB, deputising for Matt Sweeting, Medical Director (Chair).
- Fatemah Leedham (FL), Pharmacy, up to item 8.
- Nisha Thakrar (NT), Senior Clinical Fellow.

Attendees

- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- Scott Baker (SB), Director of Allied Health Professions and Leadership, MSE ICB.
- Stephanie Carey (SC), Alliance Clinical Lead, MSE ICB, for item 7.
- Helen Chasney (HC), Corporate Services & Governance Support Officer (Minutes).

Apologies

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Feena Sebastian (FS), Mental Health.
- Simon Griffiths (SG), Social Care.
- Owen Richards (OR), Resident Engagement.

1. Welcome and Apologies

JH welcomed everyone to the meeting and apologies were noted as listed above. The meeting was not quorate, so papers would be circulated virtually to members not in attendance for comment.

2. Declarations of Interest

JH 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.

JH declared his interests, however there was no conflict anticipated with the items being discussed.

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

3. Minutes

The minutes of the last Clinical and Multi-Professional Congress (CliMPC) meeting held on 25 June 2025 were presented for comment due to the meeting not being quorate.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 25 June 2025 would be presented for approval at the next CliMPC meeting on 29 October, due to the meeting not being quorate.

4. Matters Arising/Action Log

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

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

5. Outcome of commissioning discussions since last meeting

JH advised that the following Service Restriction Policies (SRPs) were virtually circulated, and responses received were broadly supportive and those recommendations would be made to commissioning board.

- Nasal Obstruction SRP (incorporated Sinusitis)
- Colonoscopy SRP
- Electrocardiogram (ECG) SRP

6. Upper Gastrointestinal Endoscopy Evidence Based Intervention Service Restriction Policy

SB reported that the Upper GI Endoscopy Service Restriction Policy (SRP) was based on Evidence Based Intervention (EBI) guidelines and developed with clinical engagement, although this proved challenging. The Clinical Lead at West Herts and Essex ICB (HWE ICB) had recommended changes, notably on the flow chart and inclusion of non-urgent direct access endoscopy. Clinicians indicated that this approach was already being followed so financial savings were unlikely. While difficult to evidence, the policy aimed to discourage overuse of endoscopy for surveillance purposes.

NT advised that the SRP was aligned to National Institute for Health and Care Excellence (NICE) and British Society of Gastroenterologists (BSG) guidelines.

PW noted that the flow chart was useful as the ICB commissioned Direct Access Endoscopy and needed to be embedded within commissioned services. SB confirmed that the current service specification was reviewed to ensure compliance with all criteria.

JH advised that the SRP would be circulated to Congress members in attendance with no further amendments.

Following circulation of the documents to Congress members not in attendance, OR, SG, RF, MS and PS confirmed support of the proposal.

7. Spinal Injection Service Restriction Policy

SB advised that the current Spinal Injection SRP focused on low back pain injections. Following review of the EBI guidance, there had been issues with coding and usage, however these had been addressed in the revised SRP, which also provided clarity and structure, notably around the types of procedures, such as spinal radiculopathy, diagnostic assessment or radio frequency, to ascertain activity and ensured that prior approvals were completed as required.

The updated SRP, which now covered the whole spine, was shared with Victor Mendis, Pain Consultant, MSEFT. It was noted that the National Institute for Health and Care Excellence, (NICE) guidance did not support injections for non-specific low back pain. The rationale for updating was there was limited evidence base. No alternative criteria were identified, so alignment was made with the policies from Greater Manchester and Hampshire and the Isle of Wight ICBs, who had adopted this position.

Alternatives such as pain management programmes were available and supported by evidence, particularly for chronic mechanical neck pain.

The SRP also provided clarity on repeated injections and timelines. It was highlighted that if new evidence became available, the SRP would be reviewed and updated. The proposed SRP offered the most evidence-based and resource efficient approach.

PW suggested that the rationale for repeat injections should be clearly defined to avoid routine repetition. A criterion to define pain level or function impairment for repeat injections was recommended. SB acknowledged the challenge of balancing administrative burden on consultants and noted that currently tracking was not possible, which would be addressed in the revised SRP. It was acknowledged that the process needed a safeguard against repeated cycles and the prior approval process would enable that robustness. PW also suggested amending the rewording for the funding of repeat injections from ‘two procedures in a year’ to ‘two procedures in a 12-month period’ for clarity.

JH queried whether the criteria for initial injections, being moderate or severe and persistent radicular pain, would apply for repeat injections. PW recommended clarifying that repeat injections should only be considered if pain remained severe and controllable, noting that in the private sector, routine six-monthly injections were common. The process should be agreed with the Trust, as GPs would not want patients returning for new referrals. It was queried whether repeat injections would be managed through patient initiated follow up. Clearer wording was recommended to confirm the number of injections and that the criteria for initial injections also applied to repeat injections. If prior approval was required for each injection, then a particular criterion should be met for a repeated injection.

FL advised that clear clarification and guidance on the number of injections would manage patient expectations. Pain was subjective and varied from each individual, but there should be clarity on the inclusion and exclusion criteria.

PW requested clarification on the 12-month interval for radiofrequency denervation, noting that NICE guidance indicated greater cost-effectiveness if the effect lasted at least 16 months. SB confirmed that the proposed SRP followed Get it Right First Time (GIRFT) guidance. JH suggested adopting a 16-month interval from a financial perspective, unless unintended consequences arose. SC noted that earlier intervention might be necessary if pain significantly worsened, due to socioeconomic impact. PW proposed initially setting the

interval at 16 months, with policy review if frequent early requests were received. JH added that a decision for an Individual Funding Request would not made if there were as little as two patients in that situation.

In response to a query from JH, SB confirmed that the procedure was an injection or intervention, which was given at the symptomatic level or side, rather than having many injections and that two injections could be given but would need to be on the same level or next to each other on the same side. SC noted that currently multiple levels on multiple sides were being treated, but the intention was to use a diagnostic injection to identify the affected area. PW asked how pain origin was determined and SC explained that different areas had different referral patterns for pain and the level would be identified through assessment. In response to a query from PW, SC confirmed that if symptoms were present on both sides, both should be treated simultaneously. Clarification would be required that the injection was being given as necessary and for the right reason.

JH summarised that funding would apply only to symptomatic areas level or side, and it was confirmed that additional charges would apply for multiple entries. FL commented that sometimes pain was one sided so why would both sides be treated, if not required. PW asked for clearer definitions of facet joint pain and its presentation. SC explained that pain referral varied by level. SB noted that repeat injections were common, but only diagnostic injections leading to radiofrequency treatment were funded. PW recommended clearer guidance for providers, including private providers. JH requested that the wording was reviewed and agreed with consultants. PW also suggested aligning the funding wording for facet joint pain with that used for sacroiliac joint procedures.

PW asked whether pain relief was routinely recorded. SC confirmed that a follow-up call was conducted within two weeks to assess the patient's improvement.

SB to review and amend wording and circulate round congress members for review before presentation to Executive Committee.

Following circulation of the documents to Congress members not in attendance, OR, SG, RF, MS confirmed support of the proposal.

PS highlighted that if there was evidence for the epidural steroid injections for isolated spinal pain or for neurogenic claudication in patients with central spinal canal stenosis procedure then a discussion may be required for that subset of patients. Neurogenic claudication was similar to radiculopathy which was funded under the SRP, so should be checked whether this should be classed as "Non-specific spinal pain". SB explained that neurogenic claudication was specific diagnosis and clinically very different from a radiculopathy and non-specific low back pain (this term denoting there is no specific cause for the pain). The existing and revised policy did not recommend epidural injections for neurogenic claudication hence there was no formal evidence review as it has not changed. Keeping this position was in alignment with NICE and the EBI guidance. Epidurals for neurogenic claudication would not have good clinical outcomes and therefore should remain as a do not do.

PS commented whether it could be recommended that any realised cost saving / avoidance was directed towards preventative / community pathways. Mid and South Essex provided MSK services in acute and community settings with both a preventative and curative focus, so should be recommended that investment supported those strategic directions.

8. Specialist Obesity Services - Bariatric Surgery Service Restriction Policy

PW took the report as read.

JH noted that PS had proposed a review of multiple actions rather than a single one. PW disagreed and advised that initially a review of the access to bariatric surgery was required due to the change of access to Tier 3. Currently, patients were required to access Tier 3 before being able to access Tier 4. However, the access criteria for Tier 3 was for people with a BMI 40 plus a co-morbidity which excluded people with a BMI of 40 without a co-morbidity from being entitled to bariatric surgery. This had been superseded by the ICB transition to a proposed Essex ICB and the need to harmonise policies. A summary table was comparing policies from EBI, NICE, Mid and South Essex Integrated Care Board (MSEICB), HWEICB and Suffolk and North East Essex Integrated Care Board (SNEEICB).

PW proposed adopting the HWE policy, which would require minor changes and request that an assessment was required within Tier 3, reflecting a common approach across the region.

JH requested a summary of key criteria differences between the different policies. PW explained that NICE was not definitive in terms of progression through levels, whilst EBI allowed direct access to bariatric surgery for people with a BMI 50+. The difference between the EBI and HWE policy was the requirement to complete Tier 3. The Tier 3 assessments helped demonstrate patient compliance with weight loss and dietary requirements. Bariatric surgery could be more cost-effective long term compared to ongoing medication. The proposed approach included specialist and psychologist assessments in Tier 3, with direct referral to Tier 4 if criteria was met and was the most appropriate treatment. JH summarised that Tier 3 should not be a barrier but a means to improve access and outcomes, while reducing system-wide costs. PW advised that NICE recommendation for medication had no end date at a cost of £330 per month for the highest dose, making bariatric surgery a more sustainable option.

JH referred to a query from PS regarding the cost implications of adopting the HWE model. PW confirmed that cohort numbers could be identified, but the main issue was provider capacity at Luton and Dunstable and Homerton. It was noted that Tier 3 service had long waiting lists under the previous policy. The other limiting factor would be the Tier 3 assessments, depending on commissioning arrangements.

JH asked whether the preferred HWE policy option conflicted with NICE recommendations. PW confirmed that the HWE policy could be tweaked to align with NICE by allowing Tier 4 access for patients with a BMI 50+ and a co-morbidity, which would be consistent with Tier 3 access criteria and would reduce the numbers slightly. The patient would be assessed by Tier 3 as stated in the EBI criteria. Whilst NICE recommended either Tier 3 completion or direct access to Tier 4, completing Tier 3 may not be cost-effective if assessment indicated direct referral was appropriate. Provider capacity and patient eligibility required review. The bariatric surgery costs varied depending on the intervention provided.

JH sought clarification on the criteria of lack of sleep, unless caused by sleep apnoea, which could be an indication for surgery. PW explained that this is what the current Tier 3 weight management policy stated. The intention was that sleep apnoea should be excluded

as the reason for the lack of sleep. JH also reiterated a further point which stated that sleep apnoea was a condition that might make someone eligible for surgery. It was agreed that this would be reviewed for clarification.

PW would redraft the paper and include associated costings and the potential impact on SNEE and HWE and bring back to November meeting with a specific recommendation.

9. Horizon Scanning

The following was noted for discussion at the October meeting.

- Elective Care Specifications
- Musculo Skeletal (MSK) (including use of ultrasound guided shoulder injections)

10. Escalation to SOAC/ICB Board

There were no escalations.

11. Any other Business

JH advised that MS and PS were reviewing membership and representation to make more feasible going forwards, noting the pan Essex geography.

PW highlighted that NICE had produced a new draft In Vitro Fertilisation (IVF) guidance, so it would be necessary to review the IVF SRP and decide whether this should be harmonised across the East of England. It was agreed that this would be discussed at the next Clinical Leadership and Innovation Senior Leadership meeting.

There were no items of any other business raised.

12. Date of Next Meeting

Wednesday, 29 October 2025 at 9.30am – 11.30am via MS Teams.

Minutes of MSE ICB Quality Committee Meeting

Held on 5 September 2025 at 10.30am – 12.30pm

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).
- Denise Townsend (DT), Acting Chief Nursing and Quality Officer, Mid and South Essex Foundation Trust (MSEFT).

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.
- Yvonne Anarfi (YA), Deputy Director of Nursing for Safeguarding, MSE ICB.
- Angela Little (AL), Associated Designated Nurse, Safeguarding, MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company (up to item 8).
- Wellington Makala (WM), Quality Lead, Mid and South Essex Community Collaborative (MSE CC).
- Emma Timpson (ET), Associate Director of Prevention and Health Inequalities, MSE ICB.
- Sophia Morris (SMo), System Clinical Lead, Health Inequalities, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Viv Barker (VB), Director of Nursing for Patient Safety, MSE ICB.
- Dr Christine Blanshard (CB), Chief Medical Officer, MSEFT.
- Kim James (KJ), Healthwatch.
- Rebecca Jarvis (RJ), Alliance Director, Thurrock, MSE ICB.

- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.

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 27 June 2025 were reviewed and approved.

Resolved: The minutes of the Quality Committee meeting held on 27 June 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 – Medicines Management

PW explained that the deep dive focused on medicines that were initially prescribed by a doctor which patients could become dependent on.

A Regulation 28 notice (Prevention of Future Deaths (PFD) report) was a legal notice issued to organisations following an inquest where the coroner believed action could be taken to prevent future deaths in similar circumstances. The CCG/ICB had received Regulation 28 (PFD) notices in November 2019 and June 2025 relating to medicines, with further detail provided in the report.

Dependence-forming medicines included benzodiazepines, zopiclone, opioids and anti-depressants. A recent study found a higher mortality risk for morphine users compared to codeine, and for those using multiple opioids. Data interpretation was challenging due to reference to ‘all-cause’ mortality, which included illicit drugs.

Mid and South Essex Integrated Care Board (MSE ICB) was in the lower quartile nationally for overall opioid use (excluding co-codamol and co-dydramol); the upper quartile for high-dose opioid prescribing with the second highest number of patients; and mid- quartile for patients dependent on both opioids and other drugs, with slight improvement noted. There was variance across the Primary Care Networks (PCN). Maldon and Witham PCN were in the upper quartile, although the PFD notices received arising from patient inquests

highlighted that high dose opioids were not involved. Data was influenced by populations served and higher opioid use correlated with areas of greater deprivation. PW noted Aegros PCN was in the lower quartile.

A timeline of actions since the first PFD report in November 2019 was presented, beginning with the development of a local enhanced service for prescribed opioid dependence. The June 2025 Regulation 28 notice highlighted the ongoing absence of a specialist commissioning service for GPs to refer patients needing support to reduce dependence on prescribed dependency forming medications. However, this work was underway and included advice and guidance on deprescribing of opioids delivered through Essex Specialist Treatment and Recovery Service (StaRS), MSEFT's pain management service, locally approved guidance, training courses for GPs and prescribers, community pharmacy services and Primary Care Networks (PCN) Directed Enhanced Service (DES) funding whereby GPs were expected to complete structured medication reviews (SMRs).

The Aegros PCN model identified priority patients and employed a counsellor to support staff with psychosocial counselling and provided education for patients withdrawing from these medications. GPs or pharmacists conducted medication reviews, and the service was then extended to all patients on high dose or dependent forming medicines (DFM). Clinicians were trained to support opioid deprescribing conversations. The pain clinic supported this model and held multi-disciplinary team meetings for complex patients. This resulted in 47 patients stopping medication and 39 patients were following a reduction programme.

A new opioid reduction and deprescribing pathway was planned with in the community Musculoskeletal (MSK) service, currently in procurement and due to be launched in February 2026. Whilst the urgency was recognised, implementation depended on available resources and addressing disparities. A paper on the Aegros model was presented to the ICB's Executive Committee for potential wider rollout across the system. Next steps included developing a business case for a commissioned DFM deprescribing service. It was noted that North East London Foundation Trust (NELFT) offered a de-prescribing service which was costed per case whilst the Aegros model would be the cost of the staff commissioned/employed to provide the service as a whole.

In response to a query from SP, PW confirmed that prescribing of high dependency drugs was decreasing. Hospital contracts included key performance indicators (KPIs) to avoid discharging patients on opioids or to include a stop date. Following commissioning, the community Musculoskeletal (MSK) service would be closely managed through the service specification and contract.

DD commented that MSE previously received regional support to review population health analytics focused on suicide prevention. A key finding was that long term use of certain prescribed drugs significantly increased suicide risk. Aegros PCN had identified 13 individuals with multiple risk factors, and the challenge would be communicating this risk to the patients in an ethical manner. LW highlighted that cumulative suicide risks were deeply concerning.

NIB thanked PW for her work in this area and pushing forward the change required.

Resolved: The committee noted the Deep Dive on Medicines Management.

6. Executive Chief Nurse Update

6.1 Safety Quality Group – Escalations

There were no escalations from the Safety Quality Group reported.

6.2 Emerging Safety Concerns/National Update

SM highlighted that the ICB continued the organisational change process. Paul Burstow had been appointed as the Designate Chair of the new ICB and Executive appointments were nearly complete. Some teams, such as Safeguarding, had activated business continuity plans, due to sickness and vacancies.

Diane Sarkar had stepped down as Chief Nurse at MSEFT. MSEFT recently underwent a Care Quality Commission (CQC) Well Led inspection. Concerns were raised about Paediatric Services following an inspection which prompted a rapid quality review and safeguarding boards being alerted. An independent cultural review was being conducted to identify improvement areas.

A Section 31 CQC notice remained in place for the neonates service, particularly at the Broomfield site. Discussions were ongoing with the Regional Chief Nurse on whether that should be removed. A recent maternal death had occurred on the Basildon site.

An independent review of learning disabilities arising from the Section 75 Agreement had been completed, focussing on the ICB's statutory oversight responsibilities, including Learning from Deaths (LeDer) reviews and Care and Treatment Review (CTR) processes. The service, commissioned via Essex County Council (ECC), had not kept pace with changes, particularly during the pandemic. Consideration was required of future commissioning arrangements through the new Essex ICB landscape.

EPUT had been under significant pressure with demand and capacity, affecting out of area placements which impacted the challenged acute and mental health suites. North East Essex were undergoing an independent review on their inpatient wards, which could directly impact MSE ICB.

Concern had been raised with regards to one GP practice and support options were being reviewed. Dr Bekas medical centre had returned its CQC contract, and relevant patients were now under the care of another provider.

National issues persisted with Attention Deficit Hyperactivity Disorder (ADHD) prescribing, referrals and treatment options for adults and children and patient complaints had increased during June/July.

For AACC the level 2 incident regarding care agency CQC registration had been stepped down with work continuing to address all issues identified.

Public hearings for the Lampard Inquiry were expected to commence in October 2025. Former CCG/ICB staff were approached for witness statements and would be supported throughout the process. A Rule 9 request regarding six example cases that reflected geography and diagnosis at a specific point in time was being prepared.

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. EPUT/Mental Health Update

AS took the report as read and highlighted the key points.

As of 4 September 2025, there were 50 inappropriate out of area (OOA) placements, of which 21 were within MSE. An action plan was in place to reduce this further, although discharges remained a challenge due to system and internal factors, but was supported from a multidisciplinary perspective.

CQC inspection reports had been received for acute inpatient and psychiatric intensive care units and the rating had improved from 'Inadequate' to 'Requires Improvement'. Key learning was medication management, particularly supporting people after rapid tranquilisation.

The Section 29A warning notice was lifted as part of the CQC review.

Colchester area wards were undergoing a quality review, with NEE ICB support, reviewing key issues of culture, leadership and pathways.

'Safewards' was a strategy within mental health settings to reduce conflict and restrictive practices, aligned with the national programme on long term segregation and seclusion. Data management was an expectation and the CQC would be informed if timescales were not met.

With regards to the Lampard Inquiry, hearings would review historic cases and actions taken following PFDs. MS confirmed that a Lampard Inquiry update paper would be presented to the ICB Board in September.

In response to a query from MS, AS explained that EPUT was working with the Kings Fund to review culture. The cultures of the previous two trusts remained at EPUT, so building a unified identity was important and would be influenced by the ongoing inquiry. DT confirmed that MSEFT was undertaking similar work, with a cultural programme being mapped out. Both organisations planned to meet and work collaboratively. NIB noted that former colleagues providing statements to the inquiry presented an opportunity to gain insights into the organisational culture.

Resolved: The Committee noted the EPUT / Mental Health update report.

8. This item has been minuted confidentially.

9. Safeguarding (Adults)

AL presented the safeguarding report and highlighted the following key points.

Safeguarding team capacity remained challenged due to long-term absences and vacancies, however, statutory responsibilities were being met and a prioritisation plan was in place. A new designated lead for adult safeguarding had been appointed.

The commissioned domestic abuse service across Essex was launched on 1 April 2025 which enabled referrals from acute services and promoted collaboration. Work continued to improve GP engagement within Essex, through an information sharing agreement, although some resistance remained.

There were 14 Domestic Abuse Related Death reviews (DARDRs) with the Home Office at various stages, either waiting approval or awaiting return with amendments. Two were awaiting publication and learning would be shared once published. Suspected suicide cases linked to domestic abuse had increased but remained difficult to evidence due to underreporting. The Southend, Essex and Thurrock Domestic Abuse Board (SETDAB) had published two briefings, including one on suspected suicide, and the learning was being extracted.

There were 17 Safeguarding Action Reviews (SARs) in Essex, many in the scoping review phase, with learning and recommendations detailed within the report.

National changes to Prevent were underway, with rising referrals for children being linked to neurodiversity and poor mental health. The outcome from Lord Anderson's review and new Prevent guidance were awaited. NIB suggested Prevent as a future deep dive topic.

YA presented the all-age safeguarding annual report covering Strategic Leadership, Assurance and Accountability, Partnership & Collaboration and Learning and Development.

DT raised concerns regarding child deaths at MSEFT which involved children on child protection plans.

Resolved: The Committee noted the Safeguarding (Adults) update report and the Safeguarding.

Action: HC to add Prevent to the deep dive plan.

10. Equality and Health Inequalities Update

10.1 Equality and Health Inequalities Impact Assessment (EHIIA) Panel Summary Report

ET reported that the Equality and Health Inequalities Impact Assessment (EHIIA) Panel had been operating for 11 months, supporting the ICB in meeting its statutory duties under the Equality Act and Public Sector Equality Duty. The panel reviewed EHIIAs for service changes and promoted cultural development, embedding equality considerations into decision making. Training had been delivered across the organisation and individuals and teams were supported on the completion of EHIIAs. Whilst assessments were often received late during the business case development, earlier engagement had improved.

The report summarised the assessments received and highlighted potential negative impacts on protected characteristic groups, with mitigations explored to minimise the impact.

A digital solution (ImpactEQ) was under review, however significant improvements were required. The processes and assessment tools in other ICBs were being reviewed in preparation for establishment of Essex ICB.

MS thanked ET and SM for their support with EHIIAs associated with Service Restriction Policies and general commissioning policies.

VC offered support on reviewing the template in line with National Quality Board recommendations. NIB suggested that the finalised template should be shared with Quality Committee.

Resolved: The Committee noted the Equality and Health Inequalities Impact Assessment (EHIIA) Panel Summary report.

Action: ET to share the finalised Essex ICB EHIIA template with Quality Committee.

10.2 Patient Safety Healthcare Inequalities Reduction Framework

SM reported that the patient safety healthcare reduction framework was published in May 2025, and was developed with system wide input and lived experience. The framework built on the Patient Safety Incident Response Framework (PSIRF) and CORE20PLUS5 approach which ensured that patient safety reviews also addressed health inequalities.

The framework, based on five principles, included improving communications and information for patients and residents, workforce training, data quality and coproduction. Recommendations that required consideration to support system wide implementation were provided in the report.

SP queried whether all protected characteristics were being captured. SM noted improvements in data collection for deprivation and ethnicity, but some systems lacked sufficient demographic recording for theme identification. The aim was to work with providers and internal incident reporting to ensure recording was more robust.

PW highlighted the positive impact of the training on completing EHIIAs and stressed the importance of understanding reasonable adjustments, It was noted that some Individual Funding Requests misinterpreted specialised services, when it would be the duty of the organisation to ensure that certain services were available, such as the provision of sign language. PW agreed with the principles, particularly the involvement of people and patients and asked how individuals could be linked to particular groups to provide their own life experience. SM advised that work was ongoing to develop groups, such as the research engagement network. The groups required increased visibility to enable collaboration with different parts of the system. ET added that these groups were consulted on specific projects requiring engagement.

JF noted that Patient Safety Partners offered valuable support from a patient perspective. Healthwatch and local medical support groups, such as Parkinsons or Epilepsy societies also contributed useful insights.

NIB commented that patient representatives on groups should be regularly rotated to ensure diverse views and experience were captured and suggested that future reports include qualitative and quantitative data to provide assurance on the effective use of impact assessments.

Resolved: The Committee noted the Patient Safety Healthcare Inequalities Reduction Framework.

11. Patient Safety & Quality Risks

SOC took the report as read and highlighted the following key points.

The Quality Committee received a risk register based on its remit and the ICB Executive Team regularly received a register of all red rated risks across the organisation.

There were currently 25 risks within the remit of Quality Committee, of which, eight were currently rated red. No new risks had been opened since the last meeting.

One risk (Risk ID35: Children and Young People Special Educational Needs and Disability (SEND) was recommended for closure as detailed in the report and comments were invited.

SP asked if the Risk ID 35 should be closed in the event of a poor CQC rating. SOC explained that if a poor rating was given, the improvements required would still be able to be implemented, in partnership with the relevant local authority. SP suggested that the wording should be amended.

The latest iteration of the Board Assurance Framework (BAF) submitted to the ICB Board in July was attached. The BAF was currently being updated in readiness for the next Board meeting on 18 September 2025.

An update on the outcome of the two workshops held to pilot National Quality Board guidance on assessing and managing risks would be provided at the next Quality Committee meeting on 31 October 2025.

SM advised that the Executive Committee recently received a presentation on corporate risks, with key feedback highlighting the need to align risk scores proportionately with system-level risks.

No further comments were received.

Resolved: The Committee noted the Patient Safety and Quality Risk report and approved closure of Risk ID35 (Children and Young People Special Educational Needs and Disabilities (SEND).

12. Provider Quality Accounts 2024/25

SM advised several provider quality accounts for 2024/25 had been received as detailed below:

- MSEFT
- Springfield Hospital (Ramsay Healthcare Group)
- East Anglia's Children Hospices (EACH)

Six small provider quality accounts remained outstanding and were being followed up.

No comments were received.

Resolved: The committee ratified the provider quality accounts.

13. Nursing and Quality Policies

Extension of Existing Policies

SOC requested extensions to review deadline dates for the following policies to March 2026, due to limited staff capacity and to enable sufficient time for changes arising from the ICB reorganisation.

- 062 Complaints Policy
- 064 Safeguarding Supervision Policy
- 068 All Age Continuing Care Policy
- 069 PHB Implementation Policy
- 071 Prevent Policy

In preparation to transition to the new Essex ICB, work would be undertaken as part of the due diligence process to develop a final list of policies required for the new organisation. A process was underway to compare MSE ICB's policy framework with those of Herts and West Essex (HWE) ICB and Suffolk and North East Essex (SNEE) ICB. Policy leads/authors would be contacted in due course with detail of the process to be followed.

NIB asked if some policies would be merged or no longer required. SOC explained that was a possibility, but was dependent on the future functions of the ICB. Any different arrangements at HWE and SNEE ICB relating to the Essex area would also be considered.

SM advised that the AACC Team were currently reviewing the PHB Implementation Policy and he anticipated it should be ready for approval by the next committee meeting.

Resolved: The Committee approved the extension of the review deadline dates to March 2026 for the policies listed above.

14. Discussion, Escalations to ICB Board and agreement on next deep dive.

14.1 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.

14.2 Agreement on next deep dive

HC confirmed that the next deep dive for the October meeting would be Community Optometry Services, with Community Pharmacy and End of Life Care (with a Medium-Term Plan focus) at subsequent committee meetings.

Resolved: The committee noted that the next deep dive would focus on Community Optometry Services.

15. Any Other Business, including discussion on effectiveness of meeting

NIB noted that despite organisational change, business as usual continued. However committee functions and the ICB's constitution would be reviewed, and an update provided once confirmed. In future discussions, it would be sensible to build upon harmonisation.

No other business was discussed.

16. Date of Next Meeting

Friday, 31 October 2025 at 10.00 am to 1.00 pm via MS Teams.

NB: This was subsequently amended to Friday, 7 November at 10.00 am to 1.00 pm via MS Teams.

Part I System Oversight & Assurance Committee (SOAC)

Minutes of Part I meeting held 22 August 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).
- Simon Wood (SW), Regional Director for Strategy & Transformation, East of England, NHSE, and Co-Chair of committee.
- 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

- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB.
- John Walter (JW), Director of Operations - All Age Continuing Care, MSE ICB, deputising for Dr Giles Thorpe.
- Sarah Davies (SD), Finance Improvement Lead, MSE ICB (deputising for Jennifer Kearton).
- Sara O'Connor (SO), Senior Manager Corporate Services, MSE ICB.

Apologies Received

- Jennifer Kearton (JK), Chief Finance Officer, MSE ICB (chaired committee on behalf of Tom Abell)
- Pam Green (PG), Alliance Director, Basildon and Brentwood and ICB Primary Care Lead.
- Dan Doherty (DD), Alliance Director, Mid and South Essex, MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director, Thurrock, MSE ICB.
- Zoe Pietrzak, (ZP), Regional Director of Finance, NHS England (East of England).
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- 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 quorate.

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 27 June 2025 were reviewed and approved by those present with no amendments requested.

SO confirmed she sought approval of the minutes of the previous meeting held on 25 April 2025 from ZP and SW.

Outcome: The minutes of the committee meeting held on 27 June 2025 were approved by those present.

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:** TA advised that the spreadsheet used by the ICB's Programme Management Office (PMO) to track delivery against actions was shared with committee members. TA suggested this was sufficient to close this action although he was happy to deal with any queries.

All other actions were noted as complete.

Outcome: Members noted the updates on the action log.

5. Financial Recovery (presented by S Davies on behalf of J Kearton)

SD advised that month 4 (M4) had just closed. MSEFT's position had moved off plan and would be discussed in detail at the Part II SOAC NOF4 (National Oversight Framework) meeting on 26 August 2025. Pharmacy's financial position was quite challenging and the ICB was therefore working with MSEFT to identify areas where the ICB could act to support. Indicative activity plans appeared to be higher than anticipated and it was therefore likely activity management plans would be developed soon.

With regard to EPUT, work was being undertaken with NHSE colleagues regarding new Risk of Non-Delivery Assessment (RONDA) metrics to understand their implications on the cash position. A this was a quarterly metric, there was sufficient time to undertake internal work to understand the likely position at the end of the quarter and whether deficit cash support would be required/forthcoming.

Colleagues were working through non-current mitigations, of which few were available, and all organisations were trying to close the gap on unidentified cost improvement plan targets.

SD advised that although the system was currently significantly off plan, the majority of the financial year was available, and must be used to get finances back on track.

TA asked PS what his level of confidence was regarding how this would play out across the year. PS advised that there was currently circa £2 to £4 million worth of risk, and EPUT was trying to get the provision re-stated through the national team. Where possible, the Trust would also mitigate costs associated with the Lampard Inquiry, although this was difficult due to the statutory responsibility to ensure the Inquiry's requests were fully met.

TA asked SD to check that the EPUT risk position was fully reflected within relevant risk registers.

JC asked SW if the deficit position, and retrieval of it should plans not be achieved, was a 'system issue' or an issue for individual organisations.

SW advised he would endeavour to discuss this with ZP and suggested this could be picked up at the NOF4 meeting on 26 August 2025.

Resolved: The committee noted the verbal finance update.

- **Action 215:** SD to check that the EPUT financial risk was fully accounted for within relevant risk registers.

- **Action 216:** SW to discuss with ZP whether the deficit position, and retrieval of it should plans not be achieved, was a 'system issue' or an issue for individual organisations.

6. Deep Dive – All Age Continuing Care and Discharge to Assess: (presented by J Walter)

JW shared a presentation on All Age Continuing Care (AACC) and Discharge to Assess (D2A).

JW highlighted factors which significantly impacted on quarter 1 performance, including: the treatment of disease, disorder or injury (TDDI) registration issue; ongoing vacancies within the Band 6 clinical workforce; increased sickness absence at senior and clinical workforce levels; a 21% on-year increase in referral demand for continuing health care (CHC), not including children; organisational safeguards relating to four homes which required additional clinical visits as part of a safeguarding response; and ongoing social care workforce pressures.

The 28-day standard relating to completion of the checklist to completion of the Decision Support Tool (DST) was 83.09% in April 2025, meeting the NHS England target (80%). This subsequently deteriorated due to factors mentioned above but was now improving and currently reaching internal targets. Going forward, alternative ways of undertaking work would be considered to ensure the standard was consistently maintained.

Slide 5 set out core AACC performance relating to annual reviews, which showed an adverse position, the main cause of which was de-prioritisation of annual reviews to focus on patient safety/quality issues. It had also been identified that some patient contacts were not actually being formally logged as reviews, which was being addressed.

Although there had been a 21% increase in demand, there had also been a 21% in activity to meet that demand.

The number of referrals relating to children and young people continuing care (CYPCC) had also increased, although the numbers were much smaller than adults.

It had been highlighted that there was significant variation in ICB CYPCC caseload sizes nationally, for example some had 40 whereas MSE ICB currently had over 120 which, considering the criteria for CYPCC was much clearer than for adults, warranted more exploration. In addition, the Senior Operational Lead was holding this caseload which was not sustainable.

In relation to D2A, JW advised he had been tracking performance via statistical process controls to identify when action made a positive difference. JW explained that new D2A starts went into nursing home placements, residential home placements or domiciliary care. By its nature, this had been a health-led pathway but anyone requiring residential care should probably be discharged via a social care pathway, although there might be some individuals with an additional health need. JW was ensuring this was the exception rather than the rule,

thus reducing the trend. There was a similar trend in relation to domiciliary care starts. However, there had been a slight increase in nursing home placements, which would be monitored, probably due to the acuity of patients and improvements made in the Care Transfer Hub which had reduced delays.

Some people required enhanced supervision or one to one (1:1) support, the data for which was generally around the mean. By getting a tighter grip of the pathway and implementing the multi-disciplinary team (MDT), the average number of 1:1 days had reduced, with an associated financial benefit. D2A Length of Stay (LoS) had also been reduced.

JW explained the MDT enhanced the pathway further. The data available so far showed LoS was now much closer to 40 days, but he would like it to be closer to the four-week target for intermediate care, although dependent on patient needs and complexity.

Mountnessing Court in Billericay, which was used as a pilot, continued with a continual improvement process. LoS was around 35 to 42 days which was good, and in terms of CHC eligibility, the vast majority of individuals were not eligible at completion of the DST, illustrating the benefits of the recovery, reablement and rehabilitation approach.

Residential care was cheaper and generally more beneficial for individuals than nursing home care and staff were now better at identifying individuals' potential for rehabilitation, albeit some improvements might be small, e.g. from being in-bed, to sitting in a chair. JW highlighted that most individuals would previously not have received therapy or an MDT review and the new arrangements therefore had potential to create benefits for patients, plus significant financial savings.

The overview slides provided a breakdown of efficiency programme schemes, showing £8,718,453 delivery, along with a summary of current workstreams including personal health budgets (PHB).

The TDDI review highlighted several issues that needed to be addressed but it also realised several efficiencies following thorough reviews of individuals' care needs.

PS acknowledged the significant amount of work being undertaken to address ever rising demand, alongside national challenges and asked what could be done differently, including within broader health and care provision, to meet growing demand.

JW advised it was his view that market management and procurement should be prioritised and undertaken strategically in collaboration with local authorities to avoid problems experienced in the past. Also, a review of the infrastructure of the D2A pathway was required, because individuals were currently placed on the basis of availability or beds, rather than need, and therefore unwarranted variation occurred at the end of the pathway. If this was addressed, it would allow discharge to intermediate care beds aligned to individuals' needs.

Internally, there were changes required to the operating model, for example creating teams of staff dealing with specific parts of the pathway, as it was evidently difficult for staff to manage the current breadth and complexity of current caseloads.

JW also highlighted there were several cases, especially in the jointly funded space, where the ICB was having to fund healthcare tasks in addition to what it was already commissioning, because of capacity issues or changes in specification, at significant cost.

TA advised that MSE was on track to spend circa £200 million on AACC this year. The market was fairly saturated which would increase due to demographics and workforce challenges. However, there was an opportunity to consider providing care in a fundamentally different way

which could also support the core resilience of the NHS. JW's initial focus had been on stabilising the service, but the next stage was to discuss future pathways at strategic level, including at the Chief Executive Officer Forum, especially as many service users had complex needs often requiring input from other services, which meant there was potential for duplication to occur.

SW advised that output from national work relating to CHC, possibly including suggested future models, was imminent and would help to inform strategic conversations.

Resolved: The committee noted the AACC and D2A deep dive presentation.

Action 217: SO to share the AACC and D2A presentation with SOAC members.

7. Update on Treatment of Disease, Disorder or Injury (TDDI) Registration Issue (Presented J Walter)

JW advised that since the previous update, the AACC team had continued to process affected individuals, assigning them a RAG (red/amber/green) rating, with those who absolutely needed to move provider being prioritised, e.g. those with respiratory or spinal needs. The vast majority of affected individuals had moved to different providers, although a few had not for various reasons. JW explained that individuals with a PHB in place had greater autonomy regarding management of their care. In addition, some were jointly funded with Essex County Council, which due to the council being lead commissioner, required alignment of staff diaries to undertake reviews.

Where affected individuals were still with a non TDDI provider, the AACC team met patients, reviewed risk assessments and care plans to provide clinical oversight and ensure individuals were safe.

Three of the affected providers had since gained TDDI registration, meaning some patients were able to remain in their care.

A harm review exercise was being undertaken, with 29 reviews commenced and 14 outstanding. Alongside this, a harm review panel was established, with 1 case completed and 3 cases being reviewed in the next week or so. An after-action review was booked for 25 September 2025 which would generate a report. This should complete the exercise and enable the team to return to business as usual.

JW advised that since the incident occurred, no new providers had been onboarded as he wished to ensure the onboarding process was robust before doing so.

It was agreed a further update would be provided once the after-action report was available.

Resolved: The committee noted the update on the TDDI issue.

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

TA noted that financial risks are routinely reported and managed via provider and ICB Boards.

9.2 Provider Board escalations to ICB Board

No escalations from provider Boards were identified during the meeting.

9.3 SOAC to Chief Executives' Forum (CEF)

Strategic conversation regarding AACC.

Resolved: The committee noted the position regarding escalations from SOAC to other forums.

10. Review of Effectiveness of this Meeting (presented by T Abell)

TA asked members for their views on the effectiveness of this meeting. No comments were received.

11. Any Other Business

No other business was discussed.

12. Date of Next Part I SOAC Meeting

Friday, 24 October 2025 at 1.30 – 2.30 pm, via Teams.