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, 13 March 2025 at 2.00 pm – 3.30 pm

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

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	4.1 Approval of Minutes of previous Part I meeting held 16 January 2025. 4.2 Matters arising (not on agenda)	Approve	Attached	Prof. M Thorne	9 -
5.	2.13 pm	Review of Action Log	Note	Attached	Prof. M Thorne	20
		Items for Decision / Non-Standing Items				
6.	2.15 pm	Joint Forward Plan	Approve	Attached	J Cripps	21
7.	2.25 pm	Equality Delivery System 2022 – Annual Statement	Ratify	Attached	Dr G Thorpe	53
		Standing Items				
8.	2.30pm	Chief Executive's Report	Note	Attached	T Abell	120
9.	2.40 pm	Quality Report	Note	Attached	Dr G Thorpe	125
10.	2.55 pm	Finance & Performance Report	Note	Attached	J Kearton	143
11.	3.10 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty R Jarvis A Mecan	154
12.	3.25 pm	General Governance: 12.1 Board Assurance Framework 12.2 New and Revised Policies 12.3 Approved Committee minutes	 Note Note Note	 Attached Attached Attached	 T Abell Prof. M Thorne Prof. M Thorne	 177 194 196

No	Time	Title	Action	Papers	Lead / Presenter	Page No
13.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
14.	3.30 pm	Date and time of next Part I Board meeting: Thursday, 15 May 2025 at 2.00 pm, in Function Room 1, Barleylands, Barleylands Road, Billericay, Essex, CM11 2UD.	Note	Verbal	Prof. M Thorne	-

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Tom	Abell	Chief Executive Officer	Aidsmap, a HIV information service charity			x	Direct	Chair of Trustees	Jan 2020	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
Tom	Abell	Chief Executive Officer	Community First Responder			x	Direct	Community First Responder (voluntary)	Nov 2023	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
Kathy	Bonney	Interim Chief People Officer	Nil								
Anna	Davey	ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemead Medical Services Ltd
Anna	Davey	ICB Partner Member Primary Care)	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not participate in any discussion, decision making, procurement or financial authorisation involving the Colne Valley PCN.
Anna	Davey	ICB Partner Member (Primary Care)	Mid and South Essex Integrated Care Board	x			Direct	Employed as a Deputy Medical Director (Engagement).	April 2024	Ongoing	I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented
Peter	Fairley	ICB Partner Member (Essex County Council)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	x			Direct	Essex County Council (ECC) holds pooled fund arrangements with NHS across Mid and South Essex. I am the responsible officer at ECC for the Better Care Fund pooled fund. ECC commissions and delivers adults and childrens social care services and public health services. ECC has some arrangements that are jointly commissioned and developed with NHS and local authority organisations in Mid and South Essex. ECC hosts the Essex health and wellbeing board, which co-ordinates and sets the Essex Joint Health and Wellbeing Strategy	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.

Mid and South Essex Integrated Care System

Register of [voting] Board Members' Interests - March 2025

NHS Mid and South Essex

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Peter	Fairley	ICB Partner Member (Essex County Council)	Essex Cares Limited (ECL) ECL is a company 100% owned by Essex County Council. ECL provide care services, including reablement, equipment services (until 30 June 23), sensory services and day services, as well as inclusive employment	x			Direct	Interim CEO	03/04/23	Ongoing	Interest declared to MSE ICB and ECC. Be excluded from discussions/deicsions of the ICB that relate to ECL services or where ECL may be a bidder or potential bidder for such services. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Joseph	Fielder	Non-Executive ICB Board Member	Four Mountains Limited	x			Direct	Director of Company - provides individual coaching in the NHS, predominantly at NELFT and St Barts	01/05/17	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Joseph	Fielder	Non-Executive ICB Board Member	North East London Foundation Trust	x			Indirect	Partner is NELFT's Interim Executive Director of Operations for North East London (Board Member).	01/03/19	Ongoing	I will declare my interest as necessary to ensure appropriate arrangements are implemented.
Joseph	Fielder	Non-Executive ICB Board Member	NHS England	x			Indirect	Son (Alfred) employed as Head of Efficiency.	Jan 2023	Ongoing	No conflict of interest is anticipated but will declare my interest as necessary to ensure appropriate arrangements are implemented.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be made to manage any conflict of interest.
Matthew	Hopkins	ICB Board Partner Member (MSE FT)	Mid and South Essex Foundation Trust	x			Direct	Chief Executive	01/08/23	Ongoing	Interest to be declared, if and when necessary, so that appopriate arrangements can be made to manage any conflict of interest.
Neha	Issar-Brown	Non-Executive ICB Board Member	Queen's Theatre Hornchurch (QTH)			x	Direct	QTH often works with local volunteer sector including Healthwatch, social care sector for various community based initiatives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Jennifer	Kearton	Chief Finance Officer	Colchester Weightlifting Limited			x	Direct	Director	01/10/24	Ongoing	No conflict anticipated. To declare as appropriate.
Robert	Persey	ICB Board Partner Member (Thurrock Council)	Thurrock Council	x			Direct	Interim Executive Director of Adults and Health at Thurrock Council	16/01/25	Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be made to manage any conflict of interest.
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.

Mid and South Essex Integrated Care System

Register of [voting] Board Members' Interests - March 2025

NHS Mid and South Essex

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Matthew	Sweeting	Executive Medical Director	Mid and South Essex Foundation Trust			x	Direct	Part Time Geriatrician - hold no executive or lead responsibilities and clinical activities limited to one Outpatient clinic a week and frailty hotline on call.	01/04/15	Ongoing	Any interest will be declared if there are commissioning discussions that will directly impact my professional work. I will liaise with CEO or Chair, as appropriate, for mitigations. These could include removal from said discussions, not voting on any proposals or nominating a deputy. For sign off of commissioning budgets, if a conflict arises, I will delegate to the CFO.
Mike	Thorne	ICB Chair	Nil								
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.

Mid and South Essex Integrated Care System

Register of Board Attendees' Interests - March 2025

NHS Mid and South Essex

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	System Recovery Director	Lime Academy Trust (education)			x	Indirect		June 2023	Ongoing	No conflict is anticipated.
Daniel	Doherty	Alliance Director (Mid Essex)	North East London Foundation Trust	x			Indirect	Spouse is a Community Physiotherapist at North East London Foundation Trust		Ongoing	There is a potential that this organisation could bid for work with the ICB, at which point I would declare my interest so that appropriate arrangements can be implemented
Daniel	Doherty	Primary Care ICB Partnership Board Member	Active Essex		x		Direct	Board member	25/03/21	Ongoing	Agreed with Line Manager that it is unlikely that this interest is relevant to my current position, but I will declare my interest where relevant so that appropriate action can be taken.
Barry	Frostick	Chief Digital and Information Officer	Nil								
Pamela	Green	Alliance Director, Basildon and Brentwood	Kirby Le Soken School, Tendring, Essex.			x	Direct	School Governor (voluntary arrangement).	September 2019	Ongoing	No action required as a conflict of interest is unlikely to occur.
Sam	Goldberg	Executive Director of Performance and Planning	Mid and South Essex NHS Foundation Trust	x			Direct	Substantively employed at Mid and South Essex NHS Foundation Trust		Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Claire	Hankey	Director of Communications and Partnerships	Nil								
Rebecca	Jarvis	Alliance Director (South East Essex)	Nil								
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company - Mecando Limited	x			Direct	Potential Financial/Director of own Limited Company Mecando Ltd	2016	Ongoing	Company ceased activity due to Covid-19 pandemic currently dormant; if any changes occur those will be discussed with my Line Manager
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	x			Direct	Potential Financial/Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	2021	Ongoing	Company currently dormant; if any changes occur those will be discussed with my Line Manager
Geoffrey	Ocen	Associate Non-Executive Member	The Bridge Renewal Trust; a health and wellbeing charity in North London		x		Direct	Employment	2013	Ongoing	The charity operates outside the ICB area. Interest to be recorded on the register of interest and declared, if and when necessary.

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Shahina	Pardhan	Associate Non Executive Member	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	Lead for Grant to Anglia Ruskin University to improve eye health, prevent eye disease and reduce eye health inequality in mid and south Essex	01/05/23	01/04/27	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various Universities	x				PhD Examiner	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various grant awarding bodies UK and overseas		x		Direct	Grant reviewer	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Visionary (Charity)		x		Direct	Trustee	20/04/22	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Cambridge Local Optical Committee	x			Indirect	Member			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	x			Indirect	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	Research Optometrist	10/01/09	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Lucy	Wightman	Chief Executive, Provide Health	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 arrangements 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 arrangements 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 arrangements 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 arrangements can be implemented.

Mid and South Essex Integrated Care System

Register of Board Attendees' Interests - March 2025

NHS Mid and South Essex

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
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 arrangements 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 arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide Wellbeing	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide Care Solutions	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	React Homecare Limited	x			Direct	Director		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 Provide Group Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.

Minutes of the Part I ICB Board Meeting

Held on Thursday, 16 January 2025 at 2.00pm – 4.00pm

The Garden Suite, Best Western Thurrock Hotel, Ship Lane, Aveley, Purfleet-on-Thames, Purfleet, RM19 1YN

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.
- Dr Kathy Bonney (KB), Interim Chief People Officer, MSE ICB.
- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT)
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Robert Persey (RP), Partner Member, Thurrock Council.

Other attendees

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood and Primary Care), MSE ICB
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB.
- Samantha Goldberg (SG), Executive Director of Performance and Planning, MSE ICB.
- Barry Frostick (BF), Executive Chief Digital and Information Officer, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Pete Scolding (PSc), Clinical Director of Stewardship, MSE ICB.
- Jayne Mason (JM), Deputy Director of Stewardship, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Joe Fielder (JF), Non-Executive Member, MSE ICB.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSE ICB.
- Peter Fairley (PF), Partner Member, Essex County Council.

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

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

MT introduced Sam Goldberg, Executive Director of Performance and Planning, and a roundtable of introductions were given.

MT confirmed that Robert Persey's nomination as Partner Board Member for Thurrock Council was supported and therefore his position on the Board was confirmed.

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 further declarations were made.

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

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

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

Christa Pauleit asked for detail on whether the NHS would be hiring extra Psychologists, Counsellors, or other mental health professionals to combat the mental health crisis. MT advised that the question did not relate to any items on the agenda and would be responded to in writing.

Peter Blackman asked what the plans were to provide regular communication about the progress being made by the Community Consultation Working Group to patients and public, including those living in South Woodham Ferrers (SWF) and on the Dengie Peninsular, and how would the needs of those communities, as well as those of Maldon and elsewhere, be identified and be the crux of plans for the future of community care for this area for the future. TA confirmed that the interim report from the working group had been published with the board papers ahead of the meeting, and updates had been shared for staff, wider

stakeholders, and partners to summarise the work to date. This was also shared through the Virtual Views platform to those who had expressed an interest in receiving updates regarding the community consultation. Following the feedback received, discussions were being held on increasing the frequency of these progress updates. The final report and recommendations from the working group would be presented to the ICB Board in due course, which would consider the needs of all those communities affected across mid and south Essex (MSE) by the proposals set out within the consultation document.

Syed Abrar (Limbic), asked with the rollout of an [Artificial Intelligence] AI powered digital front door for self-referrals to talking therapies now covering all regions across the ICB except Mid Essex, how could the ICB help support to ensure equity of access so that all citizens, regardless of location, received the same high level of service when referring to talking therapy services. GT advised that the Mid and South Essex (MSE) Integrated Care System (ICS) was embedding mental health as an intrinsic element of its strategic work plan, in line with its ambition set out within the Joint Forward Plan (2023). This included engaging with Talking Therapies providers as part of a procurement process, approved by the ICB Board in March 2024, to harmonise current service delivery across MSE ensuring an equitable access offer for psychological therapies to all residents.

4. Minutes of the ICB Board Meeting held 14 November 2024 and matters arising (presented by Prof. M Thorne)

MT referred to the draft minutes of the ICB Board meeting held on 14 November 2024 and asked members if they had any comments or questions.

There were two amendments; to remove Mark Bailham, Associate Non-Executive Member, from the list of attendees and add Jo Cripps, Executive Director of System Recovery.

There were no further comments or amendments.

Resolved: The Board approved the minutes of the ICB Board meeting held on 14 November 2024, as an accurate record, subject to the amendments noted above.

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

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

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

6. Specialised Commissioning (presented by Dr M Sweeting)

MS explained that specialised commissioning services were services that were complex, rare, or required specialist intervention. The aim of the Health and Care Act (HCA) 2022 was to move most of the specialised commissioning from NHS England to Integrated Care Boards (ICBs).

Fifty-nine specialist services were delegated to MSE ICB in April 2024 and the report detailed a further 11 services to be delegated from April 2025, which made the total delegation to 70 services. The six regional ICBs had formed a joint commissioning collaborative, who made decisions on the specialist services across the region. Bedfordshire, Luton, and Milton Keynes (BLMK) ICB hosted the specialised commissioning function, and it was expected that the NHS England staff would transfer over to them from July 2025.

In response to a query from MT, MS confirmed that the services ranged from specialised

stroke services, such as thrombectomy, treatment for rare forms of cancer, genetic conditions, and neonatal services.

NIB sought clarification on what was currently in place and what lessons had been learnt from those services already delegated. MS confirmed that within the delegation agreements, there was close cross-party working around service implementation and changes. The last year had focused on delegation and understanding roles and responsibilities, and the coming year would focus on strategic planning and operational delivery, such as what could be done for residents in MSE to either improve these services or explore to options to repatriate to local services where this was appropriate.

DD asked if the oversight of quality and safety in specialist services by our providers was completed locally or on behalf of the ICB. MS confirmed that a formal performance and quality review was reported through the joint commissioning collaborative and led by NHS England (and would be transferred to BLMK ICB as stated above). GT explained that whilst there was formal oversight under specialised commissioning rules for local services, there was an ICB level of responsibility and quality representatives would liaise with other ICBs to ensure that any local concern or risk profile that required further scrutiny would be referred to the local system.

MHop confirmed agreement with the arrangements described.

Resolved: The Board delegated authority to the Chief Executive Officer to sign the revised declaration and collaboration agreements on behalf of the ICB once finalised.

7. Stewardship (presented by Dr M Sweeting and Dr P Scolding)

MS introduced PS and advised that stewardship was one of the ICB's major programmes and was a source of success.

PS advised that the ICB should feel a sense of pride in the work that the staff in the 10 stewardship groups had completed within the programme over the last four years. Examples of case studies had been provided within the report, but there had been many more.

In the last year, some of those successes were celebrated nationally, but there were two main successes to highlight. The first success was the stewardship model. There were 10 different stewardship groups ranging from Babies, Children and Young People through to Ageing Well and Frailty and musculoskeletal health to mental health. The groups brought frontline clinical and operational staff together to lead change and improvement within the system with a strong driving sense of missions and purpose. The second success was the tracked record that those groups had set over the four years of delivering change, such as supporting system priorities and improving services and pathways with a strong focus on continuous improvement.

The next phase of stewardship would be to move from a 'hot house' approach of developing the group model to a whole system stewardship approach, where the principles and practices could be applied to shared big system priorities, including those shaped in the Medium-Term Plan (MTP) process. There were proposals to provide support to teams leading on the MTP priorities, to define that sense of mission and purpose and to review ways to broaden the approach to ensure that it was accessible and applicable to any staff member. The work of the 10 stewardships groups would also continue during this next phase.

PS thanked the Board for their support and staff for taking part in the programme over the last

four years.

MT commented that the success of the model resulted from the people involved who were from many different stakeholders across the system and worked collaboratively on ideas that led to material benefits. TA commented that following the confirmed priorities and shared system objectives, embedding this as a model of practice was an opportunity and important in leading change as frontline colleagues were open to innovation and different ways of working.

GO asked to what extent the programme was embedding disparities and inequalities as a principle and could there be an enhanced focus. PS advised that the groups would look at variations and gain an understanding of the inequalities, particular outcomes, access, and resource initially and develop the programme of work thereafter.

RP asked if the stewardship approach could be developed outside of healthcare, such as social care or the voluntary and community sector and utilised to work collectively together in the future around treatment to prevention, acute to community and the primary care shift. PS advised that the stewardship approach was based on an economic theory for local communities and people to come together to make the best use of their skills and resource and could be adapted accordingly.

AD asked that the Primary Care Collaborative be involved in stewardship programmes and as the left shift agenda was embraced, there was also engagement with general practice, Pharmacy, Optometry and Dentistry (POD).

MHop commented that the delivery model should be based on this type of approach to take the system to a clinically and financially sustainable future. The challenge for MSEFT would be to allocate the right people when staff capacity was challenged.

Resolved: The Board:

- **Endorsed the overall progression of the MSE Stewardship approach.**
- **Supported the development of key 'mission' or 'priority' boards as detailed in the report.**
- **Supported the development approach for these boards and for wider ICS health and care staff in principles of stewardship.**

8. Contract Awards for NHS General & Acute Services and Independent Sector Provider (ISP) Acute Contracts 2025/26 (presented by J Kearton)

JK advised that the paper sought board approval for the award of contracts outlined in the paper for which the aggregate value exceeded £10million. JK noted that for the main contract with acute provider MSEFT, the ICB had been asked to incorporate the specialist services element into the overarching contract, but that financial values were not clear at the time of the meeting and would therefore be presented to the Board in due course.

The Provider Selection Regime Direct Award Processes (DAP) A and B would be used to award contracts. It was further noted that the contract values were indicative as the NHS England planning guidance had not been received. The principles in the planning guidance would continue to be applied and would be subject to continuous negotiation going into 2025/26.

In response to a request from MT, JK explained that the DAP A process was where the most

suitable provider would be considered as there was no other provider who could provide the services. DAP B process supported the protection of the patient choice element. There would be an expectation to have a contract in place as a safeguard where patient flow dictated the need for a contract and where an organisation was receiving more than £500k worth patient flow from the MSE footprint.

Resolved: The Board:

- **agreed to award a 3-year contract to Mid & South Essex Foundation Trust for General & Acute Services from 1 April 2025 under Provider Selection Regime Direct Award Process A.**
- **agreed to award 1-year contracts to the NHS Acute Providers specified in this paper (Appendix A), for General & Acute Services from 1 April 2025 under Provider Selection Regime Direct Award Process A.**
- **approved the proposal to undertake a 'Self Declaration' Accreditation process for the existing contracted Independent Sector Providers of Acute Elective Services (Appendix B) with the intention of awarding a contract for a three-year term under Provider Selection Regime Direct Award Process B.**
- **noted that contract values for 2025/26 would be calculated in line with national guidance and using the ICBs planning principles.**

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

TA highlighted key areas of the report.

TA noted that the three-month report from the chair of the Community Services Consultation Working Group was included in the Board papers highlighting the emerging findings of the group. MT reflected that lessons were being learnt on how to address difficult issues and finding better ways to engage with people.

TA continued to discuss performance over the winter period, noting that the system had coped relatively well against a range of metrics to minimise handover delays for ambulances compared to other system in the East of England. SG would be completing a lesson learnt exercise with colleagues across the system which would inform any plans for next year.

MHop advised that the combination of flu, norovirus and respiratory infections had peaked demand leading up to Christmas and two weeks after which had impacted on pressures. The establishment of the discharge cell (the coordination of services to enable timely and safe discharge from acute beds) and the community collaborative work to reduce the length of stay in community beds were significant improvements and had helped the system to remain resilient under challenging circumstances. For hospitals, the focus was on improving the number of patients seen in the same day emergency care setting that could alternatively be seen by a physician.

GW asked if demand had peaked at the hospitals. MHop advised that the prediction from Public Health and NHS England with regards to the peak and the reduction of children presentations were broadly accurate. TA advised that one key area of focus for the remainder of winter was building on the work around discharge and optimising admission avoidance activities.

TA then highlighted issues regarding General Practice Estates, noting that Section 106 funding was being utilised to improve general practice capacity and estate.

The elective reform plan had been received and set out stretching ambitions for the NHS in relation to recovery of elective waiting times. Work would be required for detailed modelling and planning for effective delivery, in both activity requirements and transformation pathways and would be reflected in the operating plan for next year. Stewardship would assist with some of the reform and changes in moving some pathways delivered in hospital settings to community settings.

In response to MB, DD and AD discussed the impact of Primary Care Estate on the recruitment of staff within GP Practices because of a lack of space. AD advised that there were GP and Additional Roles Reimbursement Scheme (ARRS) workforce that could be accommodated if there were additional estate. AM advised that the section 106 monies would also be used for refurbishment and utilising void spaces or unused office space for clinical space, where appropriate. PG advised that the 106 monies would fund additions or a change of utilisation but had never been used to fund a whole building.

Noting the update in the report on medium-term plan (MTP), GO asked for clarification on engagement with other partners. TA advised that there had been engagement with all key stakeholders including the voluntary sector, which would continue when developing delivery plans. The challenge would be balancing the way the system worked in a period of resource restraints.

In response to a query by MT regarding the list of priorities in the report, TA explained that the priorities for the ICB were set to establish clear objectives for the remainder of the financial year, with metrics or deliverables associated with many of them, to be delivery focused as an organisation. The Executive Committee would be having more structured thematic conversations, to ensure that the priorities were being covered with a focus on quality and safety of services.

NIB sought assurance regarding the realisation of benefits. TA advised that the list detailed priorities that could be completed within the timeframe available, for the longer-term work was underway to ensure a focus on realising benefits set out in the MTP. JC advised that the work on the MTP was to create a system that was clinically, operationally, and financially sustainable.

Resolved: The Board noted the Chief Executives Report.

10. Quality Report (presented by Dr G Thorpe)

GT highlighted the following key points and two escalations from the Quality Committee.

There were some outstanding actions that had not been fully evidenced for the sodium valproate patient safety alert and a deep-dive report would be provided to the Quality Committee in February to gain further assurance that actions had been completed.

GT highlighted the risks of long-term opioid use, its connection with suicide and the work being undertaken to address its use, noting that usage across MSE was lower than other Integrated Care Systems. GT thanked colleagues in acute, primary care and musculoskeletal (MSK) settings who were making progress in reducing the use of opioids.

AD suggested commissioning the opioids service to provide a formal deprescribing programme in primary care. It was a complex area and often required support for patients with mental health conditions and would be supported by general practitioners and community pharmacy colleagues. MS agreed and advised that a paper was being presented to the

Quality Executive on the work that had been undertaken previously, the potential options and linking in with primary care around future development.

MB advised that the Pharmacy and Medicines Optimisation Committee focused on monitoring the trends in those areas. AM suggested also linking with public health teams who held several substance misuse contracts.

It was noted that the national nursing and quality strategies would align with the 10-year plan, and that the focus on Kindness to Professionals' and 'Sexual Safety' which would sit within the nursing strategy and remained an ongoing area of focus.

Referencing the Insightful Board guidance being published, GT suggested implementing the guidance would form part of the ICB Board development programme.

GT spoke of regulator (Care Quality Commission) visits to Providers noting that, there were ongoing delays with reports, but work continued and there was assurance that there were no immediate patient safety concerns.

It was noted that the ICB commenced a pilot with NHS England to implement principles for assessing and managing risks across integrated care systems. Two system level risks would be identified to test approaches outlined in the National Quality Board guidance so that the system understood their risk appetite and risk profile. A new national tool, RASCI (Responsible, Accountable, Support, Consulted and Informed) was recommended and would support an understanding of who held responsibility for certain areas in the system. The tool was utilised in other industries and would form part of quality development. This would run alongside the development of the approach to system risk management across the MSE system.

Resolved: The Board:

- **Noted the points of escalation from the Quality Committee relating to Sodium Valproate and Opioid usage.**
- **Noted the national updates shared with the Quality Committee.**
- **Support the implementation of NHS Insightful Board guidance, in line with NHS England recommendations.**
- **Noted the position in relation to regulatory oversight by the Care Quality Commission.**
- **Supported the implementation of new risk methods for assessing system risks in line with the national guidance.**
- **Supported the implementation of the RASCI Tool in line with national guidance.**

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

JK highlighted the following key points:

The system had a nationally negotiated and agree deficit plan position for 2024/25 of £96million. NHS England provided deficit allocation funding adjusting the deficit to break-even, noting that the additional funding was repayable in future years.

There had been an improvement of £1million in the financial position at month 8. Month 10 would be reflective of the pressures faced over the winter period and would be give a more realistic indication of the potential year-end position.

The ICB projected achieving a balanced position by month 12 but recognised the financial pressures in All-Age Continuing Care (AACC), in both value and volume.

JK reported that delivery against efficiencies as not to plan and could add £30million on the position reported. MSEFT had reported four months of gradual improvement.

MHar asked of the driver of the improvement in AACC, JK explained that it was primarily driven by the changes made to ensure patients were in the right place, at the right time following discharge from hospital. Discharge to Assess had previously been recognised as a cost pressure, and pathway review had reduced the backlog. Data analysis and understanding pathways had enabled targeted interventions.

JK advised that it was a challenge to deliver the commitments made in the operating plan and meeting the constitutional standards. The mental health constitutional standards were however sustainably delivered.

MT asked about to work to address cancer performance. MHop advised that a meeting was being held with ICB colleagues to understand the drivers of the challenged position and how this could be rectified. The changes made in the organisation to drive down cost, such as bank and agency spend, had exposed some longstanding lack of resilience in some specialities. The faster diagnostic standards based on how quickly cancer was diagnosed was improving. The challenge remained with the capacity needed to see patients within the required waiting time, which had resulted in a dependence on temporary workforce, in many specialties, which often consisted of own staff working extra hours.

MT sought further assurance regarding reduction in unnecessary referrals. TA advised that there was an agreed set of priority areas with the hospital on how pathways could be supported, and new pathways created for various cohorts of patients, particularly the higher-volume specialities. More resource was anticipated in the cancer alliance which would accelerate that work.

NIB queried plans relating to substantive workforce, MHop explained that work was being undertaken to benchmark medical staffing rotas with similar organisations as part of planning for staffing safely.

Resolved: The Board noted the Finance and Performance Report.

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

PG presented highlights from the report and noted that the team continued to support general practice and some redesign of primary care networks (PCN) and would report back, when those were completed.

The report included a patient story which related to the Transfer of Care Hubs (TOCH) and was a good demonstration of the transformation at ‘place’ that connected the hospitals, discharge, and flow processes back out to primary care. It also demonstrated the shift from treatment to prevention.

AM advised how Alliances were supporting the developing maturity of Integrated Neighbourhood Teams (INTs) through being data driven and utilising the clinical support provided by stewardship colleagues. It was highlighted that JF and GE had recently visited the Alliances.

DD advised that the Mid Essex Alliance Chair had resigned and thanked her for her contribution as Alliance Chair and as Chief Executive of Farleigh Hospice.

In response to a query from MT regarding the next steps for the Better Care Fund, DD confirmed that a meeting was scheduled for 17 January 2025 for all Executives within Essex. AM confirmed that the same applied to Thurrock and MHar confirmed the same for South East Essex.

GO requested an update on local enhanced services (LES). PG clarified that there was a programme of LES for primary care, in addition to Directed Enhanced Services (DES). The latter being nationally defined with less flexibility. The LES were under review to harmonise and standardise the programme of services because of differences in historic commissioning across the 5 predecessor Clinical Commissioning Groups. There was focused support on medicines management and optimisation because of the change in platform of drugs coming on and off licence. It was discretionary spend and with the current financial position, best value was being sought, whilst supporting primary care. MT requested that a report be provided at a future meeting on the agreed actions and the rationale and detailed the range of services affected.

MHar advised that the new guidance was awaited and would signal a change in metrics, such as no national performance indicators, because they were to be locally derived.

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

Action: PG to provide an update report at a future Board meeting on Local and Directed Enhanced Services including agreed actions, rationale, and detail of the range of services affected.

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

13.1 Board Assurance Framework

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

TA advised that there would be an opportunity for the Board to consider how the BAF could be focused around the strategic objectives and link the work plans in place within the system. Also, to reflect on the agendas being considered and to what extent the risks were being addressed and assurance provided.

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

13.2 New/Revised Policies

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

- 044 Absence Management Policy
- 053 Learning and Development Policy
- 056 Dignity at Work Policy
- 080 Defining the Boundaries between NHS and Private Care Policy
- 089 Patient Safety Incident Response Framework (PSIRF) Policy

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

13.3 Approved Committee Minutes

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

- Clinical and Multi-Professional Congress (CliMPC), 28 August 2024.
- Finance and Performance Committee (FPC), 1 October 2024, 5 November 2024, and 3 December 2024.
- Primary Care Commissioning Committee (PCCC), 9 October 2024.
- Quality Committee (QC), 25 October 2024.

Resolved: The Board noted the latest approved committee minutes.

14. Any Other Business

There were no items of any of business raised.

MT thanked the members of the public for attending.

15. Date and Time of Next Board meeting:

Thursday, 13 March 2025 at 2.00 pm, Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend on Sea, SS2 6ER.

Mid and South Essex Integrated Care System

Agenda item 5
ICB Board Part I Action Log, March 2025

NHS Mid and South Essex

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
54	14/11/2024	7	**EDI High Impact Actions** TA and MT to discuss the joined up EDI approach and KB to provide a regular assurance report from People Board on the progress of the high impact actions.	T Abell M Thorne K Bonney	30/04/2025	Report to be prepared for May 2025 Board meeting. Reporting built into 2025/26 Board workplan.	In progress
56	16/01/2025	12	**Primary Care and Alliance Report** Provide an update report on Direct Enhanced Services, including agreed actions, rationale and details of the range of services affected.	P Green	15/05/2025	To be included in May 2025 PC/Alliance report to Board.	In progress

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board Meeting, 13 March 2025

Agenda Number: 6

Joint Forward Plan Refresh

Summary Report

1. Purpose of Report

The report requests Board approval of the refreshed version of the Mid & South Essex (MSE) NHS Joint Forward Plan (JFP), in advance of this being published on our website, in line with our statutory duties.

This is the third year of our JFP, which is refreshed annually. All ICBs have been asked to undertake a 'light touch' refresh of the JFP this year because of the impending publication of the NHS 10-year plan. Locally in MSE, we are also working to develop a delivery plan for the medium-term to enable the system to become clinically, operationally and financially sustainable over the coming years.

We have shared the draft JFP with NHS England (NHSE) for comment.

The refreshed JFP is in three parts:

- **Part 1 (Appendix A)** recommits us to the strategic ambitions agreed with our three Health and Wellbeing Boards (HWBs). Once approved, this section will be published on the ICB website.
- **Part 2 (Appendix B)** is a 'look back' at 2024/25 celebrating some of the successes the system has delivered. Once approved, this section will be published on the ICB website.
- **Part 3** is currently under development and will effectively become our forward plan including delivery of:
  - The 25/26 NHS Operating Plan actions
  - The NHS Reforming Elective Care for Patients planning actions
  - The NHS 10-year plan commitments (once published), and
  - Our local Medium Term Plan, which the NHS in MSE has been working to define.

To note: Parts 1 and 2 of the JFP are presented here for Board approval, subject to any comments received from NHSE. Part 3 will be developed over the coming months for submission to Boards and HWBs for approval at the appropriate time.

Engagement on the above approach will be shared with HWBs during March/April 2025.

2. Executive Lead

Jo Cripps, Executive Director, System Recovery

3. Report Author

Phil Read, Associate Director, Programme Management Office (PMO).

4. Responsible Committees

This light-touch refresh of the Joint Forward Plan was approved by ICB Executive Committee.

5. Impact Assessments

Not applicable. The relevant impact assessments will be conducted by specific programmes where required.

6. Financial Implications

Not applicable.

7. Details of patient or public engagement or consultation

The JFP utilises insight from regular engagement events undertaken by the ICB and its partners.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to approve this refresh of Part 1 **(Appendix A)** and Part 2 **(Appendix B)** of the Joint Forward Plan for publication, noting that:

- An overview of the work will be shared with our three Health and Wellbeing Boards.
- The full refresh of the JFP (including Part 3, the forward plan) will take place once the NHS 10-year plan is published and our local Medium Term Plan has been finalised.

Mid and South Essex Integrated Care System

NHS Mid and South Essex

NHS Mid and South Essex

Joint Forward Plan 2024-2029

Section 1 - April 2025 Refresh (draft)

Contents

About this Document

This document provides a refresh of Mid and South Essex Integrated Care Board's (MSE ICB) Joint Forward Plan for 2024-29 (section 1). It recommits the NHS system in MSE to the strategic ambitions set out in the 2023-28 Joint Forward Plan, which were developed in partnership with local stakeholders and approved by the Essex, Southend and Thurrock Health and Wellbeing Boards in June 2023 and by the ICB Board in May 2023.

MSE ICB is a system that is currently facing significant financial challenges. There are challenges to meeting growing and evolving local population needs from the financial position in MSE.

- MSE ICB in-year (2023-24) total healthcare allocation was £2.8 billion.
- We estimate needing a total £247 million in additional recurrent saving by 2029/30.

The ICB's immediate focus is on recovering a sustainable financial position, delivering on national operational planning requirements, and maintaining a focus on addressing health inequalities as we do those.

The details of how this will be delivered in 2025/26 and beyond have been considered through the delivery NHS system's 2025/26 Operational Planning requirements and the development of a new system 3-to-5-year Medium Term Plan (MTP). Strategic priorities and refreshed delivery plans are provided in updated sections of this Joint Forward Plan.

This refreshed 2024-29 Joint Forward Plan for MSE ICB includes:

1. A reminder of the strategic ambitions the system has committed to.
2. A summary of some of the commitments the ICB delivered on in 2024/25.
3. A summary of what the ICB will deliver in 2024/25 and beyond *(please refer to section 3 for detailed action plans).*

Foreword from our Chair

I am delighted to present the Mid and South Essex Integrated Care System Joint Forward Plan for 2024-2029. In this refresh of our Joint Forward Plan, we are recommitting to the strategic ambitions we developed with our partners last year. These ambitions are the foundations for how we will continue to develop and improve our services to better meet the needs of our population and communities. As a priority, we must address our cancer waiting times, which compare poorly with other systems.

We know that we can only deliver on our ambitions by continuing to build on our existing joint work with local government and by listening to our people and communities to deliver change.

As is the case for many Integrated Care Systems, we face a number of significant challenges. The Covid pandemic exacerbated health inequalities in our population and our primary care services are under extreme pressure. Demand on our mental health, urgent and emergency services are significant, we have long waits for planned treatments, and we are not meeting nationally set standards in relation to cancer care. Collectively, our providers are carrying significant vacancies and we over-rely on bank and agency staff to fill rotas – as a result the quality of care we offer can sometimes suffer. Within these many challenges, we are also a system that has high ambitions to improve the health and wellbeing of the population that we serve. During 2024/25 we have delivered impressive and long-lasting improvements and have had many successes.

In addition to recommitting to our strategic ambitions, this revised plan highlights the good progress we have made in 2024/25, a summary of these achievements is included in section 2.

We are committed to continuing to work together across health, local government and with our communities to do all that we can to improve outcomes for our local population.

Our system's strategic ambitions and plans for this year are set out in this Joint Forward Plan.

Professor Michael Thorne CBE
Chair
NHS Mid and South Essex Integrated Care Board

JFP Section 1: Strategic Ambitions

1. Introduction

Mid and South Essex Integrated Care Board (MSE ICB) oversees the NHS budget for the 1.2 million people that live and work in mid and south Essex. In 2025/26 that budget is £2.8 billion. The ICB is responsible for developing a plan for how to invest and spend this money to deliver care and support services that will help improve people's health, deliver high quality care that meets their needs and that offers value for money.

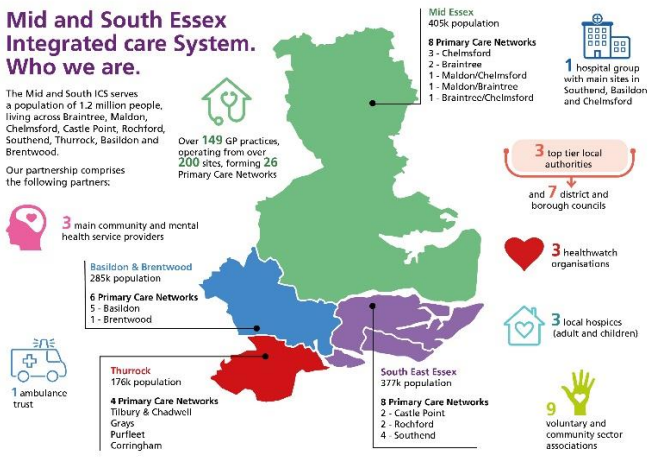
Figure 1 shows the shape of our partnership across MSE, which includes 144 GP practices working across 26 Primary Care Networks, three community and mental health providers, one acute hospital trust working across three large hospitals, one ambulance trust, three upper tier local authorities and seven district and borough councils, three Healthwatch organisations and many community, voluntary, faith and social enterprise sector organisations.

Throughout 2024/25 the financial and operational context across the NHS in MSE has remained challenging, with the system facing increasing financial challenges as it aims to deliver sustainable services that meet the needs of local residents. At the end of 2024/25 MSE reported a system-wide deficit and is currently working within a 'triple' lock, with any unplanned expenditure or requests over £25,000 being scrutinised by NHS England, as well as the ICB.

Despite this, the ICB remains committed to being a health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident supported to make informed choices in a strengthened health and care system. We want people to live longer, healthy lives, to be able to access the best of care and to experience the best clinical outcomes, and for us to be able to attract good people to work with us, recognising we offer meaningful careers.

This Joint Forward Plan recommits the ICB to the strategic ambitions that were developed by the system in 2023 to align with the Mid and South Essex Integrated Care Partnership (ICP) Strategy. These ambitions are supported by the delivery plans set out in section 3 of the Joint Forward Plan, which outline how we will deliver on our ambitions in 2025/26 and beyond.

Figure 1: Mid and South Essex Integrated Care Partnership



2. Our Strategic Ambitions

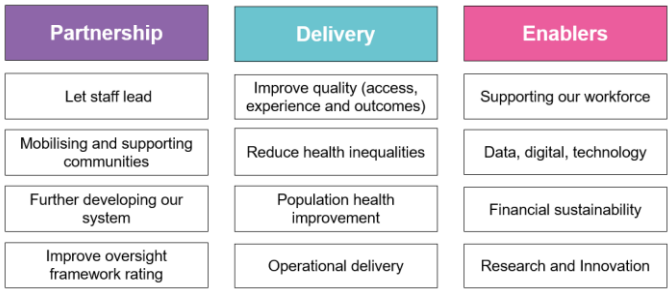
In 2023, the ICB committed to twelve strategic ambitions for our health and care system. These strategic ambitions inform the system's operational planning and delivery, ensuring that the ICB can deliver on its statutory duties and maintains a focus on the Triple aim of improving the health of our local population, improving the quality of services we provide and improving the efficiency and sustainability of local services. The ambitions also support the four key aims of Integrated Care Systems to:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money; and
- Supporting broader social and economic development.

For the 2024-2029 Joint Forward Plan, the ICB's strategic ambitions have been grouped under three headings that reflect areas of focus across the ICB:

1. **Partnership:** These ambitions focus on how we work together to develop and deliver our plans and provide collective assurance on the quality and value that services offer to local residents.
2. **Delivery:** These ambitions focus on operational delivery to drive improved quality of care for patients, adjusting how we deliver to address health inequalities and look at upstream delivery to improve the health outcomes across our populations.
3. **Enablers:** These ambitions focus on the critical enablers in our system that are needed to support successful delivery and effective partnership working to improve care outcomes. Those include our workforce, data, digital and technology, financial sustainability and research and innovation.

Figure 2: Description of 12 strategic ambitions



In May 2024 the ICB Board agreed a set of Strategic Priorities that provide focus for how the ICB will deliver on the Strategic Ambitions. These Corporate Objectives are:

1. To ensure that the MSE ICB and ICS deliver good quality health care and services within financial resource limits.
2. To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
3. To improve standards of operational delivery, supported

by collaborative system working to deliver patient centred care in the right place that the right time and at the right cost to the NHS.

4. To develop and support our workforce through compassionate leadership and inclusion, achieving significant improved by March 2026.
5. To develop effective oversight and assurance of healthcare service delivery across mid and south Essex, ensuing compliance with statutory and regulatory requirements.
6. To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.
7. To be an exemplary partner and leader across mid and south Essex ICS, working with our public, patients and partners in the ICP to jointly meet the health and care needs of our people.

Central to these priorities is the need to recover our financial position. The development of a system-wide recovery programme, the Medium-Term Plan (MTP), has been a key priority for 2025/26 and beyond recognising that recovery will require a multi-year approach. This work, led by the Executive Director of System Recovery, provides a structured approach to overseeing both organisational and system level recovery projects and programmes. The governance that oversees this work, and how it feeds into the ICB's overall governance, are set out at the start of Section 3 of the Joint Forward Plan.

Looking more broadly across mid and south Essex, in March 2024 the Integrated Care Partnership agreed a set of joint priorities to focus on in 2024. These priorities focus on wider determinants of health and focus on areas where there is value in partners coming together to improve services for the local population. Between January and March 2024 an initial set of priorities was identified by drawing on priorities in the three local Health and Wellbeing Strategies and local health priorities.

This initial 'long list' was tested with community partners through the Community Assembly, with an updated list proposed back to the ICP Delivery Group that was overseeing the work. This led to an agreed set of five priorities for a 'Healthy MSE' were developed across the partnership through a Steering Group which drew on priorities identified from the three local Health and Wellbeing Strategies, as well as the local health priorities.

The five priorities for a Healthy MSE, which are reporting into the Integrated Care Partnership, are:

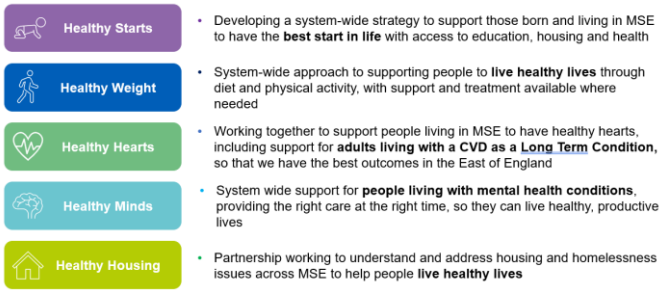


Figure 3: Description of five healthy MSE priorities

In 2025/26, this will be extended with two further priorities; of 'Healthy work' by supporting individuals into employment and 'Healthy living' supporting people to make and maintain healthy lifestyle choices.

3. Working in Partnership

3.1 Let Staff Lead

Our workforce are our biggest investment and our greatest asset. An engaged and empowered workforce is more likely to deliver high quality care and support the transformation that is needed in our system.

Working with our stewards and clinical leaders

The 'Stewardship' programme in MSE is putting clinical and operational leaders at the centre of work to drive the transformational change that is needed in our system. Stewardship offers staff the chance to receive training and development that will help them engage with data, information and evidence to help them identify and address challenges in the services they are working in. Our stewards also ensure that we have access to the expert advice that we need to inform the development of clinical and operational pathways to support the ongoing improvement of care.

We are supporting our Stewards to lead clinical change through regular leadership and development opportunities, including our Summits. As the programme evolves, we will be bringing the Stewards closer to our overall Financial Recovery programme and considering how they can help us drive improved productivity alongside improved outcomes and experience for patients.

Alongside our Stewardship programme, we have reviewed our System Clinical Leadership to ensure resource efficiency, system value and a focus on quality improvement. This work is being supported by the Clinical Leadership and Innovation Directorate and is underpinned by the national principles that will see clinical leaders better connected, developed and supported in our system. Our clinical leadership development programme 'Leading Better Together' will support those stepping up to lead in our system.

Staff are often best placed to identify opportunities to improve our services. The ICB is committed to developing a model for Quality Improvement that will help equip and support staff to speak up and step up in suggesting ways that they can improve the quality and value of care offered to patients.

Supporting NHS net zero ambitions

As the ICB has re-ignited its Greener NHS programme, we have sought Green Champions within our organisation to join those who have already come forward in other organisations. These champions are invited to join others across the system in the MSE Sustainability Forum to share ideas and insights and help lead action to support the system to deliver on its Net Zero ambitions. We aim to publish our greener NHS strategy during summer 2025.

3.2 Mobilising and Supporting our Communities

It is important to acknowledge the breadth of assets that exist across our communities in MSE. We recognise that there is more that we can do to work with communities to acknowledge, draw on and support those assets to support our residents. This is central to the work we are undertaking in our Alliances, including the development of local Integrated Neighbourhood Teams.

We are committed to continuing to listen to and work with individuals, groups and communities to ensure that we both understand local challenges and develop asset-based responses to local need. MSE Virtual Views has been established as an online community for local people to share their views, experiences and ideals about local health and care services. In addition, we will continue to develop our approach for engaging our people and communities through our placed-based Alliances and the development of our Community Assembly.

3.3 Developing our system

The ICB is continuing to develop as both as organisation and as a system. Investing in our collective development and partnership working is critical to enabling our success as an integrated care system. As we continue to mature as a system, we will continue to support and develop our leaders as individuals and our teams so that they are equipped to help lead effective decision making and delivery across our system.

Commitment to working with Local Authorities

We are continuing to strengthen our partnership working with local authorities across mid and south Essex at all levels, including our district and borough councils. We recognise the importance of collaborating in how we plan and deliver health and care services for the benefit of local residents, and the ICB and ICP continue to align with and support the priorities identified by the three upper tier Health and Wellbeing Boards and our local placed-based partnerships, our Alliances.

Our Alliances and local place-based partnerships

A core part of our system development is our place-based Alliances. We will continue to develop and mature these partnerships so that they can better understand the needs of local communities and support delivery of integrated services that support improve population health outcomes, quality of care, experience and value. Alliances will develop delivery plans around shared local outcomes that contribute to our priorities as an ICB and ICP.

They will use an asset-based approach to community development to drive transformation and focus on the wider determinants of health to improve health outcomes, particularly through the vehicle of integrated neighbourhood working. As Alliances continue to mature and develop, they will look for opportunities to make best use of the collective resource to deliver sustainable change.

Commissioning and Supporting our Primary Care Partners

The ICB is now responsible for commissioning all primary care services, including community pharmacy, optometry and dental services. This provides us with a further opportunity to strengthen primary care services in our system and consider new ways of delivering care and treatment to meet local need. MSE is one of the first systems in the country to receive delegated responsibility for commissioning specialised services. We are excited about the opportunity this provides us to review how we commission services to best meet the needs of our local population.

The ICB is also supporting the development with providers and provider collaboratives across our system, including:

- The **Primary Care Collaborative** for Mid and South Essex, including a focus on supporting the sustainability of general practice and implementing the recommendations from the Fuller review.
- The **Community Collaborative**, which brings together Essex Partnership NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NEFLT) and Provide Community Interest Company (CIC).
- The **NHS Specialist Mental Health, Learning Disability and Autism Provider Collaborative** across East of England with MSE participation.
- **Mid and South Essex NHS Foundation Trust** (MSEFT) to reduce variation and increase the quality and value of care offered across its acute and community hospitals.

Supporting wider social and economic development through Anchor Programmes

The NHS in MSE remains committed to being an anchor in our community. With a budget of over £2 billion and a workforce of over 23,000 we are a huge contributor to our local economy. Through the MSE Anchor programme the ICB continues to explore ways that we can contribute to wider social and economic development through:

- **Our workforce:** helping local people to gain jobs in the NHS through the Anchor Ambition programme, anchor youth programme, apprenticeships and then ongoing career development. We will also continue to focus on the wellbeing of our workforce and their families as potential users of our health and care services.
- **Our purchasing:** the NHS is committed to ensuring social value remains an important consideration in our procurements. This includes including requirements around ethical and labour standards, including net zero and modern slavery requirements, in all our procurements and contracts.

- **Our buildings and spaces:** we are currently developing our infrastructure strategy, which will consider how we can make better use of the buildings, spaces and assets we have across MSE to better serve our patients and the wider community.
- **Our environmental impact:** MSE has established and new Greener NHS Programme Board to oversee system progress in supporting our Net Zero ambitions. This Board will support the refresh of the MSE Greener NHS plan for the system to ensure that we are taking appropriate action to reduce NHS emissions, including reducing carbon and air pollutants. The plan will also consider what adaptations health and care services will need to take to respond to the challenges climate change is presenting today and in the future.
- **Our partnerships:** we remain committed to working with and learning from others, both in our communities and beyond. We want to be a learning system, working to make best use of the assets and resource that we have access to so that we can best serve the people living in MSE.

3.4 Improving our NHS oversight framework rating

The NHS oversight framework looks at how local NHS partners are aligning with wider system partners and aims to identify areas where systems might require additional support.

MSE ICB remains committed to improving its oversight framework ratings, recognising that this is a system facing significant financial and quality challenges and is currently failing to recover care in line with the national targets.

To support the system in its financial recovery, an Executive Director of System Recovery has started working across the ICB and MSEFT.

4. Operational Delivery

4.1 Improving Quality

Whilst the NHS in MSE been working hard to address known quality issues, several challenges remain in the system, including the delivery of sustained improvements in mental health, perinatal/maternity care, and supporting our children and young people with Special Educational Needs and Disabilities (SEND). These are evident from current CQC ratings and Ofsted Inspection findings, as well as patient experience indicators and inquiries into local services, specifically in mental health provision. We are working in partnership across the system to continue to address these issues and improve the quality of services available to residents.

The system's response to the Ofsted and CQC visit to Thurrock is an example of how system partners are collaborating effectively to both understand opportunities for improvement and working together to drive improvements. The ICB is

committed to supporting all providers to improve the quality of care they provide, including working across the system to deliver the CQC 'should do' and 'must do' recommendations, and Ofsted Inspection recommendations, through evidence assurance and triangulation of improvements across the system.

Ensuring quality oversight and system governance

This work will be overseen by the Quality, Contract, Performance Review meeting, which is a formal sub-committee of the ICB Board, which remains a focus on ensuring it continues to listen to patient voices around areas of concern, improving patient experience and outcomes.

Work is further supported by quality groups and forums such as the MSE System Quality Group, the Harm Free Care forum and a system Learning from Deaths group. The system also remains committed to participating in national work streams, including the national Maternity and Neonatal Safety Improvement Programme and will be looking at mental health pathway reconfiguration in line with the wider Essex All Age Mental Health Strategy and national standards.

This work will be supported through the development of an updated ICB Quality Strategy for 2024/27 which will align with the National Quality Board principles. This new ICB quality strategy will build on a review of the previous 2021/23 Quality Strategy and Implementation plan. It will contain a set of quality objectives which will use quality information and data to provide a clear understanding that reflects our local system intelligence. The ICB will develop robust system quality dashboards which will align quality metrics on processes and patient outcomes. This will evidence ongoing sustainable and equitable improvement. The ICB Quality strategy will articulate our quality priorities and will go beyond performance metrics and include outcomes and preventing ill-health and use the Core20PLUS5 approach to ensure inequalities are considered.

Safeguarding in partnership

The ICB maintains its statutory functions relating to safeguarding, forming partnerships with local authority and police partners to ensure that the system safeguards children and adults at risk of abuse as part of its collective responsibility. Safeguarding responsibilities are led by the ICB's Executive Chief Nursing Officer, supported by clinical leads to ensure that the partnerships focus on prevention of abuse. The ICB Safeguarding Team will be working with system partners to ensure that the updated Working Together to Safeguard Children (2023) guidance will be implemented across the system.

During 2025/26 the ICB will be focussed on ensuring that quality data is synthesised and delivered in a way that is consistent, and in line with Data for Improvement. Data dashboards which focus on key clinical quality improvement priorities are being designed at the current time to enhance an understanding of variation in outcomes across populations, in

order to focus resources on addressing where greatest need is identified.

Furthermore, the ICB team will consider how it can link with the NHS IMPACT (Improving Patient Care Together) team in order to support organisations maximise quality improvement opportunities. NHS IMPACT is a single improvement approach to support organisations, systems and providers to shape their strategy underpinning this with continuous improvement, and to share best practice and learn from one another.

4.2 Reducing Health Inequalities

Reducing health inequalities for the population who live and work in mid and south Essex is the Common Endeavour that sits at the centre of the system's Integrated Care Strategy. We know that existing health inequalities have been exacerbated by Covid and we must continue to listen to the experience of individuals and communities regarding their experiences, and work with them to help us design support, together. On average, deprivation in MSE is lower than the national average.

However, an estimated 133,000 people, or 10.5% of the population of MSE live in the 20% most deprived areas nationally. Figure 4 shows the number of people across each Alliance living in the 20% most deprived area nationally.

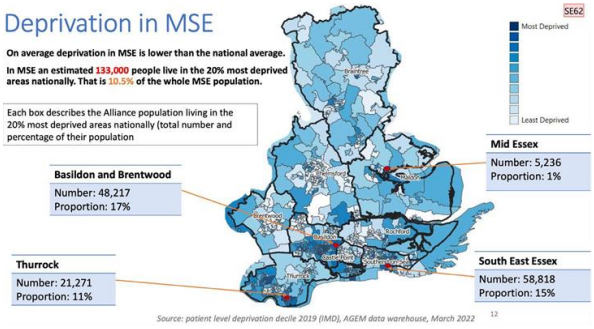


Figure 4: Deprivation in MSE

Looking across MSE, there is variation in life expectancy at birth. Those living in Essex generally have a higher life expectancy than the English average, men living in Southend have a higher life expectancy than English males, but women in Southend and all those living in Thurrock have a lower life expectancy than the English average (see figure 5).

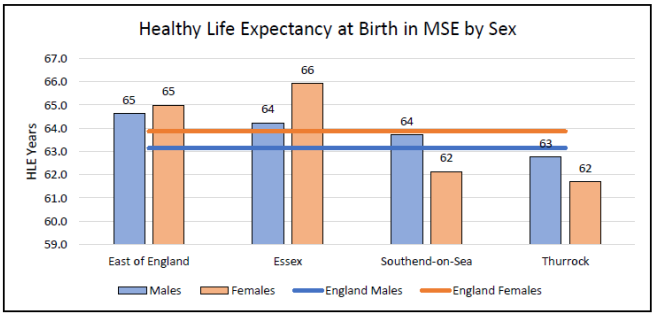
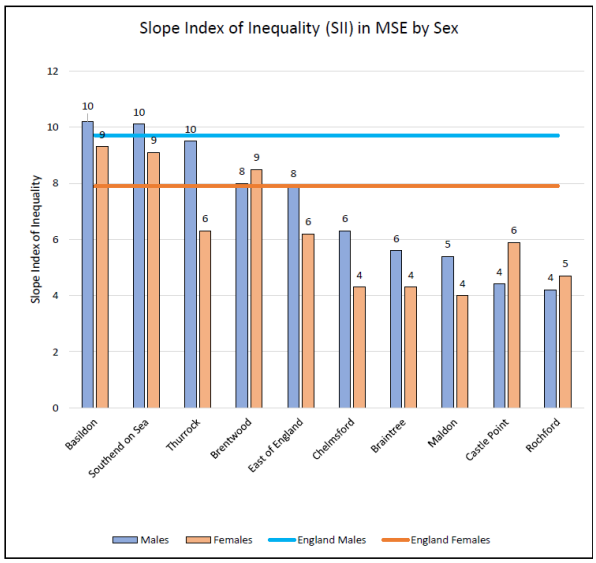


Figure 5: Life Expectancy at Birth in MSE

The areas that have a lower life expectancy overall, also tend to have greater inequality of life expectancy within their populations. The inequality gaps are greatest across Basildon, Southend and Thurrock, with the inequality gap across Chelmsford, Braintree, Maldon, Castle Point and Rochford being significantly lower, and lower than the national average (see figure 6).

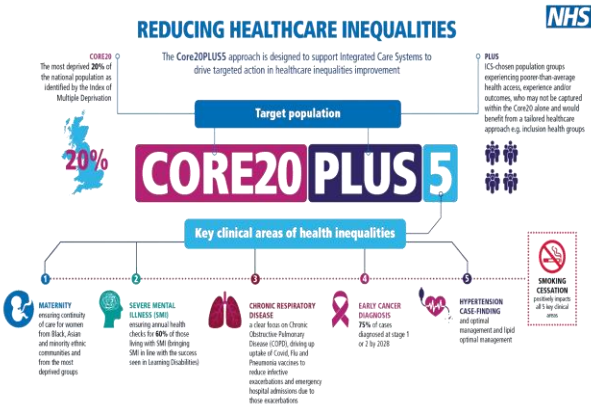


Source: ONS data from fingertips 2020

Figure 6: Slope Index of Inequality in MSE

Using data, both quantitative and qualitative, to better understand the specific drivers of health inequalities experienced by local residents is key to developing our services and to overcoming potential barriers to access, outcomes or experience.

MSE is committed to using the 'core20PLUS5' frameworks developed by NHS England to help us understand and address health inequalities in our communities. This includes both the 'core20PLUS5' for adults and for children (See figure 7).



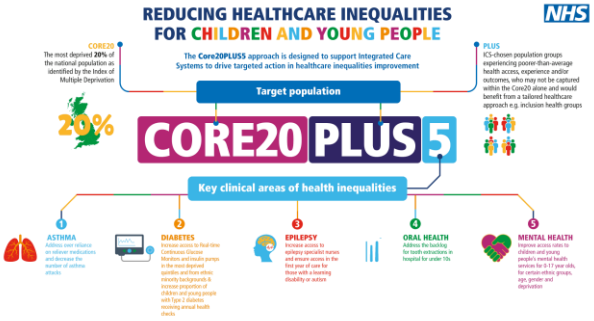


Figure 7: Core20PLUS5 frameworks

In addition to focusing on the needs of the communities that live in our most deprived areas, we have identified a number of local 'PLUS' groups for adults and children who live and work in mid and south Essex and are committed to working with partners and communities to develop plans for how we can address the barriers they experience in engaging with health and care services.

The adult groups that have been identified as being at risk of experiencing poorer health outcomes in MSE are:

- Black and Minority Ethnic groups
- Carers
- People with Learning Disabilities
- People experiencing Homelessness
- Gypsy, Roma, and Traveller communities.
- Veterans

The groups of children and young people that have been identified as being at risk of experiencing poorer health outcomes in MSE are:

- Young Carers,
- Ethnic minorities
- Roma, Gypsy, Travellers,

- Looked After Children, Care Givers
- Learning Disability
- Special Educational Needs and Disabilities (SEND),
- Neurodiversity (ASD and ADHD, Tics and Tourette's)
- Young people in the criminal justice system
- Families in Temporary Accommodation,
- Emotionally Based School Avoidance (EBSA),
- Unaccompanied asylum seekers, migrants
- CYP affected by Domestic Abuse

We remain committed to progressing this work through Alliance-level health inequalities funding and targeted system supporting priority areas.

As a Core20PLUS5 accelerator, with clinical, financial and programme ambassadors, we remain committed to embedding a focus on addressing health in equalities in all that the ICB does. This will include having a focus on ensuring that any recovery plans take account of the need to identify and address health inequalities alongside our drive to improve financial sustainability.

4.3 Improving population health

Traditionally the NHS has focused on treatment and curative activities. While we have, more recently concentrated on early identification and intervention, we recognise that we must play a full part, with our public health teams and wider partners, on prevention. As we seek to do this, we must recognise the importance of supporting more personalised care that responds to an individual's needs and situation. Empowering patients to make informed choices and enabling a more personalised approach to managing their health and any treatment they may need should be embedded in how we offer care across mid and south Essex.

The importance of focusing on improving health overall was reinforced through engagement with our Community Assembly in February 2024. When considering the components of the Integrated Care Strategy's 'Plan on a Page', those who were in the discussion highlighted prevention and early intervention as being the things they considered to be most important for the system to focus on.

Supporting system wide public health improvement

Delivering on these ambitions is a core focus of MSE's Population Health Improvement Board (PHIB). PHIB brings together stakeholders from across health, public health, local governance, alliances and community and voluntary partners to identify, develop and oversee delivery of plans to improve overall population health, prevention and reducing health inequalities.

The PHIB is committed to focusing on joint prevention priorities relating to smoking cessation, supporting healthy weight, addressing wider determinants of health such as employment; and to using population health management approaches to support targeted programmes to improve health

outcomes and tackle health inequalities. This PHIB will also support the five priorities for a Healthy MSE that have been identified by the ICP, working to support collaborative progress in prevention and action to tackle the wider determinants of health.

Integrated Neighbourhood Teams supporting population health improvement

Improving the health of our populations is also a core focus of our place-based alliances which bring together and integrate services across a wide range of local partners in health, care and beyond. Central to this is the development of our Integrated Neighbourhood Teams and the development of our Primary Care Networks.

This local approach supports delivery of personalised care, supporting patients to more involved in the decisions about their own care and their right to choose. Alliances are also lead local decision making on the best use of the Better Care Fund to support patients to access the care and support that they need as close to home as possible.

4.4 Commissioning healthcare services

The NHS in MSE needs to do more to ensure that patients can access high quality care at the right time, first time. The ICB remains committed to improving access to and experience of care for local patients and ensuring that patients can exercise their rights to choose which provider they receive consultant-led care from

The NHS is working to continuously improve how we offer care to our patients across all settings of care. In MSE we still have a long way to go to recover care in line with national targets in areas including urgent and emergency care, planned care and cancer.

We remain focused on using data, insights and benchmarking in relation to our activity, outcomes and experience to understand the areas where we are doing well, and the areas where we are falling short. Through our alliances and provider collaboratives we want to share learning and best practice and ensure a targeted focus on improving care for those who find care hard to access or are having a poor experience, specifically those who have identified health inequalities.

Improving primary care access

The longer-term ambitions for primary care in MSE will be updated through the primary care strategy, due for publication later in 2025. This will be the first integrated primary care strategy covering primary medical services, community pharmacy, optometry and dental services that has been produced by the local system. This will build upon “The Fuller Stocktake” (the development of Integrated Neighbourhood Teams), the local response to the Primary Care Access Recovery Plan and the Dental Plan. This strategy will be developed in dialogue with provider representation and wider stakeholders.

The ICB recognises the importance of good access to primary care services as, for most people, this is where the

majority of NHS provision is delivered. Sustainable and effective primary care will have a stabilising effect across the wider health and care system.

Whilst the strategy will provide a long-term direction of travel, the ICB will maintain momentum with the transformation of primary care services. We will:

- Continue to make changes in line with our Primary Care Access Recovery Plan.
- Expand the number of self-referral pathways that our patients can utilise and promote these through social media, practice websites and other outlets.
- Promote access into community pharmacy, optometry and dental services who are best placed to support patients with a range of issues that currently present to general practice.
- Support practices to use digital tools and new triage approaches to ensure that patient need is consistently assessed and managed in the most appropriate way and avoid the current 8am rush on phones where despite best efforts, need is often managed on a first come first served basis rather than being based on clinical need.
- Work with dental providers to better support our population through increasing capacity in contracts, piloting innovative approaches to address specific needs and encouraging retention through career development linked to new services.
- Improve collaboration between general practice and community pharmacy to support both providers with their long-term sustainability.

Transforming community care through our collaboratives

MSE is working closely with its Community Collaborative to explore ways that we can support more patients to receive care in the community where it is appropriate to do so. The introduction of Virtual Wards has supported more patients to receive more care at home, avoiding time in hospitals that can lead to greater deconditioning and greater cost to the system. Use of these digital solutions can also help reduce health system emissions and contribute to net zero ambitions.

A review of Discharge to Assess pathways is underway to support more patients to return to their primary place of residence as fast as possible. Cross-system working throughout 2025 will support a shift to more ‘home first’ approaches that will improve outcomes for patients and help reduce demand on acute beds.

Increasing community diagnostic capacity

Further shifts from acute hospitals into the community will be supported by the opening of Community Diagnostic Centres (CDC) in MSE. Construction work is well underway on the Thurrock CDC (opening in summer 25) with

further centres scheduled for Southend (late Spring 25), Braintree (Dec 25) and Pitsea (Winter 26). Modalities within the centres include Endoscopy, MRI, CT Ultrasound, heart scans, lung checks, blood tests, and X-rays. Once fully operational the centres will provide 320,000 diagnostic activities annually.

Figure 8: Artist impression of Thurrock CDC

Transforming mental health services

To support improvements in Mental Health across our system we have developed a Southend, Essex and Thurrock All Age Mental Health Strategy in partnerships with our providers, local government colleagues, partnering ICPs and Essex Police.

The vision that underpins this strategy is to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill health, enabling them to recover and live well.

Our work to improve mental health services must cover all ages, recognising the increased pressure facing today's Children and Young People and the associated impact that is have on demand for services.

Supporting patients with learning disabilities and autism

Working in partnership with education and the voluntary sector, we will be looking to find ways to increase support through prevention and early intervention initiatives that also address the health inequalities facing children support people of all ages with Learning Disabilities, Autism and others with neurodiversity in our community.

We will review our support and develop a more sustainable model of provision for patients across Southend, Essex and Thurrock, with the aim of improving access and experience of support to all people who need it. This will also include a focus on ensuring that the ICB responds to the expected assent of the Downs Syndrome Act.

This work will be overseen by the Southend, Essex and Thurrock Strategic Implementation Group, who will also ensure that activities support the broader ICP priority 'Healthy Minds'.

Improving care for babies, children and young people

MSE's Growing Well Programme Board is being refreshed and will look to develop a strategy to improve care

and support available to babies, children and young people in our system. This work, which considers both physical and mental health needs, will build on existing plans to improve care for children in areas such as: special educational needs and disabilities (SEND), asthma, diabetes, epilepsy, urgent and emergency care, oral health and end of life care. This work will support the ICP's 'Healthy Start' priority.

Optimising medicines and reducing waste

Medicines optimisation looks at the value which medicines deliver, making sure they are clinically and cost-effective. MSE is working to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions. Work to reduce medicines waste, unnecessary prescribing and shift to lower-carbon inhalers will deliver both financial and carbon savings that can contribute to the NHS' Net Zero ambitions.

We are maintaining a focus on achieving antimicrobial resistance prescribing metrics and reducing risk of medicines-related harm from high-risk drugs through improved monitoring. Central to this is embedding shared decision making when prescribing and making better use of clinical decision support tools to reduce variation across MSE.

Community pharmacists support patient care through delivery of a number of clinical services including New Medicines, Discharge Medicines, Blood Pressure Check and Oral Contraceptive Services, and most recently 'Pharmacy First' which launched in January 2024. Digital integration of community pharmacies with general practice and PCN Community Pharmacy Lead roles will support implementation of these initiatives.

Improving productivity

Over the period of this Joint Forward Plan, the Integrated Care System will increase its focus on improving productivity across all parts of the system. We need to ensure that we are maximising the use of the resources that we have to ensure that people are being seen as quickly as possible in the setting that best suits their needs. We will continue to innovate and test new ways of supporting people to access care in the best way for their current needs, whether that is an urgent or planned care need.

Developing our system ensuring corporate governance and decision making

To support the delivery of these operational objectives, we are continuing to review and strengthen how we govern our system through partnership working, but also effective oversight and assurance.

Following the restructure of the ICB, completed in January 2024, we have undertaken a Corporate Review which has supported strengthened approaches across our Operating Model, Decision Making and Organisational Development, all of which are enabling our approach to recovery.

Through this work we have strengthened our risk management,

with the introduction of Datix and a review of the Board's risk appetite, along with agreed new strategic objectives.

We have also refreshed our governance following the annual committee effectiveness reviews ensuring effective and integrated decision making, continued access to appropriate advice and developed an Organisational Development programme that specifically responds to the challenges identified through our staff survey results.

5. Key System Enablers

5.1 Supporting our workforce

We want people to see the NHS in mid and south Essex as a place they want to work and build a career in. We want to attract a diverse workforce and support people from mid and south Essex to work and progress in our system. We want to train and maintain the best clinical and non-clinical talent and are aware that to do that, we need to create environments and opportunities that will appeal to all.

Developing our workforce to be able to deliver the care models of the future requires effective workforce planning. Attracting and Training clinical staff takes years, so we need to strengthen our workforce planning processes mapping out our long-term workforce needs and supporting people through training and placements in our system. We want to keep building on exciting developments in medical and nursing training through local university and college partnerships with Anglia Ruskin University, the University of Essex, local FE colleges and other education providers to create life-long careers for both those leaving school and those looking to retrain. We will also continue to develop our Healthcare Assistant Academy to attract, develop and retain Healthcare Assistants across the MSE Workforce.

We will continue to develop our system careers website Our People Your Future. This website gives our local population one platform to access information about the different careers within the NHS including entry routes in and work experience opportunities.

Recruitment and retention

We have made significant strides in our work to provide recruitment, retention and development support to our Primary Care workforce. The MSE Training Hub, supported by the ICB People Directorate and led by a team of clinical leads and ambassadors, is highly regarded across the region for its best practice work in supporting primary care transformation and developing the current and new workforce required to deliver world-class patient care.

The hub supports our PCNs with their breadth of workforce planning, including the embedding of new roles through the Additional Roles Reimbursement Scheme (ARRS). It develops, delivers and procures education and training for GPs and primary care teams. It supports educational placements in PCNs and practices and career support to staff from new to practice, mid and late career. The hub delivers clinical practice specialty and refresher training, development for clinical supervisors and educators, CPD and

training in management and administration.

Our continued commitment to equality, diversity, and inclusion

The ICB is fully committed to the implementation of the comprehensive NHS Equality Diversity and Inclusion Action Plan with its six high priority actions:

1. Measurable objectives on Equality Diversity and Inclusion for Chairs Chief Executives and Board members.
2. Overhaul recruitment processes and embed talent management processes.
3. Eliminate total pay gaps with respect to race, disability and gender.
4. Address Health Inequalities within their workforce.
5. Comprehensive Induction and onboarding programme for International recruited staff.
6. Eliminate conditions and environment in which bullying, harassment and physical harassment exist.

This plan provides specific actions that we know from evidence and data will make a real difference to our ambition to be a highly inclusive organisation, but the plan always shows how we can learn and respond to lived experiences.

Our People Board leading workforce changes

Our Mid and South Essex People Board is leading the development and oversight of the systemwide plans to support all this work and help us ensure that we attract, train and retain staff to help us deliver high quality and high value care to our patients. Below are some of the initiatives we plan to implement or develop further to meet our NHS workforce challenges in Mid and South Essex:

Initiative 1: Train

This initiative focuses on Identifying hot spots where targeted recruitment and retention is critical and highlighting where enduring unfilled vacancies can be addressed with new skill mixes and new ways of working. New innovations regarding recruitment and apprenticeship offers are included.

Over the next 12 months we will further develop programmes through the Health & Care Academy that respond to areas of short supply whilst also working with higher education linking long term workforce plans to 2037. Mapping will be a key part of this.

By the next academic year, we will expand our College Enrichment Programmes to engage with and develop Health and Social Care Further Education Students, providing a clear understanding of the Healthcare Assistant role, work experience and an early recruitment pathway into health and social care careers.

By Summer 2025 we will implement a local Supply Delivery Group which will report into NHSE Train Board. This group will oversee delivery on attraction strategy and widening participation, recruitment and entry

level supply. Bringing all supply initiatives into one place.

Implementation of a new Centralised Placement Management Platform across MSE will increase the transparency regarding placement capacity and utilisation. The platform will also encourage the use of a variety of different clinical learning environments, to ensure learners are provided with a diversity of learning experiences. While improving the visibility of and access to placement experiences it will also aid the understanding of undergraduate student numbers and allow for early engagement and proactive recruitment.

Initiative 2: Retain

This initiative focuses on developing system-wide legacy practitioner vision. Building awareness and understanding of the value of this role in supporting the recruitment and ongoing workplace support (and therefore retention) for Nursing Associates, newly qualified practitioners, Trainee Nurse Associates, and other students. A similar advocacy/sponsorship approach will be taken to healthcare assistant champions, Physician Associate leads and Advanced Clinical Practitioner Leads across organisations (and recognising those roles in permanent Establishments).

To continue to develop and expand the learning opportunities available to our MSE workforce via 'My Learning Platform' – our free virtual learning environment. We will increase the diversity of courses available to ensure our workforce have the right skills and knowledge.

Ambition in MSE continues to be a workforce strategy that is clinically led, and work will continue in 2025/26 to secure the sponsorship of clinical leaders to the adoption of new roles and increase their receptiveness to new skill mixes.

To help support the retain agenda we will further develop the work undertaken in the Colleague Engagement, Wellbeing and Retention workstream which focuses on several retention initiatives across MSE. We will work in partnership to support an improvement for staff in areas of health and wellbeing, personal and professional development, and flexible working. Our health and wellbeing strategy will focus on mental health, one of the current leading causes of sickness related absences across all system partners.

We continue to create a culture and environment where people feel safe and supported to work and through system engagement groups organisations have been able focus on attracting and retaining talent.

We must take the time to understand and address the issues highlighted in staff attitude surveys creating a culture and environment that people want to and feel safe and supported to work in. This is particularly true in the acute hospital, where high vacancy rates continue to drive the use of more expensive temporary staffing which can also impact on the quality of care offered to patients. Having said this there has been a reduction in

temporary staffing, through the recruitment of permanent staff which improves the support to staff and quality of care offered to patients.

Initiative 3: Reform

Given significant financial deficits relating to workforce, financial improvement plans are in place to support urgent reduction in temporary staffing. In the Acute, the cost drivers are urgent and emergency care, elective care and cancer care. In Mental Health Trust they are increased acuity, observation and engagement.

Essex Partnership University NHS Foundation Trust:

The Trust is working hard to eliminate long term agency placements, tightening rostering practice, increasing Direct Engagement uptake for medics and AHPs; potential transfer to NHS Professionals Secondary Bank and re-negotiating rates with preferred suppliers.

Targeted work on staff groups with high temporary staffing spend (especially Community nursing), while maintaining Time to Care safe staffing levels.

Establishment Control panels are in place for all care units and corporate services as well as recruitment strategies for consultant posts and active establishment controls.

Mid and South Essex NHS Foundation Trust:

The Trust continues to support service changes with particular focus on:

- Nursing, Medical and Corporate Assurance - senior leader approvals on resourcing.
- Improved rostering processes in train (now need to be scaled, including all medics onto e roster)
- Regular audit of most costly locums, alongside clear recruitment plans to fill posts. Maternity and paediatrics areas of particular challenge, due to sickness levels and vacancy gaps.
- Improved accuracy of staffing categories – specifically 'unique post identifiers'
- Upskilling and training for off framework and booking approach.
- Review of doctor's bank booking platform with view to more robust controls
- Push to move staff from temporary to substantive.
- Active establishment controls.

5.2 Data, digital and technology

We know that healthcare is lagging behind many sectors when it comes to making best use of both its data and the potential that technology has to offer. The ICB is committed to working collectively to improve both the data and intelligence that we have and use in our system, and the use of digital and technology solutions that will improve the staff experience of delivering care and the patient experience of receiving it.

Delivering a system wide electronic patient record system

MSE is the first system in the country to commit to implementing a Unified Electronic Patient Record (UEPR) across our local providers. Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust have jointly procured a technology partner that will see them have the same Electronic Patient Record system in place. The trusts are targeting quarter two of 2026, which is subject to investment case approvals and contractual agreements. This joint approach will allow for more integrated care pathways across our acute, mental health and community pathways, offering a better experience for patients and staff.

In implementing the UEPR it is expected to deliver significant cash releasing and non-cash releasing benefits. Detailed benefits scoping has identified opportunities around reduced agency, local and temporary staffing costs. A reduced need for managing paper and consumables. From a clinical and operational perspective, the UEPR will drive standardised care pathways reducing unwarranted clinical variation. It will enable the trusts to optimise care services improving productivity across the organisation. Using new technology the UEPR will also improve system compliance and resilience for cyber security.

Implementing a shared care record

Across our Health and Care partners have gone live with our Shared Care Record. We have a role out programme in place with partners that will enable more partner access to the shared care record and improve the level of information shared. We have seen over four thousand documents being viewed since our go live in August 2024.

The shared care record enables information to be shared across health and care partners and provides capabilities that can support joint ways of working, helping to underpin the transformation needed to deliver on our operational and clinical priorities.

Developing a Patient Engagement Portal

Our digital patient interface, Patients Know Best (PKB), is now live across MSEFT and EPUT. It integrates with the NHS App, providing our patients with a digital front door to access their records, view appointments and corresponding documentation. Further enhancements are planned over the coming year we are working with our clinical specialities to create bespoke spaces within PKB that can offer patients access to a library of information relevant to care, the ability to receive questionnaires, develop care plans jointly or send and receive messages with their clinician.

New technologies supporting service transformation

The success of Virtual Wards in MSE demonstrates how effective use of technology can transform how we deliver care and deliver broad benefits across the health system, such as reducing emissions. We must continue to build on these successes to implement proven technologies that

will allow us to transform and improve how we deliver care at all stages of the pathway.

As we do this, we will continue to support our staff, partners and patients to receive the training needed to help them improve their digital literacy and use of emerging tools. An example of this is our primary care 'tiger teams' that are working to help local practices maximise the use of new technologies and data that is available to them.

Continuously improving our data capture and data technologies

Work is ongoing to establish a virtual Business Intelligence (BI) hub and its overarching vision to have a single way of managing information, which can be manipulated and collated to provide a single source of truth. This enables better planning at an integrated care system level, to provide evidence-based decision making and the ability to focus on improving services and the health and wellbeing needs for the 1.2m population in MSE.

We have built interactive dashboards on our strategic data platform, Athena, to provide insights and support action lead interventions that underpin service transformation across our stewardship groups.

As we improve our ability to collect data and integrate our data, we must continue to work on our supporting data and digital infrastructure so that we can generate and use insights to inform improvements in planning and operational delivery. Alongside the technical platform that will allow greater integration and data reporting, we will continue to train and develop our staff to draw out and use the insights that such solutions provide. As part of this work the ICB and its partners are exploring how best to utilise the opportunities of the nationally provided Federated Data Platform.

Engaging patients and communities in how we are developing our data, digital and technologies across the NHS is key. It is important that we ensure that digital solutions enable the provision of care, and don't increase digital exclusion or become a barrier to access. We must recognise the differential needs of our population and ensure that we are listening to where technology can help, as well as being transparent in our plans to use data to improve how and what care we provide.

5.3 Financial sustainability

MSE ICB remains committed to delivering high quality care that offers value to the taxpayer. As the system enters another year facing a significant financial deficit, there is a significant challenge ahead to develop and deliver plans that will allow us to live within our means and meet the needs of residents.

As the financial challenges in the system increase, the financial scrutiny and oversight also increases. In April 2024, MSEFT was placed in segment 4 of the NHS Oversight Framework (NOF4), meaning that the Trust will now be receiving additional recovery support and additional scrutiny from NHS England. In addition, the whole system has entered 'triple lock', with

more financial decisions being reviewed by both the ICB and NHS England. Collectively, this is increasing the focus on how we are managing all components of our financial plans. This includes the significant pay costs across our NHS providers, which still includes a high volume of temporary staffing, as well as non-pay and non-healthcare service costs.

Alongside this review of spend, it is important that we consider where we have made investments that have not added value. In a system that supports innovation and improvement it is important that we continue to test ways to improve our services. However, it is equally important that we evaluate those investments and review the impact that they have had. If things are not delivering the expected impact, we must commit to stopping them and considering alternative uses for that investment.

To further support our commitment to achieving financial sustainability, the system has committed to a review of corporate functions and areas which might drive efficiency and savings by consolidating our 'back office' functions across multiple system partners. A system-wide NHS infrastructure strategy is also being developed to explore opportunities to make better use of the physical assets we have to support patient care and improve the health of our local communities.

Through the newly appointed Executive Director of System Recovery, the system will continue to interrogate its costs and activities to identify opportunities for efficiency and productivity in how we work. In addition to using available tools, to benchmark opportunities for improvement, the system will continue to look at how it can transform care to offer better outcomes for better value.

We have worked cross system to develop and agree strategic priorities over the next 3 to 5 years to support financial recovery and deliver a more sustainable NHS. Our Medium Term Plan sets out the key proposed changes across the system, and within Mid and South Essex NHS Foundation Trust that will result in both the Trust and the wider integrated care system achieving financial, operational and clinical sustainability. This plan, attached in section 3 of the Joint Forward Plan sets out the key actions and timelines for delivery.

5.4 Research and Innovation

Research and innovation are integral parts of the NHS constitution and key enablers in driving improvements in clinical care. They can help attract additional investment into the local system and broader economy, can provide greater opportunities for staff to expand their experience and career opportunities and offer benefit to patients and the public through opportunities both participation and improved outcomes. As our ICB continues to mature, we will develop our strategies for both research and innovation.

Supporting NHS research

MSE aims to publish an updated research strategy during summer 2025 that will draw on organisational strategies and plans that are already in place across MSEFT, EPUT and our

university partners. The strategy will ensure that we are supporting research across all settings of care, increasing our focus on research in primary and community care and the wider determinants of health. This will be aligned with the work of the newly established Greater Essex Health Determinants Research Collaboration (HDRC).

The strategy will help increase the system's overall awareness of the value research offers in relation to improving patient care, partnership working between organisations and with patients and the public and funding opportunities. The research strategy will also be informed by the work we are currently undertaken through our Research Engagement Network project, which is looking to increase engagement from groups that are traditionally under-represented in research.

A system commitment to innovation

In developing an innovation strategy, MSE will continue to build on its established track record of innovation, including its local Innovation Fellowship programme for staff working in our health and care system, hosted by MSEFT, who also host a number of national innovation schemes. These schemes demonstrate the value we place on supporting our staff to innovate, test and learn.

Our innovation strategy will draw on the organisational strategies that already exist across the system, such as the EPUT Innovation Strategy for 2023-2026 which focuses on opportunities to optimise physical infrastructure and digitally connected things, quality improvement and innovation in working practice and digital and technology innovation.

As we do this, we will explore options to expand our innovation programmes and not only test new ideas, but also focus on scaling proven innovations that can improve outcomes and value in our system. We will remain open to new and evolving technology innovations, including the potential AI has to transform not only care delivery, but also efficiency and effectiveness in clinical and corporate support services.

MSE is part of the University College London Partners (UCLP) Academic Health and Science Network, which reaches into North East and North Central London. We will continue to work with UCLP in implementing proven innovations and practices that will help us improve the health of our local population. We will focus our adoption of innovation in areas of strategic and operational clinical priority such as cardiovascular disease, frailty and cancer care.

Alongside these strategies, we will continue to evaluate and report on the impact investment in research and innovation is having in our system and our broader economy. It will be important to recognise that not all research and innovations will deliver the expected benefits, but reporting on and learning from work that doesn't succeed is as important as continuing to invest and scale what works so that we remain a learning system.

5.5 Serious Violence and Victims of Abuse

The ICB is a member of the Southend Essex Thurrock wide Strategic Violence & Vulnerability Partnerships (VVP), which work across Southend, Essex, and Thurrock (SET) to provide a co-ordinated approach to address particular violence issues, partnership include the: Violence and Vulnerability (VVU) Operational Board and Round Table, Southend Essex and Thurrock Domestic Abuse Board and Violence Against Women and Girls meetings.

Serious Violence Strategic Needs Assessment (SNA) - Gathering this intelligence on violence into one place ensures a multi-agency lens approach which allows the VVP to better understand the levels of violence in the community across Essex.

This insight feeds into the integrated system wide action plan, allowing strategic and operational activities to be targeted towards the key drivers of serious violence within the county, as part of a preventative approach to reducing serious violence.

The insight within the SNA endorses the current approach of the VVP – that the Partnership is on the right course, delivering interventions which are having an impact and making a difference to communities.

Appendix 1 – ICB Statutory Legal Duties

As an ICB we have a number of statutory duties that it is required to fulfil by law. This Joint Forward Plan includes details as to how these duties will be delivered. We will exercise our statutory duties with the aim of:

1. **Duty to promote integration** improving quality, reducing inequalities and delivering collaboration. See sections 3.3, 4.1 and 4.2 for further details.
2. **Describing the health services for which the ICB proposes to make arrangements** meeting population needs and arrangements for provision of healthcare services. See section 4.4 for further details.
3. **Duty to consider wider effects of decisions** delivering on the triple aim and approach to decision making. See section 2 for further details.
4. **Implementing any JLHWS** setting out steps the ICB is taking to work in partnership to deliver shared ambitions and outcomes. See section 2 for further details.
5. **Financial duties** explaining how the ICB intends to discharge its financial duties. See section 5.3 and JFP section 3 (NHS Operational Planning Guidance 2025/26) for further details.
6. **Duty to improve quality of services** focus on continuous improvement including outcomes, safety and patient experience. See section 4.1 for further details.
7. **Duty to reduce inequalities** of both access to services and inequalities between patient groups. See section 4.2 for further details.
8. **Duty to promote involvement of each patient** including decisions relating to their diagnosis or illness as well as their care or treatment. See sections 3.2 and 3.3 for further details.
9. **Duty to involve the public** ensuring both people and communities are involved in planning, development of commissioned services. See section 3.2 for further details.
10. **Duty to patient choice** enabling patients to make choices with respect to aspects of health services provided to them. See JFP section 3 (elective reform plan) for further details.
11. **Duty to obtain appropriate advice** for any expert advice from partners or third parties relating to discharging its functions. See sections 2 and 3.3 for further details.
12. **Duty to promote innovation** in the provision of health services. See section 5.4 for further details.
13. **Duty in respect of research** facilitating or promoting research matters relevant to health services and the use of health service evidence. See section 5.4 for further details.

14. **Duty to promote education and training** in support of national directives as well as responding to changes in service change models. See section 5.1 for further details.
15. **Duty as to climate change** reducing emissions and supporting the drive to deliver Net Zero. See section 3.1 for further details.
16. **Addressing the particular needs of victims of abuse** having due regard to the Domestic Abuse Act 2021. See section 5.5 for further details.
17. **Addressing the particular needs of children and young persons** setting out proposals to address needs of those under 25. See section 4.4 for further details.

Other content includes:

- Workforce - See section 5.1 for further details.
- Performance - See JFP section 3 (NHS Operational Planning Guidance 2025/26) for further details.
- Digital / Data - See section 5.2 for further details.
- Estates - See JFP section 3 (MTP Delivery plan) for further details.
- Procurement / Supply Chain - See JFP section 3 (MTP Delivery plan) for further details.
- Population health management - See section 4.3 for further details.
- System development - See section 3.3 for further details.
- Supporting wider social and economic development - See sections 2 and 3.3 for further details.

Part I ICB Board meeting, 13 March 2025

Agenda Number: 7

Equality Delivery System (2022) – 2024/25 Report

Summary Report

1. Purpose of Report

The Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS provider organisations. There are three key domains; domain 1 relates to commissioned/provided services where a system response has been developed with Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust, whereas domains 2 and 3 relate to ICB development of workforce health and well-being and inclusive leadership.

The overall conclusion of the work undertaken is that the system and ICB is rated as 'Developing' under the EDS.

2. Executive Lead

Giles Thorpe, Executive Chief Nursing Officer

3. Report Author

Dr Sophia Morris, System Clinical Lead for Health Inequalities
Dr Kathy Bonney, Interim Chief People Officer
Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The Executive Committee and Audit Committee are responsible for oversight of equality issues within the ICB.

The Executive Committee approved the EDS 2024/25 report on 18 February 2025.

5. Impact Assessments / Financial Implications / Engagement

Not applicable to this report.

6. Conflicts of Interest

None identified.

7. Recommendation(s)

The Board is asked to ratify the Equality Delivery System Report.

Mid and South Essex Integrated Care System

NHS Mid and South Essex

NHS Mid and South Essex

Joint Forward Plan 2024-2029

Section 2 - April 2025 Refresh (draft)

Contents

About this Document

This document, section 2 of the Joint Forward Plan (JFP) 2024-29, sets out some of the things that Mid and South Essex Integrated Care Board (MSE ICB) has delivered in 2024/25 against the strategic ambitions that we set for our system.

JFP Section 2: A Review of Our Progress

Delivering our 2024/25 Ambitions

With support of system partners Mid and South Essex Integrated Care Board (MSE ICB) identified 403 actions against several initiatives to be delivered between 2024-2029.

During 2024/25 quarterly reviews have been completed to demonstrate progress with delivering the agreed activities with the latest in December 2024. The current status is:

- 98 actions have been delivered – 24.3% of total actions.
- 162 actions remain on track – 40.2% of total actions.
- 84 actions are under review – 20.8% of total actions.
- 59 actions are considered at risk against the initial outline timeline – 14.6%.

As described in section 1 of the refreshed Joint Forward Plan, April 2025, the mid and south Essex (MSE) health and care is currently facing significant financial challenges. There are challenges to meeting growing and evolving local population needs from the financial position in MSE.

NHS Operational planning guidance 2025/26 has been revised along with the system outlining additional strategic priorities as described within the new Medium-Term Plan (MTP). The requirements to deliver a financially sustainable NHS as described in section 3 of the Joint Forward Plan may delay, or change the actions and timescales published in the 2024/25 Mid and South Essex Joint Forward Plan. All agreed actions will continue to be monitored considering these developments.

The below provides a brief overview of some of the key areas of progress that have been made during 2024/25.

Improving Quality – Access, Experience and Outcomes

Discharge Cell

During November 2024 MSE ICS established a system-wide discharge cell with tactical / strategic overview of commissioned beds (acute, intermediate, stroke rehab, hospice, mental health and virtual wards). Since inception the Discharge Cell has seen a 30% reduction in hospital discharge delays.

Diagnostic Hubs

In August 2024 two nurse / technician led diagnostic hubs were established to provide rapid diagnostic tests in a 45 minute appointments.

Hospice Rapid Access Service

A finalist in the Health Service Journal (HSJ) Partnership Awards, this is a quicker, more effective service that can assess, provide care (inpatients or packages) for patients and supports capacity with our Integrated Care

Board All Age Continuing Care (CHC) service. The ICB has worked with the three Mid and South Essex hospices (Havens, St Lukes and Farleigh) on the development and implementation of this service.

Primary Care Dental Pilots

Dental pilots have led to improved access to care for residents of all ages.

Over 20,000 patients have been able to access dental appointments during evenings, weekends, and bank holidays thanks to additional appointment capacity we've created.

All of the 8,424 care home beds in mid and south Essex are also now covered by a dental practice, and over 4,000 courses of treatment have been delivered to residents.

We're establishing a new school's programme to give reception and year three students access to oral health education and assessments in school.

Click here for oral health website: https://www.midandsouthessex.ics.nhs.uk/work/primary-care/dental-access-initiatives

Improving Access to General Practice

Latest figures reveal that GP teams across mid and south Essex delivered almost seven million appointments in 2024, a 5% increase in appointment activity compared to 2023.

Alongside this increase, last year more patients had a face-to-face appointment than the national average (75% compared to 66%), while just over half of all appointments in mid and south Essex were delivered within the same or next day of request.

We've recruited 56 additional staff since Sept 23, increasing our GP practice workforce to over 4,300.

We are investing in digital tools and improved Cloud Based Telephony systems to enhance patient care and ease of contact with their practice.

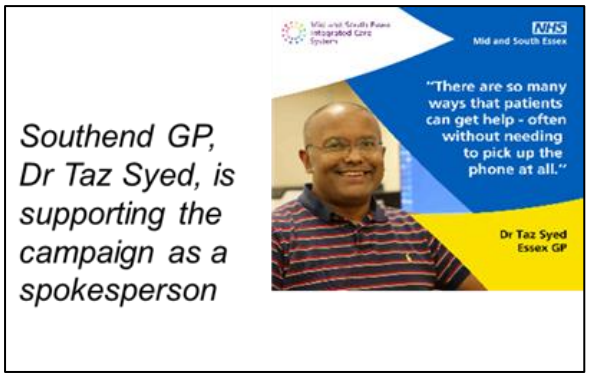
NHS Primary Care Access Recovery Plan

Work is taking place locally to help residents across mid and south Essex to access primary care services in support of the NHS Primary Care Access Recovery Plan, the aim is to:

- Tackle the 8am rush and reduce the number of people struggling to contact their practice.
- For patients to know on the day they contact their practice how their request will be managed.

Above image of Get the care you need quicker campaign.

In support of the national plan, we have launched a local multimedia campaign 'Get the Care You Need Quicker' to raise awareness of ways patients can access the care they need and help free up GP appointments for those that need them most.



Above image of quote from Dr Taz Syed in support of campaign

Community Diagnostics Improved Access

Continued progress in delivering plans for four Community Diagnostics Centres (CDCs) in Southend, Thurrock, Braintree, and Pitsea already in the building phases.

Above image of building phase for diagnostic hubs.

These centres will mean patients will receive quicker diagnosis and treatment from the NHS in line with the government's focus on reducing elective waiting lists.

We know people sometimes are waiting far longer for treatment than they should so in addition we are working hard to fix this, supporting the hospital trust to put on extra theatre sessions and improving our outpatient bookings so fewer people miss their appointments.

Emergency Department Expansion – Improving Patient Care

In August 2024 an £8.5 million expansion of Southend Hospital's Emergency Department commenced.

Above image of Southend Hospital emergency department expansion

Improvements will include a dedicated paediatrics area, linking it to the existing children's ward and creating a better experience and calmer environment for children coming into hospital.

Treatment areas, waiting rooms and resuscitation areas will be redesigned to improve flow through the hospital, meaning those coming to emergency departments get the urgent care they need, faster and allowing ambulances to handover patients as quickly as possible.

Reducing Health Inequalities

Ensuring deliver of our common endeavour of reducing health

inequality has and remains a guiding principle that underpins all our work.

The ICB has adopted the NHS Core20PLUS5 frameworks for both adults and children and young people to prioritise activities both across the system and through the local work delivered by alliance partnerships. The 'Narrowing the gap' report outlines how partners are working collectively across MSE to tackle health inequalities - Narrowing the gap Report- Mid and South Essex Integrated Care System

In 2024/25 the ICB continued to support investment of £2.2m into health inequalities transformation schemes. The funding was utilised to support innovative partnership solutions to reduce health inequalities at an Alliance level based on their local population needs. The funding also contributed towards resourcing the ICB capacity to address health inequalities including the PHM function, alongside system delivery against Core20PLUS5 priorities such as improved Hypertension case management. The ICB continues to evaluate the outcomes from this investment and learn lessons for future scale and spread of the work.

The information statement on health inequalities provides a more extensive overview of the programme of work and outcomes about the Core20PLUS5 framework, the five operational planning priorities and health inequalities funding investments and outcomes.

Health Inequalities Information Statement 2023/24 - Mid and South Essex Integrated Care System

Holistic Approach to Residents Wellbeing

Benfleet Primary Care Network is taking a holistic approach to residents' wellbeing to prevent more severe conditions in the future. The initiative is focusing on 63 residents aged 60–74 with multiple complex health issues such as depression, hypertension and diabetes.

The team supports residents to explore their personal goals, financial constraints and social support networks and then direct them to support such as weight-loss classes or therapy.

Pedal Power

Essex Pedal Power provides free bikes to encourage residents in disadvantaged communities to become more active. It also improves access to employment, training, educational opportunities and local services.

The project, run by Active Essex with Essex County Council and others, includes cycle and bike maintenance training. By January 2024 more than 1,000 people had received bikes, cycling 224,987km.

Smoking Cessation

A stay in hospital can be hard to manage for someone with a smoking habit. The acute trust is now offering patients staying overnight behavioural support, nicotine replacement therapy or other pharmacotherapy during their stay.

After they return home, they receive follow up and referral to community services. The maternity service is also delivering a programme to reduce smoking during pregnancy.

Weight Management Service

During 2024-25 MSE ICS have seen an increase of referrals into the national Digital Weight Management Service to 15%, above the national target of 13%.

Targeting Lung Health Checks

As part of our work to address health inequalities, the Targeted Lung Health Checks programme is helping identify cancer earlier in areas with higher rates of smoking and incidences of lung cancer.

Above image of lung health check promotions in the community

The checks began in Thurrock in 2020, followed by Southend, Rochford, Basildon and will be starting shortly in Brentwood.

As of October 2024, over 24,000 lung health checks have taken place in the region.

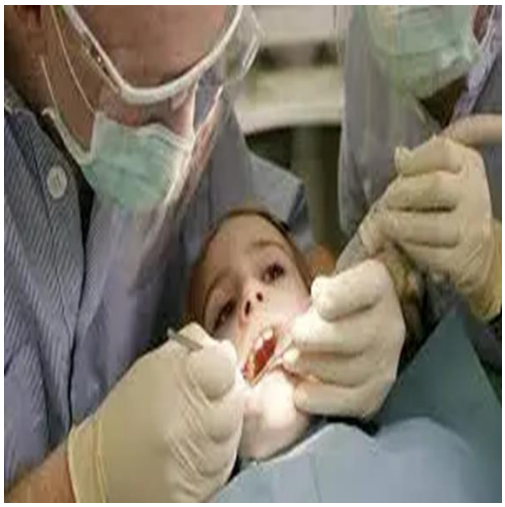
This has led to over 11,300 CT scans for people at the highest risk. As a result, 163 lung cancers have been found of which 70% were stage 1 or 2.

Click here for lung health website: https://www.midandsouthessex.ics.nhs.uk/news/saving-lives-by-finding-lung-cancer-early-targeted-lung-health-checks-programme/

Child Oral Health

We launched the Thurrock Early Year Oral Health (EYOH) Improvement program at the end of January 2024.

Tooth decay is almost entirely preventable yet, it is the number one cause of admission to hospital for five to nine-year-old children. The ICB is working in partnership with local partners across Thurrock to deliver targeted interventions to promote and embed positive oral health of children and young people within Thurrock.



Above image of child dental health procedure

The Thurrock EYOH program aims to address the causes of poor child oral health, which has resulted in children and young people in Thurrock experiencing:

- High prevalence of dental decay in five-year-olds, with the highest prevalence seen in areas of less affluence.
- High incidence of admissions to hospital for dental extractions under general anaesthetic.
- Low rates of accessing dental services.

Supporting Health and work

A system wide collaborative approach has been taken, working with local authorities, the Department for Work and Pensions (DWP), and the voluntary sector to support individuals with physical and mental health conditions, including neurodiverse individuals, in their journey back into employment. Our latest event in Southend, over 250 people received specialist employment support and information, advice and guidance from wellbeing and health services and the opportunity to engage with prospective employers.

Outreach into communities

The Health Inequalities funding secured the use of an outreach vehicle to deliver a holistic health and wellbeing service in community settings engaging with over 500 users from our most deprived areas to offers services including health checks, smoking cessation Long Covid, sexual health and weight management support.

Above image of outreach vehicle delivering holistic health and wellbeing service in community settings

Delivering Financial Sustainability

2024/25 Year End Position

To be provided once confirmed

System Financial Recovery Collaboration

Collaborative programmes have helped us release better value, reduce waste, and ensure more effective use of resources.

While system-wide focus is yielding results, unanticipated cost pressures, driven by surging demand and rising expenses, have made it challenging to stay on track with our original plans. Rising drug costs continue to affect financial forecasts across primary care, hospital services, and end-of-life care.

Clear plans are in place to address these pressures, with ongoing scrutiny from regional and national bodies to ensure we meet our agreed financial position for 2024/25.

Supporting our Workforce

Recruiting and Retaining Staff

A system-wide approach to workforce planning that is closely aligned to finance and activity planning is now in place and work is taking place to continue to strengthen these arrangements into 2025/26 and beyond.

We have delivered a system-wide platform 'Our People Your Future' to support our workforce through online courses, apprenticeship information, careers advice and job opportunities.

Click here for our people your future website: Our People Your Future | Be the future of health and care in Essex.

In June 2024 MSE ICS promoted Allyship in the workplace. Allyship is a critical component of creating an inclusive and supportive workplace for LGBTQ+ colleagues, knowing they have allies can make a significant difference in their experience at work. Allies help advocate for and support LGBTQ+ individuals, ensuring their voices are heard and respected.

In December 2024, Basildon and Brentwood Alliance were honoured with the Active Employer of the year Award at the Basildon Activity Awards 2024.

Healthcare Assistant Academy

July 2024 saw the first group of newly hired Health Care Assistants (HCAs) attend their induction with the HCA Academy. The induction built on a foundation of great work from Mid and South Essex Foundation Trust (MSEFT) to bring industry- leading training to HCAs who are set to join services across Essex.

Above image of new HCA Academy members

Newly hired HCAs from both Essex Partnership University NHS Foundation Trust (EPUT) and MSEFT are automatically enrolled to the HCA Academy upon successful appointment.

They will receive additional support from the Academy during their onboarding process and continued guidance throughout their first few months with their Trust.

The centralised induction across the two Trusts prepares them for roles in both mental and physical health, offering a comprehensive understanding of the various patient and healthcare scenarios they may encounter.

Letting Staff Lead

Our Stewardship Programme

MSE ICS Stewardship programme has been running since 2021. There are currently ten stewardship groups in

place and four that have been running since the start of the programme.

Clinical Leads appointed for a number of specialist areas including Dermatology, Maternity, Musculoskeletal, Mental Health, Cancer, Children and Young People, Inequalities, Personal and Public Engagement, End of Life, Medicines Optimisation, Service Restriction Policy, Covid, Outpatients, Population Health Management and Ophthalmology and support programme in place.

Our stewardship programme is leading the way in whole system clinical redesign and well regarded in its innovative approach.

Professor Tim Briggs commented:
"You're lucky in mid and south Essex to have stewards"

Above image of Professor Tim Briggs, NHS England National Director for Clinical Improvement and Elective Recovery.

Matthew Taylor commented:
"I'm a big fan of the approach the system is taking"

Above image of MatthewTaylor, Chief Executive, NHS Confederation

Ageing Well Stewards - Frailty Hotline

Ageing Well Stewards have been instrumental in embedding a more sustainable approach that is helping those living with frailty / dementia and those at end of life to access the right care and in the right place.

Significant Activity Levels: Currently receiving 400-600 calls per month - a vital enabler for improving clinical outcomes and experience of care to this population.

Integration into Urgent Care Pathways: Data shows 86% of calls originate from the Urgent Community Response Team (UCRT) and East of England Ambulance Service NHS Trust (EEAST) paramedics on scene.

Access to Expert Advice: Embedding the consultant frailty hotline into the UCRT, Single Point of Access (SPoA) and Unscheduled Care Coordination Hub (UCCH) work has provided clinicians with real-time access to expert advice, improving care coordination and reducing unnecessary delays for patients.

Reduced admissions: 81% of calls avoided hospital admissions within the

first 7 days, and 64% of patients still avoid hospital admission 90 days later.

National Attention: (Getting it Right First Time (GIRFT) experts, national Frailty Clinical Leads & NHS Elect Improvement team have endorsed the Mid and South Essex hotline model.

Ageing Well Stewards - FrEDA and e-FraCCS

The Frailty, End of Life and Dementia Assessment (FrEDA) and Electronic Frailty Care Co-ordination System (e-FraCCS).

We identified the challenge of incorrect data and limited tools available for staff to ensure that patients were receiving best practice within Frailty services.

The Ageing Well Stewards co-designed a common assessment tool to deliver and capture best practice within Frailty focusing on the use of 7 high impact pro-active personalised actions, known as FrEDA assessment this launched across PCNs, Community Teams, Hospices, Dementia Teams, Virtual Wards and more.

Implementation of FrEDA across MSE has had a significant impact, with key highlights below:

>12,000 new people with frailty, dementia or EOL needs identified in 1st year.

>50% reduction in older people with >3 unplanned hospital admissions in their last 90 days of life.

5% reduction in 30-day hospital readmission rates (ICS wide).

70% reduction in 30-day readmission rates in Integrated Neighbourhood Teams with highest FrEDA usage.

There have been benefits for staff too. Uniting colleagues under a whole person culture, using integrated tools so partners seamlessly collaborate for better patient outcomes, as opposed to siloed organisational practice.

Cancer Stewards – Prostate Case Finding Pilot

We designed a phased approach with 11 Primary Care Networks (PCNs) participating in the programme and 1841 patients offered the chance to participate.

As a result, we have seen:

- 865 patients seen in prostate initial clinics, 287 seen in follow up clinics.
- 768 patients had normal results with 32 patients discharged and fast tracked into the Acute Trust.
- Many cases were identified for diagnostic follow up.

Cancer Stewards – Colorectal Cancer Referrals

A FIT (Faecal Immunochemical Test) is a test that looks for blood in a sample of your faeces. It looks for tiny traces of blood which could be a sign of cancer.

in people with possible colorectal cancer, there was significant variation in referral practice from primary and secondary care, and confusion about best practice.

GPs in MSE were being asked to request and wait for the patient's FIT result before sending an 'Urgent Suspected Cancer' referral to MSE FT. We identified that many referrals had no FIT test were being sent and rejected in secondary care.

If the FIT was <10, and the patient had no other concerning symptoms, they were asked not to refer.

However, some consultants were also still scoping patients with a FIT <10, which was sending mixed messages to the GPs.

In order to improve this, the Cancer Stewards organised a number of educational webinars including at the MSE Cancer Summit to facilitate discussions around the FIT pathway.

In 2022, 33% of all colorectal referrals received into secondary care had a FIT result attached.

In 2024, 73% of all colorectal referrals have a FIT result attached.

Cancer Stewards – Teledermatology

Teledermatology refers to the use of digital images to triage, diagnose, monitor or assess skin conditions without the patient being physically present.

The skin cancer pathway had below nationally expected patient experience, lengthy diagnosis and treatment times, accompanied with poor performance and variation in pathways.

The Cancer Stewards invested in relationship-building, attending dermatology outpatient meetings and Primary Care 'time to learn' education sessions. They shared the improvement that the interim teledermatology pathway had made, including improving relationships between key stakeholders. They challenged some of the norms and existing ways of working, enabling a system approach to support the introduction of the teledermatology pathway.

Over six months, the interim teledermatology service triaged over 9,500 patients.

A 4-week snapshot period showed a 68% reduction in skin cancer referrals through to MSEFT specialists.

Many more people are now receiving a timely diagnosis, improving from 22% to 76% of people who wait no more than 28 days between referral and diagnosis (Faster Diagnostic Standard).

More people are also starting timely treatment (within 62 days of referral), increasing from 23% to 53.6%.

Cancer Stewards – Breast Pain

The Cancer Stewards coordinated and facilitated a breast cancer workshop for primary and secondary care across MSE, we also included the Women's Health Hub lead to ensure we were engaging all key colleagues.

We successfully agreed a new Urgent Suspected Cancer Referral (USCR) form and a digital approach to allow the patient questionnaire (which is essential for the Trust to triage) to be initiated by primary care.

Currently, it is too early to evidence the results and impact.

This did bring the primary and secondary care interface together to work more collaboratively. This work will also be the starting point for the Cancer stewards to start developing Community Breast Pain Clinics in the future.

Cancer Stewards – Breast Screening

Concerns were raised to the Stewardship group by primary care.

We had discussed these issues with East Suffolk and North Essex NHS Trust and South Essex Breast Screening Services (providers of breast screening services across MSE), we also involved Alliance delivery and transformation managers to ensure everyone was included.

A number of positive outcomes were shared including:

1. Agreement on how to communicate with patients.
2. The two screening service providers to share how patient lists can be obtained.
3. Development of a Standard Operating Procedure (SOP) for primary care with coding advice.
4. An educational event to follow the agreement on the SOP.

Cancer Stewards – Ardens Cancer Template

Improving ease of primary care referrals of suspected cancer has been a key development during 2024/25. We have worked with primary and secondary acre partners as a group to support earlier and faster diagnosis as it was identified as a key area that would support the patient pathway.

We undertook an audit of 50 referrals across four specific tumour sites within certain metrics in place and used audit data to help develop this. This was important as the Ardens cancer template will be designed for primary care to help support them.

Cancer Stewards – Prehab / Rehab

Two programmes of work have been funded by the Cancer Alliance through Active Essex & Health Inequalities budget.

These were the ‘Digital Health Optimisation Plan (Alvie)’ and ‘Living well with Cancer exercise programme’.

This programme of work aims to support patients in completing their cancer treatment, improve their outcomes and reduce length of inpatient stay post prehabilitation across MSE.

In the first six months of the Digital Health Optimisation programme, there have been 540 referrals of which 56% are from our most deprived communities.

Cancer Stewards – Cancer Summits

On 7th November 2023, Cancer stewards had organised a MSE cancer summit for primary and secondary care colleagues for influencing partnerships and pathways. This was a whole day event which was supported by national keynote speakers such as Professor Peter Johnson.

There were 4 breakout workshops throughout the day that enabled

networking and troubleshooting of key issues that we face across the system within Cancer. Outcomes from this event were improved understanding of cancer pathways, primary care involvement, troubleshooting issues resolved and shared learning.

On 18th September 2024, our Stewardship Group were asked to run a regional workshop on the stewardship approach to addressing the skin cancer issue within MSE, 36 attendees were at the event. The workshop highlighted key successes in implementing the stewardship model across MSE system, with a particular focus on Teledermatology.

Several strategic opportunities were identified during the workshop for the region, including replication of the stewardship model to allow for region-wide improvements and broadening Teledermatology access as the current infrastructure provides a solid foundation to expand these services.

Diabetes Stewards – Type 2 Remission Programme

The stewards worked to address low referrals to the national low calorie diet programme (the NHS Type 2 diabetes path to remission programme).

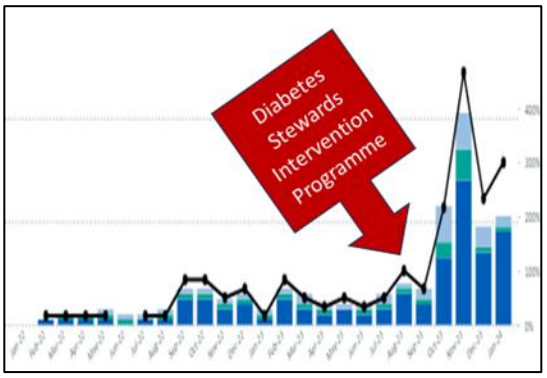
Research has shown this national programme helps people to lose over 10kg in weight, improve their blood sugar levels, reduce diabetes-related medication and, in almost half of participants, put their type 2 diabetes into remission.

However, prior to stewards' involvement, there were less than 40 referrals per month from across the system. The stewards identified several barriers to referrals including, lack of awareness of programme, workload, workforce capability, patient factors, the ICB restructure and change in providers.

The stewards worked to increase referrals through engagement with patients, providers, and Diabetes UK. They supported training, and most significantly used digital tools as an enabler by putting prompts onto the clinical systems that flagged patients who would be eligible for the programme.

Eligible participants are offered low calorie total diet replacement products including soups and shakes consisting of 800 to 900 kilocalories a day for 12 weeks.

Below image of Mid and south Essex Referrals to T2 Path to Remission Programme.



Since the stewardship interventions, referrals have increased from less than 40 to over 100 per month (peaking at 200+ in November 23). MSE ICS now has the highest referrals in the region, and the second highest nationally.

Eye Care Stewards – Childrens School Vision Screening

The Eye Care Stewards mapped the School vision screening programme

pathway across all schools, including Independent, Special Education Needs and Disabilities (SEND) and home-schooled children.

In Southend, 600 out of 2300 (26%) four- to five-year-olds failed their screening test, with 382 (64%) children unaccounted for, who could go on to develop permanent vision problems. This figure is 265 children (91% of those failing their screening test) in Thurrock, and 381 children (51%) across Essex.

Across MSE, there was no mechanism is in place to ascertain if a child had attended an optical practice for further tests following a failed school vision screening test.

The Eye Care Stewards worked to establish partnerships and collaborate with key stakeholders i.e. School Screening Teams, local councils and Primary Eye Care Services. They also identified inequalities e.g. SEND, home schooled children in service provision across MSE and an agreed plan established to address issues.

Southend Council have agreed to screen all Independent Schools and commission OPERA (an IT platform) to ensure children have had a follow-up sight test, closing the loop and addressing safeguarding issues. List of neurodiverse accredited Optometrists shared with school screening teams. Further results will be shared during 2025/26.

Eye Care Stewards – Certificate of Visual Impairment (CVI)

Eye Care Stewards were instrumental in developing the model and mobilising the Single Point of Access for Eyecare Referrals, and particularly the recent inclusion of the cataract pathway.

The key reasons for this were to provide a clinical triage to direct patients to the most appropriate services, ensure patients are offered informed choice where appropriate, to streamline the existing referral processes, and to provide a robust data set on Eyecare Activity to inform future planning.

Patients now have access to data regarding all hospitals including quality and waiting times to help them choose where they want to have their hospital procedures carried out.

Musculoskeletal Stewards – Community Appointment Day

We identified we had a large number of people waiting in the community for physiotherapy appointments in south west Essex. Patients had long waiting times, complex needs and care was felt to be disjointed.

A one day event, led by South West Essex MSK service with MSK stewards was held involving 21 community health and social care providers at Basildon Sporting village Community Centre. We aimed to provide a personalised approach which also focused on the wider determinants of health.

139 patients signed up to the day, 99 attended and out of these 56% discharged with Patient Initiated Follow-up.

92% of patients reported finding the day helpful in helping them manage their MSK condition.

100% of stakeholders who responded to the post event questionnaire reported enjoying the day and would participate in another event in future.

As a result of this event we identified a 3.5 week reduction in average waiting times for MSK physiotherapy services in south west Essex.

Musculoskeletal Stewards – Fracture Liaison Service (FLS)

The burden of preventable fractures on the NHS is enormous. A million acute hospital bed days are taken up by hip fracture patients and £2bn is spent annually on hip fracture care. Hip fractures are 'heart attack-level' events, which impose major burdens on hospitals, ambulances, and social care.

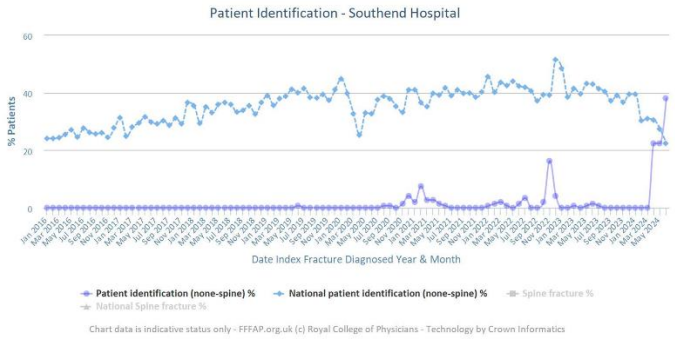
Data showed in 2020 there were an estimated 8-10,000 fragility fractures each year in MSE in adults >50 years. At this time <20% were seen in the Fracture Prevention and Osteoporosis clinics, often with a long delay between date of fracture, first assessment and treatment.

FLS identify, assess and treat osteoporosis in people over the age of 50 with a fracture.

The MSK (and Ageing Well) group supported the FLS project implementation, with the Clinical Lead from MSE FT, bringing providers and professions together to help remove barriers and facilitate the left shift to community care. This included supporting pathway design across sectors, including identification and initial treatment in acute settings, and in the community.

The FLS service has been mobilised at Southend Hospital as the first go-live phase, with Basildon and then Broomfield Hospitals to follow by the end of 2024.

At Southend Hospital identification of patients experiencing a fracture exceeded the national average within four months of mobilisation (see below), identifying and assessing over 220 people at risk.



Above image of patients identified and assessed for FLS service.

Musculoskeletal Stewards – Mental Health/ MSK Employment Advisor (EA) service

Stewards have supported the Essex Partnership University NHS Trust (EPUT) by identifying relevant stakeholders and facilitating an increase in awareness of the service.

Musculoskeletal Stewards – Get U Better App

We have supported the contract review and are now facilitating the ongoing role out/ use of the app therefore ensuring equity of access and value for money.

Musculoskeletal Stewards – ARU Magnetic Resonance Imaging (MRI) research

In partnership with Anglia Ruskin University supported with advice and guidance on planned research into how MRI results are communicated and how this can have a positive/negative image on patient outcomes.

Musculoskeletal Stewards – Lower Back Pain Pathways

Initially linked to NHS England, focus on bringing the current tier 1 and 2 providers together to understand our current situation and how we can work together to reduce inequity across the patch, delivering high quality care.

Stroke Stewards – Stroke Rehabilitation Capacity

In support of the redesign of community stroke rehabilitation capacity stroke stewards have undertaken comprehensive demand and capacity modelling.

A pre consultation business case (PCBC) has been consulted with further work planned during 2025/26 to deliver the Decision-making Business Case (DMBC) for Board consideration.

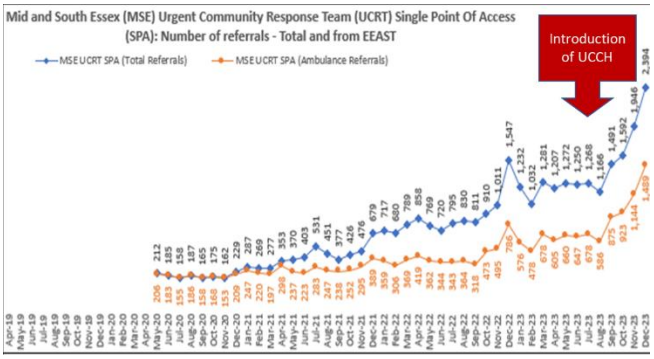
Urgent Emergency Care (UEC) Stewards – UCCH

Emergency Departments (ED) in MSE were failing to meet national waiting time standards and an opportunity to reduce the number of ambulance arrivals was identified.

The UEC stewards developed the Unscheduled Care Co-ordination Hub (UCCH) model which encouraged all ambulance crews to contact the UCCH prior to conveying a patient to ED. The UCCH multi-disciplinary team consists of Emergency Department Consultant, Urgent Community Response Team (UCRT) nurses, East of England Ambulance Service Trust (EEAST) clinicians and administrative support.

This team would speak to the ambulance crew and together they would decide whether there was a more suitable option than ED for the patient.

As a result 50% of patients were not conveyed to ED following a discussion with UCCH – with an estimated 140 ambulance conveyances per month avoided. UCCH coincided with a 50% increase in referrals to UCRT.



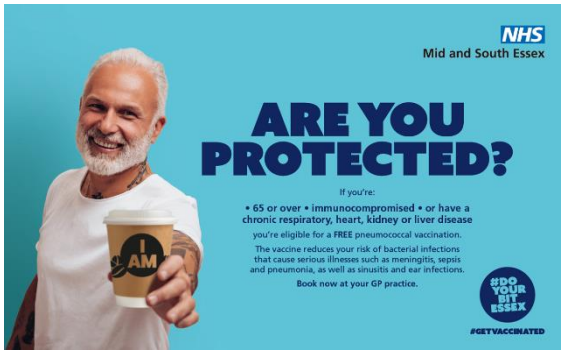
Above chart indicating increase in referrals to new service.

Further opportunities are being consider into 2025/26 with the plan to move into a phase 2 and 3 model deployment across Mid & South Essex inviting other partners, including General Practices, Care Homes and Mental Health to utilise the Unscheduled Care Co-ordination.

Population Health

Pneumococcal Vaccination uptake

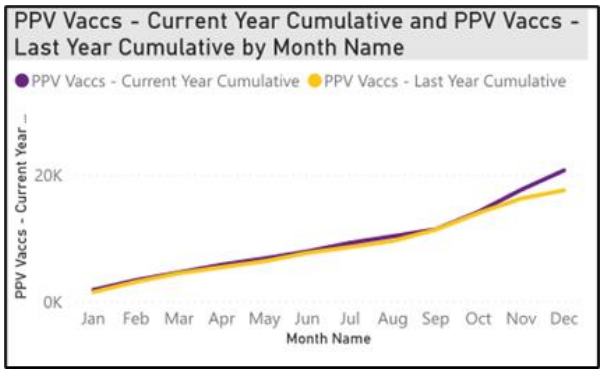
We launched a communications campaign to raise awareness and encourage eligible individuals to receive the free pneumococcal vaccination.



Above image of pneumococcal vaccination awareness campaign.

We promoted benefits of the vaccine and promoted its uptake among over 65s and individuals with chronic long-term conditions. Reducing the risk of meningitis, pneumonia, and sepsis

Most areas saw an increase in uptake among their populations. The largest increase was in Basildon and Brentwood with a 60% rise, followed by Castle Point and Rochford with a 29.3% increase, Mid Essex with a 15% increase, and Southend with an 8% increase.



Above image showing vaccination rates increase.

Moving Towards Net Zero

Climate Action Packs

During 2024 Essex County Council created free climate action packs to help residents and businesses reduce their carbon footprint.

The packs, originally launched in 2022, have been updated with new information as well as a fresh look and feel. This includes funding and volunteering opportunities. The residents pack has also been produced in an accessible easy-read version.

Gloves off Campaign

The ‘Gloves Off’ campaign has now been fully implemented across all providers including primary care. The ‘Gloves Off’ campaign utilises the work undertaken within our provider organisations, to stop wearing gloves where appropriate.

Reusing Equipment

Providers across MSE are ensuring that they reuse equipment in accordance with infection prevention control procedures and community equipment teams in south east Essex have confirmed that the only items that they do not refurbish are cutlery.

Reusing Equipment

Basildon and Brentwood Alliance received an e-bike donated from Ford Motor Company as part of the Electric

Bike Loan Workplace Pilot organised by the Find Your Active Basildon partnership. The partnership aims to improve the health and mobility of our frontline primary care support staff. This significant contribution will support their team in delivering essential one-to-one care across the community.

Above image of Ford Motor Company donating e-bike.

Kelly Herring, a dedicated Social Prescriber from the West Basildon Primary Care Network, was the first recipient of an e-bike. As a non-driver, Kelly faces unique challenges in her role, and this new addition has greatly improved her ability to efficiently reach patients and community projects.

Digital, Data and Technology

System Digital Enablement

In August 2024 Mid and South Essex ICS successfully launched the Shared Care Record, making a significant step forward in our journey towards more integrated and person-centred care across our system and beyond. The launch was a key milestone in our commitment to delivering better, more joined-up care between local health and social care organisations.

With quicker access to more comprehensive and accurate records, this digital tool allows professionals to focus more of their time on direct care rather than administrative tasks. This efficiency gain is projected to deliver £1.7 million in annual savings across MSE ICS, underscoring our commitment to a cost-effective, digitally transformed system that is future ready.

The Shared Care Record is integrated into the existing systems used by our providers. When professionals open a person's care record in their regular system, they can then directly access the individual's information within the Shared Care Record, without the need for additional logins. This streamlined, secure access allows professionals to quickly view and use vital information, ensuring more seamless care without any disruptions to their workflow. To understand what data is currently accessible and what will be added in the future.

Our Nova Electronic Patient Record (EPR) programme is a ground-breaking digital transformation programme that is a first in type in the UK. Essex Partnership University NHS Foundation Trust (EPUT) and Mid and South Essex NHS Foundation Trust (MSEFT) are united in an ambitious partnership programme driving substantial improvements in quality, safety, and patient-centred care.

In a healthcare landscape burdened by fragmented information systems and disjointed care pathways, patients and clinicians struggle to navigate a maze of data silos and inefficiencies, our Nova EPR Programme illuminates a

path towards seamless, unified care delivery where healthcare information flows effortlessly across boundaries, empowering patients and clinicians alike.

The Patient Engagement Portal is being implemented across Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University Trust (EPUT). Patients Know Best (known as PKB) was procured in February 2023 as the Patient Portal for the Mid and South Essex system.

PKB provides patients with access to their information held within our hospital systems. It is accessible anywhere, integrated with the NHS App and enables patients to share their information with friends, family and/or carers.

Our strategic data platform Athena allows partner organisations within local authority, primary and secondary care to access systemwide, linked data. Since February 2023 we have loaded over 1 billion rows of data that is now available via subject specific dashboards or for analytical research. From this we are able to make data-driven decisions and enable impactful interventions that can change lives.

Electronic Palliative Care Coordinating Systems (EPaCCS)

At its core, the main purpose of EPaCCS is to improve the quality of care for adults near the end of life. The registers achieve this by making sure that the person's needs, wishes, and preferences are properly recorded and easily accessed by professionals involved in their care.

Above image of holding hands.

As data sharing platforms, EPaCCS increase the visibility of people with palliative and end of life care (PEoLC) needs. They allow for valuable information about a person's care needs and wishes to be shared across multiple organisations, whether it is a care home, primary care, a community service, or emergency services.

People that benefit most from EPaCCS are those within their last year(s) of life. As they are living with a severe, life-limiting condition, they are likely to have contact with multiple care providers. Having their personal choices, priorities and goals for care recorded and easily accessible means they can get the most appropriate care in line with their wishes. The information recorded might include details like current palliative medication being taken, preferred place for care and personal decisions on resuscitation.

Having access to this information helps professionals improve the end-of-life experiences of people in their care. It can help prevent delays in care or avoid unplanned and unwanted urgent care or hospital admission, and it helps ensure patients' wishes are respected.

Mobilising and Supporting Communities

Community Initiatives

A number of community initiatives have been implemented during 2024/25 so support our communities.

In April 2024, Thurrock Council launched a free health lifestyle programme to provide services across the Borough. The programme helps Thurrock families improve their health and wellbeing, through engaging children with health eating and healthy habits.

In September 2024, organisations, people and communities in mid and south Essex joined together to light up buildings and landmarks green, as part of the 'Creating hope through light' event. The joint initiative between Mid and South Essex Integrated Care System and Thurrock and Brentwood Mind, and is part of their #LetsTalkAboutSuicide campaign which aims to raise awareness of suicide prevention and reducing the stigma around talking about suicide and challenge residents to take the suicide prevention training available. Click link for suicide prevention training: www.letstalkaboutsuicide.co.uk.

In October 2024 Healthwatch Essex hosted in partnership with the Trauma Ambassador Group an exhibition illustrating personal experience of trauma, and how people use creative outlets to express themselves. The exhibition, created to raise empathy and awareness of trauma and the effects it has, will feature art covering sensitive themes including bereavement, abuse, chronic pain, and forced adoption, amongst others.

Exhibitors have shared a range of multi-media pieces, with poetry and audio played throughout the exhibition, alongside interactive art pieces, paintings, textiles, photography, and more.

Specialist Bereavement Service

Above image of caring hands held out in support.

During September 2024 a free Specialist Bereavement Service was launched, delivered by Amparo for residents in mid and south Essex, provides emotional and practical support for anyone who has felt the impact of suicide at any time (recent or historical).

The service is completely confidential and can provide short-term or longer-term support. It is also available to bereaved children (Aged between 4 and 11 with agreed appropriate adult) and young adults (Age 11 upwards).

Suicide has a far-reaching impact, leaving questions and concerns on many levels. Those directly affected

are left with bereavement and loss, so it is important that help is on hand.

Experienced Liaison Workers, aim to make initial contact within 24 hours of a referral being received, offer residents:

- Support in their homes or wherever is most comfortable to the resident.
- One to one individual support.
- Help with any media enquiries.
- Practical support when liaising with the Police or Coroners including preparing for and attending inquest.
- Help overcoming feelings of isolation.
- Appropriate contact with other local services that can help.

Slipper Swap

During 2024-25 a series of slipper swap events have been held across MSE ICS to support older residents and people with frailty, to swap their old slippers for a free pair of new NHS approved slippers. The slippers have secure fastenings and robust soles to help prevent falls.

Vaccination Bus

In October 2024, members of our Alliances and Communication and Engagement Teams were joined by local community pharmacists on board the vaccination bus to provide information on winter vaccinations including flu, COVID-19 and the new RSV vaccination.

Eligible residents were able to have their flu and/or COVID-19 vaccinations onboard the bus and residents were also offered free blood pressure checks and practical health advice from our community health and wellbeing teams.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Equality Delivery System 2025

2024/2025 Report

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Contents

Introduction: Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: **EDS2: Making sure that everyone counts.**

The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted and published on the organisation's website.

The Mid and South Essex approach to EDS2 in 2024/2025

Mid and South Essex ICB has due regard of the regulatory and statutory equality requirements and delivers its responsibilities against the Equality Act in three ways; as an employer, in its function as an ICB and as part of a wider system alongside its strategic partners. At the heart of the Mid and South Essex Integrated Care Strategy is the Common Endeavour of reducing inequalities by working together to eliminate avoidable heath and care inequalities. In developing the ICB Equality, Diversity, Inclusion and Belonging Strategy, the ICB has established two overarching key equality objectives as set out below:

- ***To ensure equitable access, excellent experience, and optimal outcomes for all by addressing unwarranted variations in our services and moving towards an integrated health and care system.***
- ***To create an inclusive environment where our staff feel valued and are actively supported to achieve their potential, recognising that our culture, values, diversity and listens to the voice of our teams.***

The Equality Delivery System (EDS) was launched in July 2011, it is the foundation of equality improvement within the NHS and is used as an accountable improvement tool for NHS organisations in England. The EDS evaluation process gives MSE ICB an opportunity to embed the promotion of a healthier and more content workforce, which ultimately enhancing the quality of care provided to patients and service users. The EDS comprises eleven outcomes spread across three Domains, which are:

Domain 1) Commissioned or provided services,
Domain 2) Workforce health and well-being,
Domain 3) Inclusive leadership.

For Domain One, in 2024/25 NHS organisations, with other health and care partners, were required to select three services that they commission and/or provide for patients. MSE ICB worked in partnership with NHS organisations to evaluate three chosen services:
(1) Heart Failure Services in partnership with Mid and South Essex Community Collaborative (MSECC)
(2) Diabetes Service in partnership with Essex Partnership University NHS Foundation Trust (EPUT)
(3) Paediatric Transitions in partnership with Mid and South Essex NHS Foundation Trust (MSEFT)

This approach allowed for a co-ordinated evaluation process supported by wider community and VCSFE partnerships thus lending the 24/25 EDS evaluation cycle to taking a whole system approach.

Domain Two and Three of EDS focuses on workforce equality. To acknowledge the substantial impact of COVID-19 on Black, Asian, and Minority Ethnic community groups, as well as individuals with underlying and long-term conditions like diabetes, the EDS now aligns with the goals of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)[1]. Evaluation for domain two and three led by MSE ICB workforce team appraised workforce culture, current policies and interventions which support our stated equality objective to create an inclusive environment that values diversity and the voice of our teams.

EDS Rating and Score Card

Scoring rationale for each element of the assessment	Total scoring per domain
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

NHS Equality Delivery System (EDS): Document Control

Name of Organisation	Mid and South Essex Integrated Care Board	Organisation Board Sponsor / Lead	Dr Giles Thorpe, Executive Chief Nursing Officer
Name of Integrated Care System	Mid and South Essex	EDS Lead	Dr Sophia Morris, System Clinical Lead for Health Inequalities
EDS Engagement Dates	**Domain 1:** Diabetes Patient Engagement Event October 2024 Heart Failure range of patient engagement events September – November 2024 Paediatric Transition – Patient Engagement Jan 2025 ICB Collective Stakeholder Scoring Engagement event December 2024 **Domain 2 & 3:** None	At what level has this been completed?	**Domain 1: Partnership** Essex Partnership University FT (EPUT) MSE Community Collaborative (MSE CC) Mid & South Essex Foundation Trust (MSE FT) **Domain 2 & 3: Integrated Care Board**
Date Completed	18 February 2025	Date Authorised	18 February 2025
Date Published	18 February 2025	Revision Date	**February 2026**

Completed actions from previous year:

Domain 1: Commissioned or Provided Services 2024/25 Follow-up

This work relates to the domains reviewed in 2023/24 for Urgent Community Response Team (UCRT) in Community Collaborative, Topaz Ward Detox Service in EPUT, and Learning Disability (LD) in MSEFT.

Action/activity
1A – Patients (service users) have required levels of access to the service: • Accessible Information Standard is now included in staff induction. • The Patient Information in Plain English (PIPE) group has been re-designed (Simple, Meaningful, Understandable= SUM) and has a focus on AIS for all documents sent to approval. • Communications and marketing plan 2024 in place. • Information on how individuals refer into services has been collected and shared with communications team so information can be made public and easier to navigate for patients, families, and their carers. • iWGC reporting and training manager has had knowledge of point of access and referral systems into services built into job duties. • ELDP has a no 'wrong door' approach and if ELDP cannot help then the service will provide support that guides to the service users and families/carers to what the service user needs. • Where a services user requires the support of the community LD services and presents with enhanced support or dysphasia needs, they will be contacted as a matter of urgency and a face-to-face assessment will occur. • The Specialist Practitioners (community LD) carry out physical health Community Treatment Reviews (CCTR) to support a robust plan for where they access primary and secondary care. • The service annually update the training needs analysis to ensure training is current and address the needs of those person with an LD requiring specialist LD service. • Service are delivered in formats that is accessible for service users with the reasonable adjustments. • There are outpatient clinics where physical health needs are monitored in line with the national screening programmes. • Service users with fragility needs, a Frailty Tool is completed to scoring needs and planning interventions and included in the frailty pathway. • Out of hours GP service has been implemented. Accessibility ramps and other provisions to support access to those with a disability are in place and are readily available. • Red cards/zero tolerance principles are in place to protect the staff carers and visitors to the Trust. • Disability and Carers Passport developed
1B – Individual patients (service users) health needs are met: • Improvement with the deaf blind hearing loop accessible within areas and now the portable hearing aids available within all wards and departments. • Disability and Carers Passport developed.

Action/activity
1C – When patients (service users) use the service, they are free from harm: • Increase scope and utilisation of Patient Safety Partner role across organisation. • The Patient Safety Partner (PSP) role has now been fully operationalised with regular ward visits happening across the Trust. • A Patient safety Partner handbook has been coproduced and acts as the standard operating procedure for the PSP role. • EPUT's adoption of PSPs was nominated for a HSJ award. • The Patient Safety Partner team has increased by 50% since 2023. • The PSP's have also redesigned the patient safety question set to be utilised on patient walkabouts which allows patients to select which group of questions they would like to answer under the headings of safe, effective, caring, responsive and well-led. • Due to the positive interactions and receptiveness of patients, Patient Safety Partners are now due to take part in the trust wide audit of Therapeutic observation and will also be involved in a Quality Improvement project for Reducing Restrictive Practice. • Never Events assessments continues to prove a useful tool. Sharing from learning shared with teams. • Annual Flu campaign yearly within the Trust and Covid Vaccinations and Boosters offered to staff.
1D – Patients (service users) report positive experiences of the service: • Ensure every service within EPUT is using iWGC as the recognised patient feedback service. • Services using iWGC has increased from 1% to 49%. • iWGC is included in staff induction as a module, Dec 2023. Feedback challenge incentives set for staff. • Service specific posters have been provided for all services. • Incorporated data from iWGC into PowerBi Safety Dashboard. Monthly iWGC Reports are sent to all DDQS. • Increased scope of iWGC volunteer role; continuing to visit inpatients wards with plan to roll out to the community in 2025.

Domain 2: Workforce health and well-being 2023/24 Follow-up

Outcome	Objective/Action	Status Update
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Increase awareness of staff support available through networks and also targeting some interventions through the results of the wellbeing survey	Staff networks in place reporting to the Inclusion and Belonging Steering Group (a sub-group of the Executive Committee). Meetings are monthly. Specific wellbeing work is carried forward – that is a priority for OD during 2025/26 Wellbeing question in the staff survey was an improvement on last year. Specific wellbeing work is carried forward – that is a priority for OD during 2025/26 The intranet was reviewed and updated regularly to signpost staff to support within the local area using the Staff intranet.
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To review, refresh and promote the ICB Dignity at Work Policy and provide briefing sessions on this policy. To devise and agree a staff behavioural code in line with ICB values. Deliver cultural awareness and microaggression training.	Dignity at work policy updated and then further revised from the outcome of a grievance to demonstrate learning. Values and behaviours associated with the values included on the intranet. A managers' learning network was also conducted on this area as well as updates in staff briefings. A managers' learning network was conducting on managing diverse teams. The Board had a cultural awareness session, that led to a zero tolerance approach to any form of discrimination or harassment in the ICB.
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying	Refresh and relaunch staff support offers. Expand oversight of reporting on EDI.	The ICB is now accredited to have access to train MHFAs. Also, as a result of a grievance, we have sourced multi-cultural therapy for victims of harassment of discrimination. Also, appointed an independent mediator who has a background in discrimination and harassment cases.

Outcome	Objective/Action	Status Update
harassment and physical violence from any source		Reasons for leaving reported to Executive Committee. Exit interviews escalated to the relevant Executive Director where necessary. The outcomes of grievances and lessons learnt are also reported to the Executive Committee bi-annually.
2D: Staff recommend the organisation as a place to work and receive treatment	Improving staff experience	The ICB created a 3 Phase Organisational Development Plan which clearly outlines the many opportunities for staff to get involved in making this a great place to work and an employer of choice, 24/25 Staff data shows significant improvement in these areas' demonstrating successful delivery of the plan as a place to work. There is little improvement in staff confidence as a place to receive treatment but this is a indirect question for the ICB.

Domain 3: Inclusive Leadership 2023/24 Follow-up

Outcome	Objective	Status Update
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Regular Board agenda items around EDI To commit to the RMFI programme and learning from this. To commit to the delivery of the ICS EDI framework	The Board had regular updates and seminars on EDI. A programme of reciprocal mentoring was run with Board members and the wider Executive Team. The ICB approved an Equality, Diversity, Inclusion and Belonging Strategy. An annual report (PSED) to be drafted and presented to Executive Committee (and potentially the Board) by May.

Outcome	Objective	Status Update
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Provide Assurance to the Quality Committee that EHIIAs are fully completed, and actions taken on any required interventions. Update BME risk assessments.	EHIIAs still maintained manually, but steps being taken to implement a system ImpactEQ, to complete, monitor and manage the completion of EHIIAs. BME risk assessments are no longer required.
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Board members conversant with and act upon relevant EDI tools.	Complete WRES and WDES reporting and associate action plan. Annual report (PSED, including gender pay gap, AIS and PCREF) to be drafted and presented to Executive Committee (and potentially the Board) by May. Equality, Diversity, Inclusion and Belonging Strategy developed and approved by the Board.

Current year assessment 2024/25

Domain 1

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	**Diabetes (led by Essex Partnership University NHS Foundation Trust)** Service users with diabetes are referred to community dietetics and diabetes services through an agreed referral pathway, with accepted referrals registered on SystmOne or PARIS for mental health services. Those under Mid & West Essex mental health in-patient services receive face-to-face specialist care during admission, while outpatient mental health services also have access to a specialist dietitian. The Diabetes Specialist Practitioners can seek advice from the local secondary care Consultant Diabetologist for individuals with complex health needs, ensuring timely intervention. Primary care also supports diabetes management within GP practices through dietetic consultations. Diabetes structured education courses, including X-PERT/CIM for Type 2 diabetes and DAFNE for Type 1 diabetes, are offered both face-to-face and online, with additional self-directed learning. Individualized support is available for those unable to attend in group settings. Barriers such as lack of internet access, language differences, and homelessness are addressed through services like a daily advice line, translated SMS messages, and outreach programs. Coordinators ensure accessibility for individuals with disabilities or other health needs, and attendees can receive support from key workers, family, or friends to facilitate course completion. **Heart Failure (led by Community Collaborative)** The EPUT service processes referrals for residents with a registered GP, requiring clinician referrals, though self-referral is allowed within 12 months of discharge The EPUT service ensures that every patient receives a guaranteed assessment.	2	

Outcome	Evidence	Rating	Owner (Dept/Lead)
	The PROVIDE and NELFT service receives referrals from Primary, Community, Secondary and Tertiary care via SystmOne, email or letter. If the patient is discharged from the service, they can self-refer back in. The NELFT service provides a direct telephone number for patients to call so they can speak to someone from the service. The NELFT service provides home visits, face to face clinics or virtual appointments to all patients. The face-to-face clinics are held at various locations across Baildon, Brentwood and Thurrock. **Paediatrics (led by Mid and South Essex University Hospitals NHS Foundation Trust)** Patients receiving paediatric care with MSEFT will be supported until age 18 before transitioning to adult services, though no dedicated transition team exists. Each case is assessed individually for the best treatment, and extra capacity is arranged as needed to reduce wait times. Children and young people with disabilities have suitable access to outpatient areas and wards. A working group is improving healthcare access for children with autism and challenging behaviours. Some paediatric transition services (ages 16-18) have clear pathways to adult care, such as Paediatric Oncology and the Sickle Cell Pathway, with MSEFT's Sickle Cell Team being highly commended by HSJ for reducing health inequalities in young people in 2023. MSEFT collaborates with the Teenage Cancer Trust, referring teenage cancer patients to UCLH. The paediatric critical care team ensures access to necessary critical care services. Patients needing specialist treatment outside of cancer are referred to major London hospitals based on clinical need.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	ICB Wide An annual evaluation was undertaken of patient access and experience via review of elective care waiting list data by ethnicity, sex and deprivation, and data from the friends and family test. There was no significant difference in access based on sex. The gap between ethnicity groups on elective waiting list was closed as a result of standardisation and elective recovery work undertaken by MSEFT. Actions have been taken to improve equitable access to services by reducing barriers for example for working age women and those with learning disabilities. Learnings have been shared across the wider system. The Equality and Health Inequalities Assessment Panel reviews impact assessments to ensure that proposals to change or remove a service, policy or function clearly demonstrate the impact on reducing health inequalities and actions are identified to mitigate wherever possible. ImpactEQ is a system wide digital platform which has been developed for robust undertaking of equality impact assessments. Testing of the platform has been completed, with revisions planned to ensure maximum adoption, a complementary training package is in place. PHM Core20PLUS5 data packs, focus on adults and Children and Young People, have been distributed widely which summaries population inequalities down to a PCN level. A health inequalities dashboard has been developed that measures outcomes across a range of priority areas by age, sex, ethnic minority communities and those in the bottom 20% of Indices of Multiple Deprivation (IMD) scores. The system Athena data platform hosts a number of dashboards including Core20PLUS clinical areas with an inequalities lens applied to all datasets. Across the system continued effort has seen year on year improvement in ethnicity recording, within primary care 92% of patient records have a recorded ethnic. PHM have undertaken a deep dive into the recorded of other protected characteristics and PLUS groups to identify areas for improved data capture and recording. The ICB committed health inequalities funding to address inequalities in access in the priority area of cardiovascular disease and Cancer. Multi-morbidity clinics were commissioned to improve identification and management of hypertension and cholesterol and support		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	reduction of risk factors (smoking and weight) for those in our most deprived communities and from an ethnic background. The outcomes are currently being monitored and will be reported on in 2025/26. Pre-habilitation digital support programme for newly diagnosed cancer patients has commenced to support patients to optimise their health and wellbeing, with a focus on improving access and outcomes for those from our most deprived communities and from an ethnic background. Furthermore, health inequalities funding was deployed to secure an outreach vehicle to reach into and engage with seldom heard communities, including gypsy, Roma and travellers, those experiencing homelessness and asylum seekers, to improve access to health services by supporting registration with a GP and offering health and wellbeing services such as screening, vaccinations, health checks. The ICB's roll out of a Primary Care Access Recovery Programme has seen improvements to the way patients access and are triaged within GP practices. The number of self-referral pathways have increased to enable easier access to services. The latest GP Patient survey demonstrated a number of areas of access improvement.		
1B: Individual patients (service users) health needs are met	**Diabetes (led by Essex Partnership University NHS Foundation Trust)** Patients meeting service criteria are triaged within an agreed wait time, while others receive guidance on alternative care. Accepted referrals are registered with documented needs. All adults undergo assessment, including medical history and care planning, with pre-course support available for diabetes management. The team directs patients to relevant services such as community nursing, social services, podiatry, and diabetes support groups. An initial in-depth assessment helps create personalized care plans to empower diabetes self-management. Patients receive one-on-one consultations and are encouraged to report blood glucose levels for improved care.	2	

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Support is available for vulnerable individuals, including those with cognitive impairments, through regular check-ins, family involvement, telephone appointments, and home visits. Care home residents and palliative patients also receive tailored support. Provisions exist for patients with disabilities, language barriers, and hearing impairments through interpreters, support workers, and adapted resources. Various blood glucose monitoring options, including talking meters, are available to enhance accessibility. For at risk groups the service has implemented the following: • Daily advice line 9-12.30 Monday- Friday. • Patient email. • SMS messages so patients can have these dictated in their chosen language. • Language empire for face-to-face appointments. • Monthly visits to HARP and will attend some of the soup kitchens if unable to see the person living with diabetes at HARP. • Transition and younger people specific nurse (looking after 19-24). • Designated home visit DSN who will visit the housebound. • Engaged with staff engagement team to support the diabetes team with delivering education for festivities – i.e., Ramadan where a person may fast for prolonged periods of time. • Engaging with community nurses to change practice. • Currently engaging with ICB re changes to insulin pump processes and availability in line with NICE TA. **Heart Failure (led by Community Collaborative)** There are extensive clinical governance structures: include monitoring for serious Incidents for any themes and trends related to Equality and Diversity.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	The EPUT, PROVIDE & NELFT service takes a holistic patient assessment approach ensuring that all patients have a personal development plan in place. The EPUT, PROVIDE & NELFT service ensures that all patients are seen at home, within a clinic or in a satellite clinic. The PROVIDE service offers patients care in clinic, telephone, or home visit with or without relative / carers as needed / appropriate. The PROVIDE service offers patients a handheld record (with red flag signs) & supporting information from British Heart Foundation / Pumping Marvellous. **Paediatric Transitions (led by Mid and South Essex University Hospitals NHS Foundation Trust)** MSEFT assesses patients' health needs and directs them to appropriate services, providing strong therapy support, including physiotherapy, occupational therapy, dietetics, and psychological services. They collaborate closely with Essex County Council's youth worker service. The paediatric service maintains strong links with adult services to ensure smooth transitions, particularly in Sickle Cell services, Oncology, Diabetes, and Epilepsy. They also support patients with learning disabilities transitioning to adult care, with staff earning national recognition for their work. Despite efforts to bridge gaps between paediatric and adult services, challenges remain in standardizing transition processes. MSEFT is exploring a tool to manage complex health needs in children with disabilities, rare diseases, and long-term conditions. Electronic alerts help identify patients with additional needs, ensuring equitable care. Personalised care plans are in place for conditions like epilepsy, Sickle Cell, Cancer, and		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Diabetes, with translation services available to ensure patients understand their condition in their preferred language. I**CB Wide** A number of health inequalities funded projects have targeted interventions which aim to effectively meet the health care needs of particular groups e.g. Foot care for homeless groups, dental outreach bus targeted at homeless and migrant groups. The GP survey demonstrates that the majority of patients have a good experience of primary care. Further work is targeted at improving the experience of those with learning disabilities and autism.		
1C: When patients (service users) use the service, they are free from harm	**Diabetes (led by Essex Partnership University NHS Foundation Trust)** Patient Safety Partners at EPUT support governance and management processes, ensuring patient safety through objective feedback as part of the "Safety First, Safety Always" initiative. Serious incidents and harm reports are monitored by Essex STaRS, the diabetes service manager, and Essex County Council to identify trends in equality and diversity. No major incidents or complaints have been recorded. Face-to-face DAFNE sessions include safety measures such as hypo treatments and ketone testing. Advice on blood glucose monitoring technology and result interpretation is provided. Staff receive up-to-date, evidence-based training, maintain professional registration where required, and comply with DBS checks and mandatory training. EPUT follows a Safeguarding Policy, consulting safeguarding teams when needed, with documentation recorded in DATIX. Family, friends, and carers are involved in maintaining patient safety. DATIX is also encouraged for feedback.	2	

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Health and safety policies are followed, including risk assessments for venues and equipment. Infection prevention policies are adhered to and documented in monthly audits. **Heart Failure (led by Community Collaborative)** Patient Safety Partners are working within NELFT and EPUT to support and contribute to the Trust governance and management processes for patient safety. It is the role of Patient Safety Partners to communicate rational and objective feedback focused on ensuring that Patient Safety is maintained and improved within each Trust. Each service has risk assessments in place and are managed accordingly. Any high-level risks would be escalated where appropriate. There have been no reported incidents in the service. Within each Trust there are clinical governance structures in place to protect the safety of patients in the services. All services ensure that staff have regular supervision. **Paediatrics (led by Mid and South Essex University Hospitals NHS Foundation Trust)** The team uses regular process to ensure patient safety such as: • Datix • Never Events/SI's • Information Governance reports • Complaints • QI Projects • Risks assessed through the corporate risk register • Policies and Procedures supporting delivery of service • Business Continuity planning • Statutory/Mandatory training • Governance Structures for patient safety, Quality Governance Committee etc.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Bespoke training to ensure safe and high-quality care. In addition to this the service conducts case reviews of episodes of care where there is an opportunity to learn in the future. This the first time this service is being reported via this route and learning from this work will be embedded in the reporting next year alongside reporting more outcome related information. **ICB Wide** Patient safety training is part of the staff training programme across the ICS. A full-time patient safety specialist (PSS) supports the delivery of the NHS England's Patient Safety Strategy and associated work. The Patient Safety Strategy group aims to ensure an equitable approach to patient safety practices across the health and care system. A representative from MSE ICB has supported the national development of the upcoming NHSE Patient safety healthcare inequalities reduction framework. A weekly panel looks at patient safety incidents and investigations across the health system, to ensure the events are captured appropriately and explores opportunity for shared learning. The ICB conducts case reviews of episodes of care where there is an opportunity to learn in the future. ICB have now appointment two members of the public to be Patient Safety Partners who will be highly involved in the organisation's safety culture. The Patient Safety Partners will attend committees and meetings across the Integrated Care Board, and will be involved in patient safety, and training for staff members around patient safety. The ICB deployed the Datix risk management system in 2024/25 to support the capture, review and reporting on risks.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
1D: Patients (service users) report positive experiences of the service	**Diabetes (led by Essex Partnership University NHS Foundation Trust)** Patients are encouraged to provide feedback through IWGC (I Want Great Care) forms, the trust's contracted PREMS (Patient Recorded Experience Measure) provider. The platform is accessible in multiple languages and formats to suit different patient demographics. Post-course patients' complete questionnaires to assess whether the course met their needs, aiding team reflection. An EPUT outcome global questionnaire is used where possible for patients on the caseload. The EPUT forum, held quarterly by the Patient Experience and Volunteers team, allows individuals connected to EPUT to voice concerns and suggest areas of focus. The diabetes service scores an average of 4.86 out of 5 for patient experience, according to IWGC feedback. **Heart Failure (led by Community Collaborative)** The platform is accessible in different languages and is presented through varying methods depending on what may be most suitable to the patient demographic. There are very minimal complaints and in the last 4 years there has only been 2 complaints which related to medication changes, but these were resolved. The EPUT service has won a patient nominated national award which was. The award recognised quality of care and treatment provided. The PROVIDE service uses the Friends and Family test as a method of feedback for the service.	2	

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Paediatrics (led by Mid and South Essex University Hospitals NHS Foundation Trust) The paediatric service tailor the care they provide to meet the patient's needs, considering the emotional and cognitive maturity of young adults between the ages of 16-18 who have different needs to both younger children and adults. Friends and family results suggest that overall patient satisfaction is scored at 77/100 (based on a net promoter score system) which is higher than the Trust average of 75. There was only a 1-point difference between males and females, suggesting there is no difference in patient satisfaction based on gender. Satisfaction scores were 7 points below in patients from ethnic minority backgrounds. Males from an ethnic minority background have the lowest satisfaction scores across all paediatrics. This identifies an area for future work to reduce inequalities. When comparing satisfaction scores for teenage services specifically, services for teenagers were rated 83/100. This is higher than the overall Trust average and the paediatrics service. **ICB Wide** The system wide Research and Engagement Network has appointed a number of community champions across a variety of 'PLUS' groups that are underrepresented to engage and provide insights on barriers to access and improved outcomes. This has resulted an increase in participation in health and care research. A system wide online tool 'Virtual Views' for our residents was launched to enable the system to share information about projects, policies, and decision to foster transparent, participatory, and inclusive decision-making processes. An established insight bank shares intelligence and insights regarding the experience of different demographic groups across system, which informs Equality and Health Inequalities Impact Assessments.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	MSE is second wave Core20PLUS community connectors site, the COPD Community Connectors program objective is to better understand the lived experience of those with COPD living in the most deprived areas of Southend. Led by VCFE SAVS and Healthwatch Southend Intelligence from this program is shared across organisation boundaries and a positive output of this program is an innovative co-designed pulmonary rehab style service. Mandatory staff training includes Equality, Diversity and Inclusion, McGowan Learning Disabilities, Equality, Health Inequalities, and Impact Assessment.		
	Domain 1: Commissioned or Provided Services Overall Rating	**8**	

Domain 2: Workforce health and well-being 2024/25

Outcome	Evidence	Rating	Owner (Dept/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	The Mid & South Essex ICB continues to support an established peer staff network called "Positive Ways to Wellness" – open to employees with any long-term condition. The group is part of number of staff networks in support for staff to be able to bring their whole selves to work. The networks promote local regional and national opportunities for staff to get involved in workplace activities to support their wellbeing. All opportunities for staff are posted on our internal staff intranet pages. We are currently reestablishing our Wellbeing Champions Group and are growing our network of Mental Health First Aiders. The role is to act as a first point of contact for any employee experiencing emotional distress through to a mental health issue. We are an accredited Mindful Employer and have recently launched a new Neurodiversity Staff Network. All of the ICB staff networks are championed by an ICB Inclusion and Belonging Group which is sponsored by the Executive Committee. Staff are positively encouraged to attend the networks and chairs and vice chairs are encouraged to take the time to make the networks a positive and helpful experience. **24/25 Staff survey results are currently embargoed until the end of March.** The work on supporting staff with long term conditions continues as above and the ICB continues to support staff with long term conditions by supporting flexible working patterns, time off for appointments and extending periods of sick leave on full pay. As an ICB we have a proactive approach to the management of sickness absence with the HR Team supporting 42 sickness absence cases in the last year. We have run a Managers' Learning Network on the role of the line manager in managing absence positively promoting wellness conversations and return to work interviews. For managers unable to attend these sessions are recorded and are available to be viewed at any time on the Staff Intranet. In 2024 78% (70% in 2023) of staff said that the ICB makes reasonable adjustments to enable them to carry out their work, 86% (75% in 2023) of ICB staff said that they are satisfied with the opportunities for flexible working, and 69% (48% in 2023) of staff feel that	2	HR/Wellbeing Champions/Staff Networks

Outcome	Evidence	Rating	Owner (Dept/Lead)
	the organisation is committed to helping balance work and home life. The ICB's Health and Safety Policy sets out our responsibilities and those of employees under the Health and Safety Work Act 1974. Health and safety, fire safety and manual handling are included in the mandatory training programme for all ICB staff. Risk assessment and inspections continue to identify health and safety issues to enable appropriate action to be taken to reduce risks to staff and other users of ICB premises. Although ICB staff continue to work in a hybrid way, regular health, and safety inspections, building system tests and maintenance continued throughout the year. The ICB Stress Risk Assessment has being updated, and a Wellbeing Recovery Action Plan has also been created alongside some additional guidance on how to support with Reasonable Adjustments. Stress Anxiety and Depression remains the highest cause of sickness absence in the ICB, the system and the NHS as a whole. Staff are also required to complete working from home risk assessments and have access to support in enabling them to have the correct equipment and office furniture as required.		
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Dignity at Work Policy for the ICB to safeguard all stakeholders. This policy has been refreshed during 2024/25 as a result of lessons learnt from ICB Grievance Cases. Staff experiencing harassment or discrimination in the workplace, remains a very high priority for the ICB with an agreed zero tolerance approach. This is overseen by the Executive Committee who receive reports relating to grievance cases and concerns raised through freedom to speak up. The ICB has recently launched a new Sexual Misconduct Policy and become a signatory of the NHS Sexual Safety Charter. The Grievance and Dignity at Work policies have both been updated and a significant lens to the understanding and impact of sexual harassment via Manager's Learning Networks and all Staff Briefing Sessions has been applied. Developing cultural awareness and micro aggression training is a second OD Priority for 2025/26. We are working with colleagues in the system to implement the NHS Anti Racist Strategy, tracking our progress through the system Culture (ED&I) Delivery Group with Highlight Reports, overseen by the People Board and the 6 ED&I High Impact Actions which	2	HR/Staff Engagement Group

Outcome	Evidence	Rating	Owner (Dept/Lead)
	are reported to the Integrated Care Board. The ICB is also a partner member in a system Colleague Experience and Wellbeing Group looking at key themes and shared best practice including delivery against the NHS People Promise. Together we will build on these themes and actions for the 2025/26 survey, supporting the development of organisational planning in response to the survey and giving the opportunity to staff to shape this plan. There are regular all-staff briefings to communicate key messages, as well as operational updates and regular updates on system priorities. We continue to adopt a 'one workforce' approach, across our health and care system working together to ensure that policies and experiences are aligned and equal across organisational boundaries in order that we make people feel valued, empowered, developed, and respected. In 2024, 51% (28% in 2023) of staff would recommend our ICB as a place to work, 69% (55% in 2023) feel that the organisation respects individual differences. 51% (42% in 2023) feel that the organisation acts fairly when it comes to career progression. In terms of terms of attraction rates the ICB is very attractive in the recruitment market showing high levels of interest by high calibre applicants with a small but increasing diversity profile. Alongside this, the ICB has reviewed its recruitment practices to make them values based and inclusive. This is part of a new ICB People Management Strategy which looks at all elements of people management throughout the employees' journey from start to finish. The staff survey questions relevant to this objective all show improvements on the previous year. (Staff Survey questions 22, 23, 25, 26). Data from the ICB Workforce Race Equality Standard showed that there was a relatively equal split of staff accessing non-mandatory training and CPD for those from a white or ethnically diverse background.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	There is a Freedom to Speak Up Guardian in post for the ICB and we have active Freedom to Speak Up Champions and two Senior FTSUP Officers one of whom sits in Corporate Governance and the other in HR. The Freedom to Speak up Guardian has received 14 separate enquiries this year both from within the ICB and from General Practice. The majority of these have related to poor people management practice and/or challenging behaviours. All issues have been addressed and all but one resolved. The ICB supports union representation whereby time is given to a staff member to attend union meetings and support colleagues accordingly. This year we jointly commissioned and procured (along with one of our Health Partner Providers) a new Occupational Provider that offers an enhanced Employee Assistance Programme (EAP). The ICB continues to sponsor a Staff Engagement Group (SEG) where concerns can be raised as well as being able to access several staff networks as well as Trade Unions. See also comments in 2a regarding mental health first aiders and the work around the stress risk assessment. Equality impact assessments are undertaken on all ICB policies to determine whether any actions were needed to address inequalities.	2	HR
2D: Staff recommend the organisation as a place to work and receive treatment	In 2024 51% (28% in 2023) of staff would recommend our ICB as a place to work, 69% (55% in 2023) feel that the organisation respects individual differences. 51% (42% in 2023) feel that the organisation acts fairly when it comes to career progression. The ICB collects quantitative data via the staff survey and qualitative data via internal grievances, freedom to speak up referrals and exit interviews that are reported to the Executive Committee. Alongside this, the ICB has reviewed its recruitment practices to make them values based and inclusive. This is part of the ICB People Management Strategy which looks at all elements of people management throughout the employees' journey from start to finish. The Mangers' Learning Network had a development session to understand their line management	1	HR

Outcome	Evidence	Rating	Owner (Dept/Lead)
	responsibilities and a Managers' Toolkit was launched to give step by step guidance on how to turn the strategy into action, which has received good feedback and been shared with partner organisations in the system, at the People Board as an example of good practice.		
	Domain 2: Workforce health and well-being	**7**	

Domain 3: Inclusive Leadership 2024/25

Outcome	Evidence	Rating	Owner (Dept/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.	Board seminars have been delivered on improving health inequalities in May 2024, developing the Equality, Diversity, Inclusion and Belonging Strategy in September 2024, EDI development in November 2024. Board Members challenge EDI aspects relating to papers they received at both the Board and within Committee meetings. Board and the wider Executive Team members undertook reciprocal mentoring as part of Board development during October 2024 to February 2025. The Board received a briefing on the new ICB ED&I Strategy. The Board approved a new Equality, Diversity, Inclusion and Belonging Strategy in September 2024. Each Board member have also established specific equality objectives, supporting the objectives set out within the strategy. The Executive Chief Nursing Officer chairs the Inclusion and Belonging Steering Group. The Executive Committee are working towards a Board level sponsor for each of the staff networks. An immersive seminar was held at the Integrated Care Partnership (that included all Board Members) and gave in-depth insights to the population we serve, and they challenges they face locally. Alliance Directors attended local events and engaged with their population through various events. In November 2024, the ICB Board met to review the National ED&I High Impact Framework which requires improvement evidence against 6 prescribed areas. We have embedded fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity. We have created a system Rise and Thrive Programme which is a bespoke career	2	HR / Corporate Team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	progression training for our Global Majority Workforce. This programme is building on the practice of one of our Health Providers and is available to both health and care staff across our system. A second programme is due to launch later this year which will form part of a rolling programme of offers. We are yet to develop and implement an improvement plan to address health inequalities within the workforce, but we are currently working with Public Health Partners in our system. We implemented in our system a comprehensive induction, onboarding, and development programme for internationally recruited staff although the focus for the next 5/10 years on is much more on the domestic pipeline. The ICB has developed a WRES report and action plans that staff have had the opportunity to contribute to and will work on the WDES report and action plan in 2025. These will be regularly monitored to ensure progress against agreed objectives. The ICB has also prepared a Pay Gender Gap Report which shows that both the ICB and the NHS as a whole still has a gender pay gap, whereby there are fewer men within the organisation, but that there is a larger proportion of men within higher paid jobs in the ICB. Progress against these plans is driven and monitored by the ICB Inclusion and Belonging Steering Group, which is Chaired by the Executive Chief Nursing Officer. ED&I has also been a focus for the Line Managers' Learning Network development sessions in particular sessions on Sexual Safety, Discrimination and Managing Diverse Teams and a session on living our ICB Values.		
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts	All Board / Committee cover papers require staff to assess and comment upon how the topic impacts on equality and health inequalities where appropriate. Executive and non-executive members challenge equality and inequalities both the Board and at Committee meetings. Equality and Health inequality impact assessments are completed for all projects and are signed off at the appropriate level where required (e.g., service harmonisation).	2	Corporate Team

Outcome	Evidence	Rating	Owner (Dept/Lead)
and risks and how they will be mitigated and managed.	Each policy has an Equality Impact Assessment. Equality and health inequalities are discussed specifically at the Board in relation to addressing health inequalities and HR high impact actions. Home working risk assessments are completed for all staff.		
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.	Our ICB appraisal process (specifically for Band 9 and VSM) asks staff to commit to demonstrating the ICB values, one of which is working and leading with compassion and respect, which gives a framework to use to discuss performance against these areas. There is also a robust performance management policy in place and recruitment to Band 8a and above has a Situational Judgement Test based on the ICB Values as part of the Assessment Process. As a developing organisation, implementation of and reporting on WRES, WDES, Equality and Health Inequality Impact Assessments, Gender Pay Gap, Accessible Information Standards and EDS2 are in place with plans for further development. The Executive Chief People Officer has overarching responsibility for delivering this and being accountable to the Board, and when complete will ensure these are report to the Board and acted upon.	1	HR / Corporate Team
	Domain 3: Inclusive Leadership	**5**	

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Overall EDS Score for 2024/25

EDS Organisation Rating (overall rating): **20** – Developing (19 – Developing 2023/24)
Organisation name(s): Mid and South Essex Integrated Care Board
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

EDS Action Plan 2025/26

EDS Lead	Dr Sophia Morris, System Clinical Lead of Health Inequalities	Year(s) active	2022,2023,2024
EDS Sponsor	Dr Giles Thorpe, Executive Chief Nursing Officer	Authorisation Date	

Domain 1: Commissioned or provided services 2025/26 Action Plan

Outcome	Objective	Action	Completion date
1A: Patients (service users) have required levels of access to the service	Ensure information on what services are available, in which localities, and how to refer into them is publicly and easily available. All patients have required levels of service and access to services regardless of circumstances. Use patient data to ensure that those from marginalised communities have equal access to services. Identify opportunities to make improvements.	**HEART FAILURE (Community Collab)** Heart Failure collaborative group will review the service specification and work with commissioners to agree a new standardised threshold for accessing some HF services. **DIABETES (EPUT)** Improve data quality and visibility so that evidence is made available which shows how services accommodate patients with higher risks due to a protected characteristic or at risk of health inequalities to have adequate access to the service. **PAEDIATRIC TRANSITIONS (MSEFT)** Work with QI team to develop a business case exploring the steps the trust can take to make improvements in the transitions space. Initially Identify one service to make	Lucy Smith & Heart Failure Group Gary Brisco April 2025 Deputy Director of Nursing Clinical Director Division of Children

Outcome	Objective	Action	Completion date
		improvements to the transition pathway and then work through others	March 2026
1B: Individual patients (service users) health needs are met	Ensure patient needs are consistently being assessed/reviewed with patient, carers, and family members to allow for any changes or updates. Ensuring correct pathway of care for specific needs Ensure patients are empowered to access VCSE organisations as part of their health and wellbeing. Ensure access is standardised and equitable.	**DIABETES (EPUT)** Document routine signposting to VSCE organisations and use of social prescribing. Ensure details of how personalised care is embedded into the care for those with higher risks due to a protected characteristic is clearly evidenced. Increase scope of working in partnership with community groups, and VCSE organisations to support service delivery for those with protected characteristics. **PAEDIATRIC TRANSITIONS (MSEFT)** Develop a transitions protocol for those that present at 16+ to ensure the young person get care and treatment from right team to meet their physical, psychological, and emotional needs. Pathways should be standardised where possible across the 3 sites, but may need to remain speciality specific	Gary Brisco April 2025 Speciality leads Consultant and CNS March 26
1C: When patients (service	Increase scope and utilisation of Patient Safety Partner role across organisation.	**HEART FAILURE (Community Collab)** Service leads to consider deep dive into reports of harm as they are so low.	April 2026

Outcome	Objective	Action	Completion date
users) use the service, they are free from harm	All patients are free from harm when they utilise our services. Continue to develop the Patient Safety Partner (PSP) role in EPUT to ensure patients are free from harm. Transition is safe and comfortable for patients	**DIABETES (EPUT)** Actively include equality and health inequality themes in safety incidents and near misses. Continue and increase scope of Patient Safety visits to include community services. Agree reporting method for Patient Safety Partner interviews; ensure actions, themes, and trends from patient interviews are captured and incorporated into learning from complaints and PALS with assigned accountability. **PAEDIATRIC TRANSITIONS (MSEFT)** Work with adults to ensure that for all specialities, both paediatrics and adult have a joint role in bridging between children's and adult services. To be monitored through CYP board.	Gary Brisco April 2025 Clinical Director & DDoN Mar 26
1D: Patients (service users) report positive experiences of the service	Ensure every service within EPUT is using iWGC as the recognised patient feedback service. Positive experiences for all service users	**HEART FAILURE (EPUT & Community Collab)** Investigate potential for iWGC to report beyond ethnicity in South East and Mid localities. Work with Patient Participation Lead to increase patient experience activity outside surveys. **DIABETES (EPUT & Community Collab)** Investigate potential for I Want Great Care to report beyond ethnicity in South East and Mid localities.	Therese Williams Amy Poole

Outcome	Objective	Action	Completion date
	Improve on patient feedback scores and evidence use of iWGC results in future service developments.	**DIABETES (EPUT)** Improve access to collate data from patients with protected characteristics about their experience of the service with iWGC. Continue campaign to ensure every service within EPUT is using iWGC as the contracted provider of PREMS. Patient Experience team to work with services to engage with patients specifically with protected characteristics and other groups at risk of health inequalities about their experience of the service. Document existing and future work with the VCSE to ensure all patient voices are heard; from this create data driven/evidence-based action plans to monitor progress. Governance structure to follow PCREF; EoC and Quality committee.	Gary Brisco April 2025
	Ensure patients are engaged, involved and feel supported	**PAEDIATRIC TRANSITIONS (MSEFT)** Ensure all teams have toolkits available regarding transitions and engage with our young people parents and carers early so they feel supported in the transition to adult services.	Clinical Director & DDoN Mar 26

Domain 2: Workforce health and well-being 2023/24 Action Plan

Outcome	Objective	Action	Completion date
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Increase awareness of staff support available through networks and also targeting some interventions through the results of the wellbeing survey.	• Wellbeing champions to plan schedule of events and interventions for 2025, including planning targeted monitoring of the health of those with protected characteristics and targeted interventions to encourage self-care amongst those with long term conditions. • Analyse sickness absence data to improve targeted interventions to address top causes of sickness absence. • Develop how the reach and impact of these interventions will be measured.	September 2025
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To devise and agree a staff behavioural code in line with ICB values.	Behavioural code devised from values engagement work and shared with SEG and wider staff, also reflected in WRES action plan. This is to be developed further across each of the directorates.	July 2025
2B continued	Deliver cultural awareness and microaggression training.	Commission training as part of EDI procurement, also reflected in WRES action plan	August 2025
2C: Staff have access to independent support and advice when suffering from	None identified	-	-

Outcome	Objective	Action	Completion date
stress, abuse, bullying harassment and physical violence from any source			
2D: Staff recommend the organisation as a place to work and receive treatment	Improving staff experience	Implementing actions as a result of WRES data, Gender Pay Gap data, as well as implementation of the ICB organisational development plan should result in an improvement in this metric. In addition, a period of organisational stability for the ICB should also improve this metric.	Ongoing

Domain 3: Inclusive Leadership 2023/24 Action Plan

Outcome	Objective	Action	Owner (Dept/Lead)
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their	Regular Board agenda items around EDI. Board support for networks.	Board development programme to include structured development on EDI. To identify a Board level sponsor for each staff network.	Ongoing August 2025

Outcome	Objective	Action	Owner (Dept/Lead)
understanding of, and commitment to, equality and health inequalities			
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Strengthened transparency over data for health inequalities.	To develop business case templates to better show related health inequalities in decision making.	August 2025
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Board members conversant with and act upon relevant EDI tools.	• Complete WRES and WDES reporting and associate action plan. • Complete EDI reporting on Gender Pay Gap, AIS, PCREF. • Board members and system leaders to support the delivery of these reports and action plans and retain oversight of progress against these plans. Further action plans will be established with clear leadership identified when the EDI framework has been delivered.	Ongoing

Glossary:

ACP	Advanced Clinical Practitioner
AIS	Accessible Information Standard
BME	Black and Minority Ethnic
CIWA	Clinical Institute Withdrawal Assessment for Alcohol
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
COWS	Clinical Opiate Withdrawal Scale
CQC	Care Quality Commission
CYP	Children and Young People
DASS	Dementia Assessment and Support Service
DNA	Did not attend
ECG	Electrocardiogram
ECP	Emergency Care Practitioner
EDI	Equality, Diversity and Inclusion
EHIIA	Equality and Health Inequalities Impact Assessment
HR	Human Resources
ICB	Integrated Care Board
ICS	Integrated Care System
IWGC	I Want Good Care
LD	Learning Disabilities
LEA	Lived Experience Ambassador
LeDeR	Learning from lives and deaths - people with a learning disability and autistic people
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer
MNVP	Maternity and NeoNatal Voices Partnership
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NHSE	NHS England
PALS	Patient Advice and Liaison Service
PCN	Primary Care Network

PCREF	Patient and Carer Race Equality Framework
PHM	Population Health Management
PPC	People Participation Committee
PSIRG	Patient Safety Incident Response Group
PSP	Patient Safety Partners
Q&A	Question and Answer
RMFI	Reciprocal Mentoring for Inclusion
SAVS	Southend Council for Voluntary Services
SEG	Staff Engagement Group
SMI	Serious Mental Illness
TTC	Time To Care
VCFE SAVS	Voluntary Community Faith And Social Enterprise
VCSFE	Voluntary and Community, Faith and Social Enterprise
VSM	Very Senior Manager
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Mid and South Essex Integrated Care System

NHS Mid and South Essex

Part I ICB Board meeting, 13 March 2025

Agenda Number: 8

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.

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

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

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

Chief Executive's Report

1. Introduction

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

2. Main content of Report

2.0 Key activities since the last Board meeting

Since the last Board meeting, I have been involved in several events and activities including:

- Attending two Essex Health and Wellbeing Board meetings, including presenting on national and local work underway to inform the NHS 10 Year Plan.

- Presenting at 'Leading Better Together' with clinical leaders from across our system.

- Meeting with our diabetes stewardship group to discuss their work to reform and improve diabetes care.

- A range of meetings with MP, Councillors and other stakeholders.

2.1 Planning

Since the last meeting we completed the first stage of the development of our Medium Term Plan (MTP) for the system. This has progressed to the detailed development phase to develop individual cases across six identified priority areas, these being:

- Strengthening primary care
- Community and preventative care
- Urgent and emergency care and flow
- Acute service sustainability
- Community mental health
- Learning disability and autism
- Support services, including corporate services.

Alongside this, national planning guidance has been received, our response to which is currently being worked on for submission at the end of March 2025. The guidance sets out a refined list of priorities for the NHS during 2025/26, focusing on the following areas:

- Reduce elective waiting times, focused on both elective and cancer treatment
- Improving accident and emergency (A&E) waiting times and ambulance response times
- Improving the experience of access to GP services
- Improving access to urgent dental services
- Improving patient flow through mental health crisis and acute pathways
- Improving access to mental health services for children and young people.

These requirements, alongside a challenging financial settlement, will prove challenging to meet and requires system partners to prioritise and refocus resources significantly if we are to deliver them alongside transformational change required by the MTP to underpin sustainability of NHS services.

2.2 Quarterly review meeting

The ICB attended its quarterly review meeting with NHS England on 31 January 2025. The meeting was productive, with the key areas of continued focus identified as:

- **Cancer performance** – with the requirement to develop and implement a new governance structure to oversee the development and implementation of change to improve access for cancer services.

- **Elective performance** – there has been a deterioration in performance with agreed actions to both strengthen governance and oversight alongside delivering on opportunities to improve pathways.

- **Urgent and emergency care performance** – improvement was noted, but the requirement for an updated plan to underpin further sustained improvement in performance was identified.

- **Finance** – again stabilisation of the financial position was noted, although it was agreed there needs to be continued focus on tight controls and for fully triangulated plans (activity, workforce and finance) as the system moves into 2025/26.

2.3 Attention-Deficit/Hyperactivity Disorder (ADHD) prescribing

An issue which has gathered significant attention over recent weeks is around the maintenance of prescribing and monitoring for people who require ADHD medications following some GP practices choosing to withdraw from providing these.

This is clearly a worrying time for individuals who rely on these treatments for their wellbeing, and for their families. We have responded proactively to address this issue and are taking steps to ensure that treatment and monitoring is not interrupted.

More information on this is available on our website.

2.4 Community Services Consultation

The Community Services Consultation Working Group continued to meet monthly, with a variety of sub-groups to focus on specific areas of interest, most recently on maternity services.

The group remains on track to form recommendations for consideration by the ICB Board in May 2025, with a final Decision Making Business Case available for approval by July 2025.

2.5 Award nominations

I would like to take this opportunity to thank those within the ICB and wider system who were involved in two award nominations received since the last Board meeting, these being:

- Excellence in Clinical Innovation, for the work undertaken to implement a single point of access to maximise utilisation of community optometry services.

- Best not-for-profit working in partnership within the NHS, for the work undertaken by Farleigh Hospice, Havens Hospice and St Luke's Hospice to establish the Hospice Rapid Access Service.

3. Executive Committee

Since the last report, eight weekly meetings occurred between 7 January to 25 February 2025.

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

- Undertook a review of corporate IT provision and digital services.
- Approved a review of commissioned service for 111 service across the ICB, including an extension to contract for incumbent provider.
- Approval of additional support to Adult and Paediatric Ear Nose and Throat (ENT) services to support recovery position, utilising existing underspend elsewhere in the system.
- Approved contract award for provider of procurement service provision to the ICB.
- Undertook a review of lease arrangements for ICB estate, including extension of existing lease agreements.
- Approval of new or revised organisational HR policies:
  - Reimbursement of Staff Expenses Policy
  - Sexual Misconduct Policy
  - Car Leasing Policy
  - Cycle to Work Policy
  - Staff Volunteering Policy
- Approval for approach to utilising Section 106 funds across the system, to expand capacity in primary care.
- Approval of increased Local Enhanced Service for ADHD medication to support ADHD prescribing provision in primary care, with further work commissioned on a longer term solution.
- Undertook a review of ICB approach to Court of Protection Deprivation of Liberty (CoPDoL) cases, including additional provision approved for support to caseload.
- Review, engagement and workshopping of the system Medium Term Plan (MTP), including governance arrangements and delivery model.
- Approval of the system's Equality Delivery System Report for 2024/25.
- Approval of S106 Funds for Mid Essex Burnham Surgery.
- Approval of S106 Funds for Thurrock Purfleet Care Centre.
- Review and approval of Medicines Optimisation Local Enhanced Services Scheme (MOLES) for 2025/26.

The committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability, and worked to prepare for the NHS England quarterly review held on 31 January 2025

Decisions and work undertaken by the Executive Committee are regularly communicated to staff via a weekly summary within the ICB's communication channel 'Connect'.

4. Recommendation(s)

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

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, 13 March 2025

Agenda Number: 9

Quality Report

Summary Report

1. Purpose of Report

The purpose of this report is to provide assurance to the ICB Board through presentation of a summary of the key quality and patient safety issues, risks, escalations, and actions being taken in response. This Quality Report provides a focus on escalations from the Quality Committee relating to sodium valproate and opioid use; NHS Insightful Board guidance; the current position in relation to regulatory oversight by the Care Quality Commission; implementation of the Assessment and Management of Risk in line with national guidance'; and implementation of the RASCI (Responsible, Accountable, Support, Consulted and Informed) Tool in line with national guidance.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

3. Report Author

Dr Giles Thorpe, Executive Chief Nursing Officer.

4. Responsible Committees

Quality Committee.

5. Link to the ICB's Strategic Objectives

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

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

6. Impact Assessments

None required for this report.

7. Financial Implications

Not relevant to this report.

8. Details of patient or public engagement or consultation

Not applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board is recommended to:

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

Mid and South Essex Quality Report

1. Introduction

1.1 The purpose of the report is to provide assurance to the Board of the Integrated Care Board (ICB) through presentation of a summary of the key quality and patient safety issues, risks, escalations, and actions being taken in response.

1.2 The report for this Board provides an update from the ICB's Quality Committee with any key points of escalation.

2. Quality Committee Update

Dentistry Deep Dive

2.1 The Quality Committee received a deep dive regarding improvement activities underway with dentistry communities across Mid and South Essex (MSE). New dental incentives were outlined including the dentistry incentivisation/access scheme, and the dental cardiovascular disease prevention scheme which involved case finding those individuals with hypertension for ongoing support and treatment. The Quality Committee wished to highlight that since the commencement of the dental access pilot a total of 21,732 additional patients have been seen across our system.

2.2 The deep dive also focussed on the care home dentistry pilot. Providers have been invited to attend care homes to assess oral health, and ongoing treatment to support the most vulnerable citizens in our society. As of April 2024, all 8,417 care home beds are covered by this scheme and approximately 4,600 care home residents have received dental treatment after assessments undertaken through the pilot.

2.3 A reduction in waiting times to access community dental services has also occurred, from over 12 months to approximately 12 weeks after one year of the pilot being in place.

2.4 The slide deck relating to improvements in Dental Services is provided at Appendix A.

Babies Children and Young People Programme Update

2.5 The Quality Committee received an update from the Babies Children and Young People (BCYP) Commissioning team on progress since the last report, focussing on Initial Health Assessments for Looked After Children and Mental Health Services.

2.6 **Initial Health Assessments** – following good engagement with Community Collaborative Teams and other ICBs, a nurse-led model was proposed to the January Commissioning Board and approved. This will address the disparity between the demand expected in 2025/26 and the capacity of paediatric teams to respond in a timely way. This will be closely monitored through the ICB's Growing Well Programme Board and associated local authority committees under statutory corporate parenting requirements.

2.7 **Mental Health Services** – a contract has been finalised for counselling services for CYP from 1 April 2025. A single contract delivery model will address variation in service provision and offer a blend of digital and face to face appointments. Due to an underspend within the Mental Health Support Team work programme, commitment has been secured for additional transformation plans with North East London NHS Foundation Trust (NELFT). This includes a digital offer for young people, transition support for neurodivergent children and additional training places for emotional mental health practitioners. Additionally, commissioning posts for the BCYP team focussing on learning disabilities and mental health for 2025/26 and beyond have also been approved. This will allow the portfolio of work to be serviced and meet the changing needs of CYP across the breadth of mental health services.

2.8 **Key Risk** –the BCYP team identified that there remains a lack of oversight of children with learning disabilities and autism/neurodivergence who are at risk of admission to inpatient mental health settings. Reasons for these risks occurring include: a historic diagnostic-led commissioning approach; cuts to local authority funding (social care and education budgets) against an increased demand for Education; Health and Care Plans for children with Special Educational Needs and Disabilities (SEND); the impact of the COVID-19 pandemic and a requirement for improved workforce training, estate and needs-led support (such as social communication and sensory processing) across education settings. The GP Provider Collaborative requested a summit in January to work through the challenges across primary care to support families effectively. This prompted a shared intention to engage with the three local authorities to initiate planning towards a needs-led offer across education, health and care. The Deputy Director of Babies Children and Young People and Specialised Commissioning is the ICB lead for this initiative.

ICB Quality Strategy

2.9 The draft of the ICB's Quality Strategy was shared with Quality Committee members. Whilst positively received, it was noted that publication and finalisation should be deferred until such time that national government publications were received and the system Medium Term Plan priorities were finalised, so that the strategy could be aligned accordingly.

3. Clinical Negligence Scheme for Trusts – Year 6 Submission (Maternity Incentive Scheme)

3.1 The Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. The MIS rewards Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families, and newborns.

3.2 The MIS was established on the instruction of the Department of Health and Social Care to incentivise Trusts to actively adopt best practices and implement essential safety measures.

3.3 Obstetric incidents can be catastrophic and life-changing for families. NHS Resolution is working with colleagues across the NHS in England to do all they can to help prevent these occurring.

3.4 The MIS aims to deliver safer maternity services and reduce the cases of brain injuries or other harm that can lead to negligence claims.

3.5 The ten standardised safety actions in the scheme have been agreed by senior clinicians to help drive improvements in maternity.

3.6 By meeting all 10 safety actions it is believed that this will help Trusts to deliver safer maternity services. The safety actions can be used to highlight areas where improvement is needed.

3.7 Mid and South Essex NHS Foundation Trust (MSEFT) submitted their evidence against the 10 safety actions to the ICB's Maternity Commissioning Team for scrutiny and review. The ICB's Consultant Midwife and NHS England's Maternity Improvement Advisors to MSEFT undertook the review and concluded there was sufficient evidence to support compliance with all 10 safety standards.

3.8 The statement has been signed by MSEFT's Chief Executive Officer and the ICB's Chief Executive Officer. A formal paper will be submitted to the ICB Board outlining the statement at the next public board meeting in line with national guidance and expectation.

4. Recommendations

The Board is recommended to:

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

NHS
Mid and South Essex

Dentistry Deep Dive

Quality Committee
28 February 2025

www.midandsouthessex.ics.nhs.uk

We are collaborative
We are compassionate
We are innovative
We are living well

Mid and South Essex Dental Services Overview

- Primary Care Dental Commissioning delegated from NHS England to ICB's on 01/04/2023
- Total number of NHS General Dental Contracts in Mid and South Essex ICB = 117
- Total number of Commissioned Units of Dental Activity (UDA's) in MSE = 1,829,071
- Total Contract Value £59,846,759.50 Per Annum
- 15 Orthodontic Contracts delivering 98,407 Units of Orthodontic Activity (UOA's) at £7,146,797.72 per Annum.
- Also commissioned are: Minor Oral Surgery, Sedation, Domiciliary and Special Care Community Services (CDS).

Dental Mythbusters: highlighting differences between dental vs primary medical

- Dental providers are directly employed by the NHS – **FALSE**
  - Dental practices are classed as independent contractors who can choose whether they wish to hold a contract to provide NHS dental services or not.
- Patients are registered as a patient at their NHS Dentist practice – **FALSE**
  - Patient registration in Dentistry ceased in 2006 with the introduction of the 2006 NHS Dental Contract. There is no patient registration for NHS Dentistry.
- Under the NHS Contract Providers must see all NHS Patients that wish to be treated – **FALSE**
  - Dental providers manage their own capacity to take on NHS work meaning they can decide whether they are able to retain existing patients and / or accept new patients and therefore their lists can open and close on a frequent basis.
- The Dental Contract allows commissioners to place patients struggling to find a dentist with any NHS dental contract holder – **FALSE**
  - There is no clause in the dental contract that allows the commissioner to mandate a practice take on a patient. The Dental providers control their patient lists and can accept or refuse a new patient based on their capacity.

National Dental Incentives: On 7 February 2024, NHS England published a joint NHS and Department of Health and Social Care (DHSC) plan to recover and reform dentistry with a number of initiatives being introduced:

- **New patient premium -** NHS dentists given a 'new patient' premium of between £15-£20 to treat around a million new patients that have not seen an NHS dentist in two years or more. Currently this will continue until 31 March 2025 but may be extended.
- **National dentist incentivisation scheme -** to attract new dentists and improve access to care in areas with the highest demand around 240 dentists nationally will be offered one-off payments of up to £20,000 for working in under-served areas for up to three years. MSE were asked to fund 3 places on this scheme. Two have been filled and we are working with a third provider who is still hoping to recruit a new performer.
- **Dental Cardio-Vascular Disease Prevention – Hypertension Case Finding Pilot** – The ICB successfully bid for funding of £50k with which to remunerate dental practices to carry out blood pressure reading on consenting patients that are over 40 and have not had a reading. We have 12 providers who will begin taking readings shortly and the patients will be directed into the pharmacy pathway or to their GP in serious cases.

Hypertension Case Finding Pilot:

There are currently 12 dental contractors taking part:

MID	9
THURROCK	0
BB	2
SEE	1

- All sites have completed the training required and are awaiting delivery of their BP machines to commence the Pilot. With this being a national incentive it is being overseen by the national team.
- Work ongoing to support the referral process between dental providers and community pharmacies to ensure safe transfer of care for patients.
- Regular reviews post commencement will occur.

Local Dental Initiatives – Dental Access Pilot:

- Providers paid a sessional fee to open outside of their normal working hours to see patients in need - referred from NHS 111. 3.5-hour weekday sessions are £500 per session, 5-hour weekend sessions are £750 per session and for 5-hour Bank holiday sessions are £1000.
- Dental Access Pilot started 1st September 2023 initially running until March 2025 but Board approval has been given to extend this pilot up to March 2027.
- A total of 48 sessions per week seeing approximately 138 patients per week (averaging 2 patients per hour).
- To date (27/01/2025) a total of 21,732 additional patients seen as part of this Pilot across Mid and South Essex ICB.
- A New Direct Appointment Booking system is being trialled which allows NHS 111 call handlers to book directly into participating Pilot Practices appointment slots. This is the first known trial of its kind in the country with implications for the future including allowing patients presenting to A&E being appropriately appointed into practices for treatment.

Dental Access Pilot:

- Total of 10 Practices taking part in Access Pilot spread across the ICB area:

MID	4
THURROCK	2
BB	2
SEE	2

- Directly links to the Dental Recovery Plan for providing an additional 700,000 more urgent dental appointments per year.

- The Primary Care Quality Team hold monthly call reviews with our IC24 colleagues with varying topics, we are working with them to hold a dentistry call review themed meeting.

Local Dental Initiatives – Care Home Pilot:

- Providers are paid a fee per care home bed to send dental care professionals into care homes to assess oral health, plus a retention fee to treat and undertake treatments.
- Dental Care Home Pilot started 1 November 2023 and initially was running until March 2025 however Board approval has been obtained to bring this into a fully commissioned service from 1 April 2025.
- As of April 2024. all 8,417 care home beds within Mid and South Essex ICB are covered by this scheme and approximately 4,600 care home residents have received dental treatment after assessments undertaken from this Pilot.
- We have seen a reduction in the Community Dental Service waiting list for Domiciliary care from over 12 months before this pilot to approximately 12 weeks after 1 year of this pilot.

Care Home Pilot:

- Total of 11 Practices taking part in Access Pilot across the area:

MID	5
THURROCK	2
BB	3
SEE	1

- DB Benfleet - Silverpoint Court Residential Care Centre.mp4 - Google Drive
- We have had support from our AACC colleagues to gain access to some of our harder to reach care homes who have funded patients in.
- Feedback from care home staff, dental providers and patients is all extremely positive.
- CDS are now seeing patients who desperately need their services in a much quicker timeframe.

Local Dental Initiatives – Children and Young People Pilot:

- Providers are paid to provide 10 sessions per school of a mixture of oral health education in schools sessions, in-dental practice familiarisation sessions and a commitment to treat children and family in practice.

- This is an Evergreen offer with practices able to submit an Expression of Interest at any time when they are ready.

- Of the 325 schools, currently 202 schools are covered with a further 65 schools due to start between now and the end of March 2025.

- Pilot has been funded for three years up to March 2028.

Children and Young People Pilot:

- Current 15 practices have agreed to take part with 12 having already started in November 2024:

MID	6
THURROCK	3
BB	6
SEE	2

- The PCQT have had support from the Safeguarding team to produce guidance on consent and neglect for dental providers.

PCQT – where have we got to

- Monthly meetings set up with the CQC to share intel
- Bi-monthly Local Dental Committee (LDC) meetings set up
- Attended 1x dental provider to discuss quality assurance in greater depth
- CQC spreadsheet created for all 117 providers – all who have been inspected care currently meeting all CQC requirements
- Weekly check-ins with the Dental Contracting Team to discuss pilot progressions
- Embedding the ‘think quality’ to all new pilots and programmes within dentistry
- QAV tool currently in progress – likely to be an annual ‘self-assurance’
- FFT result spreadsheet created and monitored
- POD paper created for QC

NHS
Mid and South Essex

Any questions?
Thank you for listening!

Victoria Kramer
Senior Nurse – Primary Care Quality

www.midandsouthessex.ics.nhs.uk

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting,13 March 2025

Agenda Number: 10

Month 8 Finance and Performance Report

Summary Report

1. Purpose of Report

To present an overview of the financial performance of the ICB to date and offer a broader perspective across partners in the Mid & South Essex system (period ending 31 January 2025).

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

2. Executive Lead

Jennifer Kearton – Chief Finance Officer.

Report Author

Jennifer Kearton – Chief Finance Officer
Keith Ellis - Deputy Director of Financial Performance, Analysis and Reporting
Ashley King – Director of Finance & Estates
Karen Wesson - Director of Assurance and Planning.
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 March 2025.

4. Conflicts of Interest

None identified.

5. Recommendation

The Board is asked to note this report.

Finance & Performance Report

1. Introduction

The financial performance of the Mid and South Essex (MSE) Integrated Care Board (ICB) is reported as part of the overall MSE System alongside our NHS Partners, Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University Trust (EPUT).

The System had a nationally negotiated and agreed plan position for 2024/25 of £96m (million) deficit. Our plan was considered very stretching for 2024/25, however it is imperative we deliver so we can continue to build a strong foundation for financial recovery over the medium term.

NHS England provided Deficit Support Funding which adjusted the £96m deficit to breakeven. The system is now measured against a breakeven plan. The System were given the opportunity to revise its forecast outturn position at M10 and agreed a £32.5m deficit to plan. The deficit support funding plus agreed change in forecast outturn is repayable in future years.

2. Key Points

2.1 Month 10 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB saw a £25.32m change between M9 and M10.

Table 1 – Allocation movements between month 9 and month 10

Allocations	Funding Stream	Current Month £m	Previous Month £m	Monthly Change £m
⊟ Recurrent	Programme	2,267.57	2,268.61	-1.04
	Delegated - Specialised	286.56	286.56	0.00
	Co-Comm	227.10	227.10	0.00
	Delegated - DOP	106.92	104.83	2.09
	Running Costs	20.55	20.55	0.00
	Total	**2,908.69**	**2,907.64**	**1.05**
⊟ Non-Recurrent	Programme	250.52	233.67	16.86
	Co-Comm	4.83	4.83	0.00
	Delegated - DOP	4.12	3.15	0.97
	Running Costs	1.82		1.82
	Delegated - Specialised	(42.95)	-47.56	4.62
	Total	**218.35**	**194.08**	**24.27**
Total		**3,127.04**	**3,101.72**	**25.32**

The ICB has recovered its forecast position to break even at month 10, balancing off adverse variances with mitigations across spend categories. Additional growth above plan in All Age Continuing Care is offset by in year benefits in Acute, Mental Health Services and applied mitigations.

Our year to date position reflects the risks identified across continuing health care and discharge to assess, materialising and impacting our ability to stay on plan. The ICB has identified efficiency plans in this area and has redirected resource into supporting the mitigation of both the operational and financial impacts.

We recognised in prior months year to date pressures across high cost drugs, primary care, and community health services with action taken in these areas to bring them back into line with plan.

Within the ICB our 2 key efficiencies programmes are Continuing Care and Medicines Management. Delivery across these areas is key to supporting the overall financial delivery of the ICB in 2024/25.

However, all areas of ICB spend remain under scrutiny of triple lock to support cross organisational financial delivery.

Table 2 – summary of the position against the revenue resource limit for month 10.

Summary of ICB Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	YTD Variance Mth on Mth Change £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m
Acute	1,290.94	1,289.89	1.05	1.81	1,541.90	1,535.74	6.16
Community Health Services	200.56	199.94	0.62	0.35	240.75	239.85	0.90
Continuing Care	132.65	151.72	(19.07)	(3.23)	159.18	181.87	(22.70)
Mental Health	242.33	239.89	2.44	0.56	292.23	288.16	4.07
Other Commissioned Services	2.07	(8.75)	10.82	(0.47)	2.60	(2.90)	5.49
Other Programme Services	16.17	14.72	1.46	0.15	19.69	17.73	1.96
Primary Care	500.65	502.01	(1.36)	0.39	600.83	602.33	(1.50)
Programme Reserve & Contingency	0.00	0.00	0.00	(0.00)	0.02	(0.52)	0.54
Specialised Commissioning	202.80	200.27	2.53	0.25	243.61	240.58	3.03
Corporate	15.46	13.92	1.54	1.06	18.53	16.46	2.07
Hosted Services Admin	3.10	3.12	(0.02)	(0.00)	3.36	3.38	(0.02)
Hosted Services Programme	3.19	3.19	(0.00)	(0.00)	3.83	3.83	(0.00)
Total	**2,609.93**	**2,609.93**	**(0.00)**	**0.87**	**3,126.52**	**3,126.52**	**0.00**

2.2 ICB Finance Report Conclusion

The ICB is delivering to plan at month 10, we understand the drivers for cost challenged areas and are taking deliberate steps to mitigate. The Finance and Performance committee continue to receive deep dive reports on progress across these areas with escalation to the System Oversight Assurance Committee and the ICB Board where required.

2.3 Month 10 System Financial Performance

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

Table 3 – summary of the System position against the revenue resource limit for month 10.

System I&E Analysis	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Forecast Outturn £m	Full Year Variance £m
System Revenue Resource Limit	(2,609.93)	(2,609.93)	0.00	(3,126.52)	(3,126.52)	0.00
Total ICB Net Expenditure	2,609.93	2,609.93	(0.00)	3,126.52	3,126.52	0.00
TOTAL ICB Surplus/(Deficit)	(0.00)	(0.00)	(0.00)	(0.00)	0.00	0.00
Income	(1,786.70)	(1,847.82)	61.12	(2,135.96)	(2,227.84)	91.88
Pay	1,164.55	1,191.44	(26.89)	1,394.34	1,427.76	(33.42)
Non-Pay	582.98	649.37	(66.40)	693.57	784.18	(90.61)
Non Operating Items	39.17	34.93	4.24	48.05	48.42	(0.37)
TOTAL Provider Surplus/(Deficit)	(0.00)	(27.92)	(27.92)	(0.00)	(32.52)	(32.52)

The year-to-date position against plan is reflective of ongoing cost pressures and a shortfall in system efficiency programme delivery.

Both our system providers have implemented grip and control actions during 2023/24 and continue to work collectively with the ICB to reduce the run rate during 2024/25. The whole system continues to operate in Triple Lock with regional oversight of expenditure items greater than £25k.

2.4 System Efficiency Position

At month 10 the system has delivered £100.2m of efficiencies against a year-to-date plan of £130m reflecting the revised planning submission made to NHS England in June 2024. The system is forecasting delivery of £160.8m an adverse variance to plan of £7m.

Our overall financial position is dependent on the delivery of efficiencies and the system is collectively working together to redirect resource to the areas of greatest need.

Table 4 – System Efficiency summary

Organisation	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Forecast £m	Full Year Variance £m
EPUT	23.59	18.04	(5.54)	28.65	21.66	(6.99)
ICB	37.81	37.35	(0.46)	47.62	47.62	0.00
MSEFT	68.59	44.81	(23.78)	91.50	91.50	(0.00)
SYSTEM	**129.99**	**100.20**	**(29.79)**	**167.77**	**160.78**	**(6.99)**

2.5 System Capital Position

The forecast capital spend for the system is £125.0m, £12.9m below plan due to the Electronic Patient Record (EPR) and 23hr Surgical Unit spend being re-phased. Our actual spend year to date is £76.4m against a planned position of £99.1m. Delivery and payment is expected to continue over the year and prioritised capital commitments will be fulfilled.

Table 5 – Capital Spend Summary

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
Externally Financed						
MSEFT	49.71	30.92	18.79	72.85	61.56	11.29
EPUT	11.45	4.29	7.16	14.46	7.09	7.37
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Total	**61.16**	**35.21**	**25.95**	**87.30**	**68.64**	**18.66**
Internally Financed/System CDEL						
MSEFT	29.45	34.09	(4.65)	38.73	44.23	(5.50)
EPUT	7.85	6.00	1.84	9.92	9.92	0.00
ICB	0.68	1.14	(0.46)	1.99	2.24	(0.25)
Total	**37.97**	**41.23**	**(3.26)**	**50.64**	**56.39**	**(5.75)**
Total	**99.13**	**76.44**	**22.69**	**137.94**	**125.04**	**12.91**

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
ICB - Potential new IFRS 16 leases						
ICB	20.00	0.00	20.00	20.00	2.30	17.70
Total	**20.00**	**0.00**	**20.00**	**20.00**	**2.30**	**17.70**

2.6 System Finance Report Conclusion

At month 10 the System is working toward a revised planned year end position of a £32.5m having received £96m in deficit funding and agreed a revised forecast outturn position with regional NHS England.

The system is focused on delivering its Operating Plan for 2024/25, ensuring financial efficiencies are largely delivered whilst mitigating any potential risks to the plan in the remainder of the year. The System is under regular review with both regional and national NHS England colleagues and continues to operate under strengthened internal governance and financial control.

2.7 Urgent and Emergency Care (UEC) Performance

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

The MSE 2024/25 Operational Plan is to meet the national ask of >=78% of patients will have a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge in March 2025.

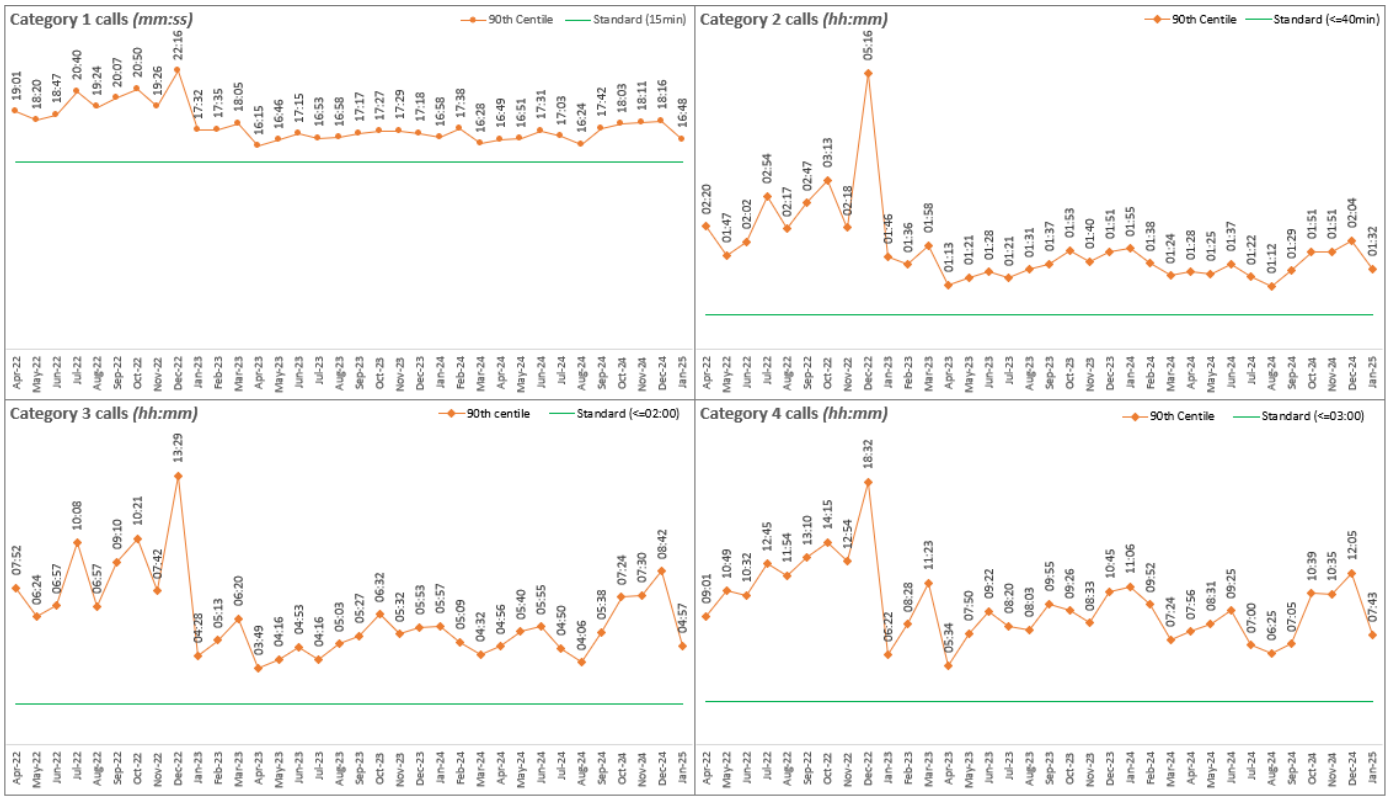
Our current performance is below the standard required as outlined below:

Ambulance Response Times

Standards:

- Respond to Category 1 calls in 7 minutes on average and respond to 90% of Category 1 calls in 15 minutes.
- Respond to Category 2 calls in 18 minutes on average and respond to 90% of Category 2 calls in 40 minutes.
- Respond to 90% of Category 3 calls in 120 minutes.
- Respond to 90% of Category 4 calls in 180 minutes.

The 90th centile response times for East of England Ambulance Service for all four categories of calls do not meet their respective standards as shown in the following graphs.

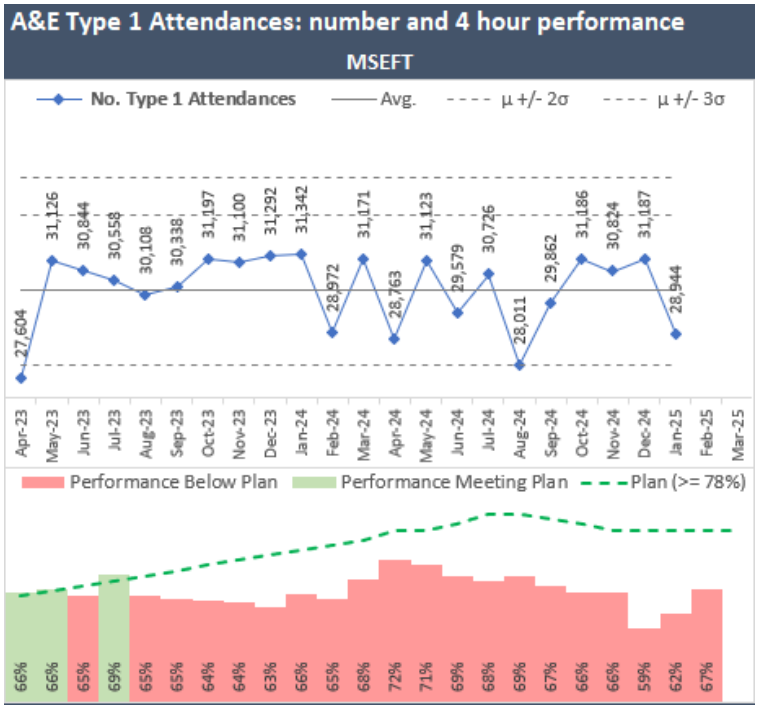


Emergency Department – waiting times

2024/25 priorities and operational planning guidance ask:

- >=78% of patients having a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge in March 2025.

The four-hour performance has not met operational plan to achieve the 2024/25 priorities and operational planning guidance across all three MSEFT sites as per following graph. February 2025 achievement of 67% remains below the Operational Plan of 78%. The MSE system performance is identical to the MSEFT reported position.



2.8 Elective Care

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

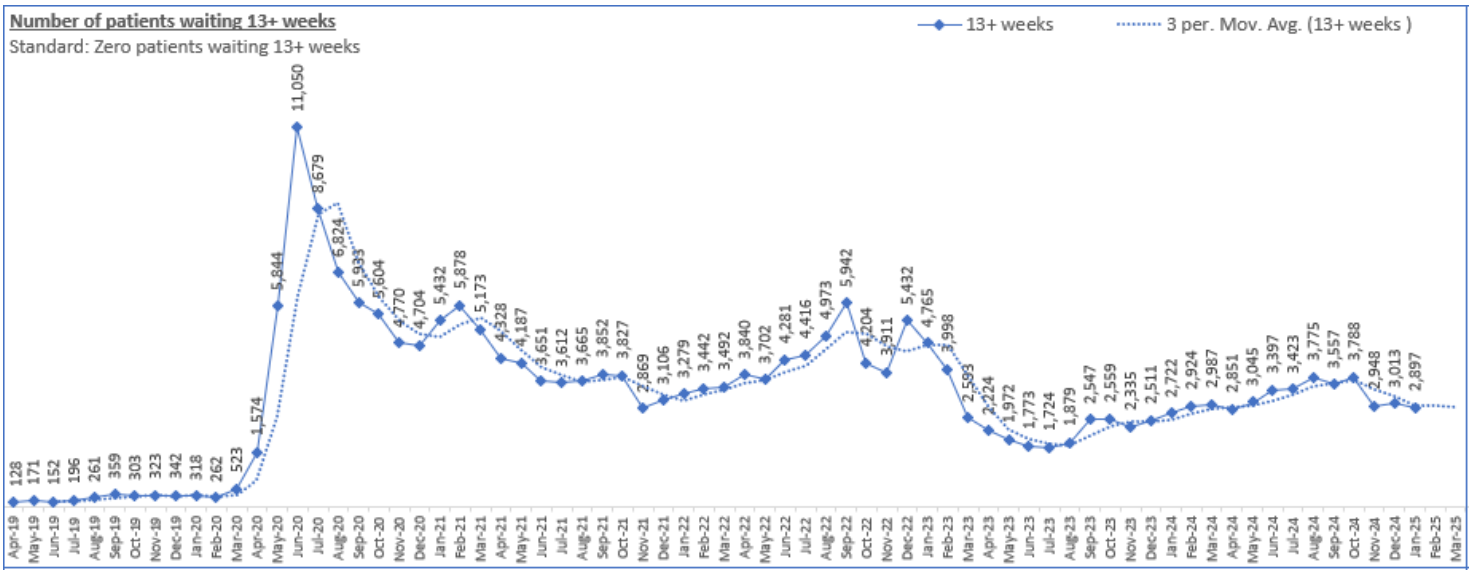
The performance does not meet the targeted national standard as set out below.

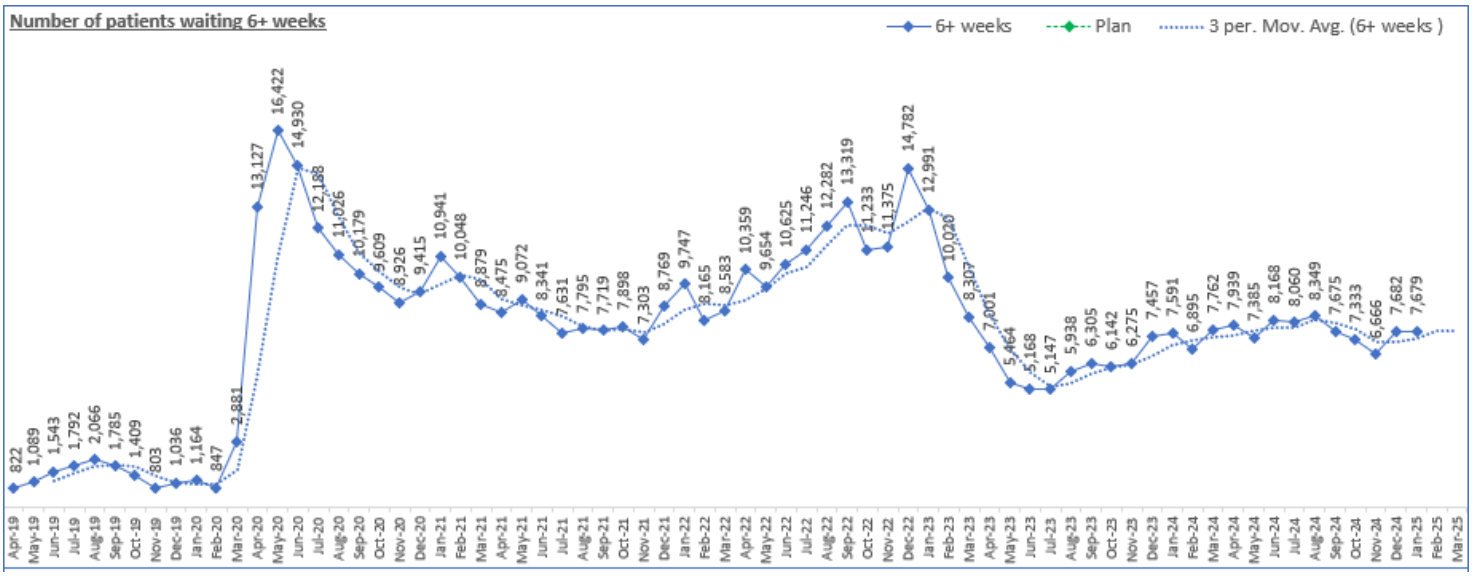
Diagnostics Waiting Times

Standard:

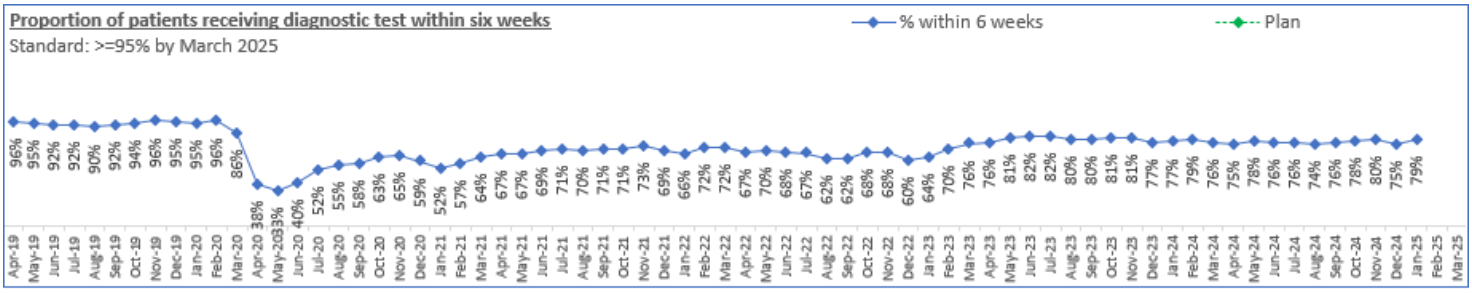
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

The following graphs show the total number of Mid and South Essex registered population waiting 13+ and 6+ weeks across all providers to January 2025.





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



As of January 2025, 2,897 people waited over 13 weeks (standard: zero) and 79% of all people waiting for their diagnostic test were seen within six weeks (standard: >=95%).

The following table shows the number people waiting over 13 and 6 weeks for their diagnostic test by test type. The areas of risk are as follows:

- Imaging: Non-obstetric Ultrasound and MRIs.
- Physiological measurements: Echocardiology and Neurophysiology.
- Endoscopy: Colonoscopy and Gastroscopy.

Jan-25	Mid and South Essex: Diagnostic DM01 waiting list summary					
Diagnostics		Number of patients waiting 13+ weeks Standard: 0	Six week wait performance and number of patients waiting 6+ weeks Standard: >=95%	Plan Jan-25	Breaches above plan	Plan March 2025
MSE patients at all providers						
Imaging	Barium Enema	2	78.9% (4)			
	CT	14	92.3% (316)	94%	148	94%
	DEXA Scan	48	85.6% (181)	89%	95	89%
	MRI	103	79.8% (1453)	91%	1,051	93%
	Non-Obstetric Ultrasound	679	90.7% (1155)	94%	511	97%
Physiological Measurement	Audiology Assessments	33	89.2% (137)	91%	39	93%
	Cardiology Echocardiography	412	56.1% (1824)	75%	890	82%
	Peripheral Neurophysiology	172	54.7% (258)			
	Respiratory Physiology Sleep Studies	110	37.8% (331)			
	Urodynamics - Pressures & Flows	13	63.3% (18)			
Endoscopy	Colonoscopy	674	57.4% (966)	84%	738	86%
	Cystoscopy	85	58.1% (156)			
	Flexi sigmoidoscopy	158	54.5% (238)	82%	164	84%
	Gastroscopy	393	63% (640)	84%	419	86%

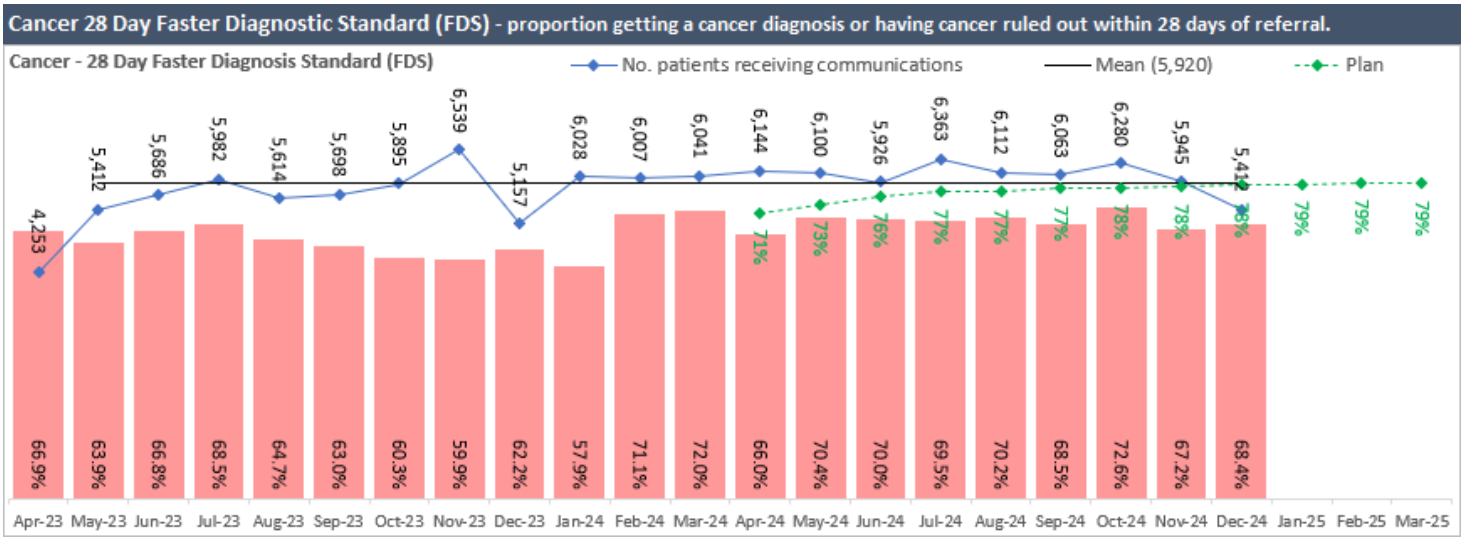
Cancer Waiting Times

Standards: For people with suspected cancer:

- To not wait more than 28 days from referral to getting a cancer diagnosis or having cancer ruled out.
- To receive first definitive treatment within 31 days from decision to treat.
- To start drug, radiotherapy, and surgery subsequent treatments within 31 days.
- To receive their first definitive treatment for cancer within 62 days of receipt of urgent referral.

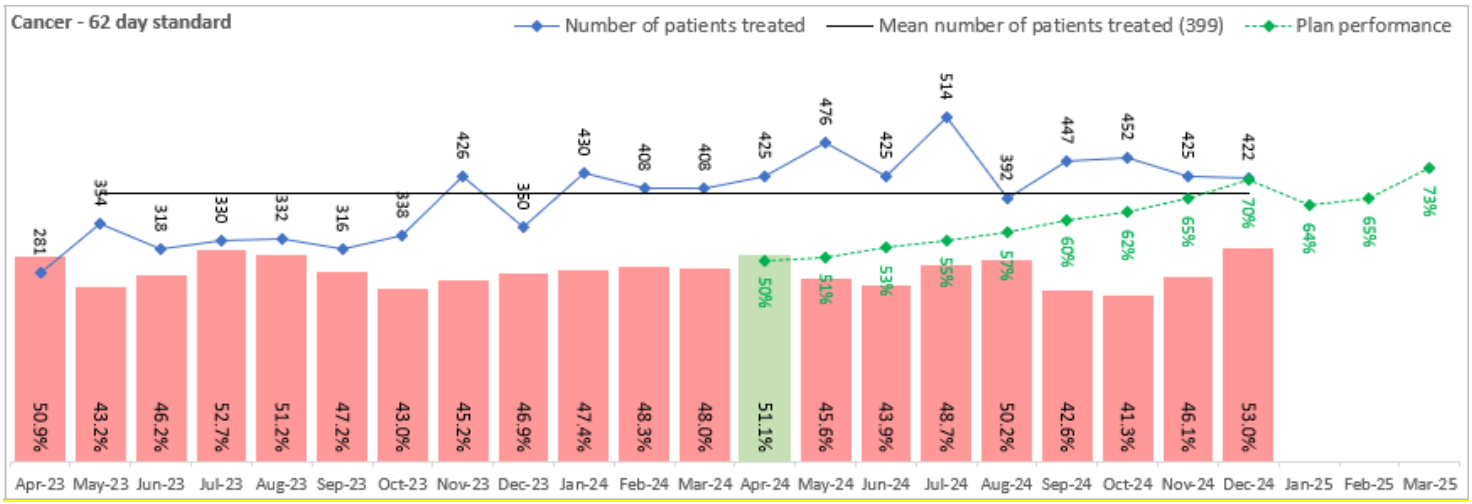
The waiting times for patients on a cancer pathway are not meeting the NHS constitutional standards.

The following graph shows the MSEFT monthly performance for the 28-day Faster Diagnosis Standard. The December 2024 performance at 68.4% did not meet the operational plan to achieve the 2024/25 priorities and operational planning guidance requirement of >= 77% by March 2025 from September 2024.



The following graph shows the 62-day general standard performance. The December 2024 performance at 53% did not meet plan of 70%. The constitutional requirement is 85%.

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



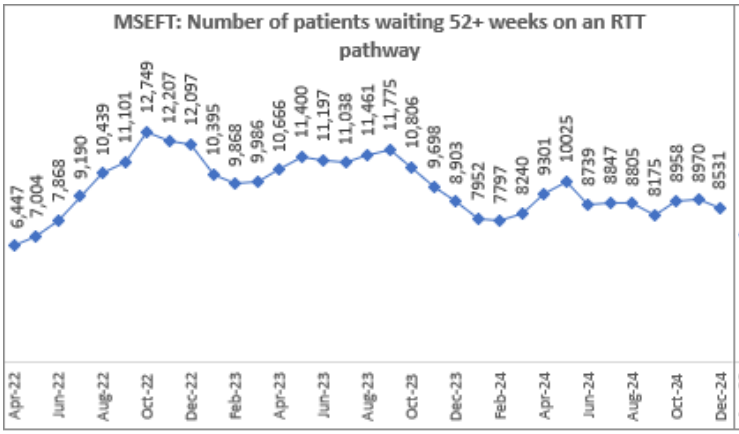
Referral to Treatment (RTT) Waiting Times

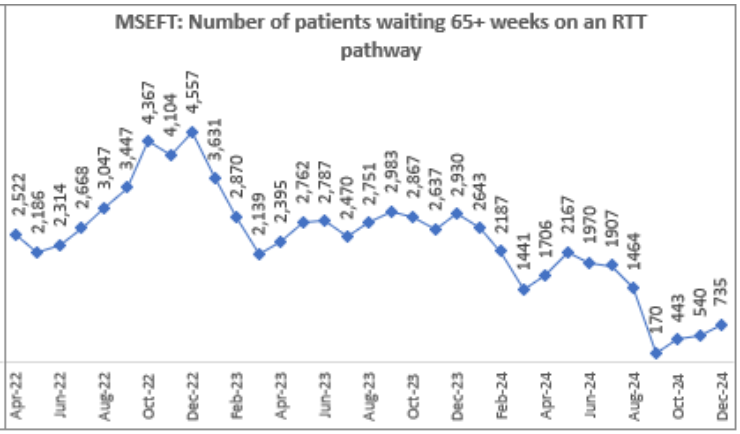
Standards:

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

As of October 2024, the following number of patients were on a RTT pathway:

- 443 patients waiting 65+ weeks.
- 8,958 patients waiting 52+ weeks.





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

The following table summarises the latest MSEFT RTT position (December 2024) by specialty.

Specialty	Total waiting list size	Average (median) waiting time in weeks	92nd percentile waiting time in weeks	Total number of patients waiting 52 plus weeks	Total number of patients waiting 65 plus weeks
Total	**163,557**	**17**	**48**	**8,531**	**735**
General Surgery Service	8,697	18	50	580	52
Urology Service	9,125	17	48	495	29
Trauma and Orthopaedic Ser	18,623	21	50	1,251	140
Ear Nose and Throat Service	16,864	26	54	1,619	169
Ophthalmology Service	12,340	15	45	417	7
Oral Surgery Service	4,599	25	59	672	113
Neurosurgical Service	95	33	50	4	0
Plastic Surgery Service	5,344	17	47	226	35
Cardiothoracic Surgery Service	0	-	-	0	0
General Internal Medicine Se	2,468	12	36	34	0
Gastroenterology Service	9,609	17	45	347	9
Cardiology Service	10,892	13	35	67	0
Dermatology Service	13,003	18	51	956	12
Respiratory Medicine Service	4,587	16	38	52	0
Neurology Service	5,949	18	47	247	8
Rheumatology Service	2,612	14	42	35	1
Elderly Medicine Service	773	8	26	3	0
Gynaecology Service	12,670	17	42	351	3
Other - Medical Services	12,780	12	42	342	11
Other - Mental Health Service	0	-	-	0	0
Other - Paediatric Services	3,817	22	58	489	112
Other - Surgical Services	6,099	12	43	205	30
Other - Other Services	2,611	12	48	139	4

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

2.9 Mental Health

Our Mental Health Partnership Board oversees all aspects of mental health performance. The key challenge for the work programme relates to workforce capacity.

Improving access to psychology therapies (IAPT)

Standards include:

- 75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within 6 weeks of referral and

95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.

This standard is being sustainably achieved across Mid and South Essex (latest position: December 2024).

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: December 2024).

3.0 System Performance Report Conclusion

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

Across the System there remains a challenge in achieving delivery of the Constitutional Standards in a number of areas. The oversight of acute delivery includes the national Tier 1 meetings being held fortnightly and the Urgent Emergency Care Portfolio Board for the Integrated Care System.

4.0 Recommendation

The Board is asked to note this report.

Mid and South Essex Integrated Care System

NHS Mid and South Essex

Part I ICB Board Meeting, 13 March 2025

Agenda Number: 11

Primary Care and Alliance Report

Summary Report

1. Purpose of Report

To update Board members of the development of services by the Alliance teams including the Primary Care Team.

2. Executive Lead

Dan Doherty, Alliance Director – Mid Essex
Aleksandra Mecan, Alliance Director – Thurrock
Rebecca Jarvis, Alliance Director – South East Essex
Pam Green, Alliance Director – Mid Essex

3. Report Author

Kate Butcher, Deputy Alliance Director – Mid Essex
Margaret Allan, Deputy Alliance Director – Thurrock
Caroline McCarron, Deputy Alliance Director – South East Essex
Simon Williams, Deputy Alliance Director – Mid Essex
Vicki Decroo, Deputy Director of Integration
Paula Wilkinson, Director of Pharmacy and Medicines Optimisation
William Guy, Director of Primary Care

4. Responsible Committees

Primary Care Commissioning Committee

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

New Contract Settlement for 2025/26

Most notably since the last meeting of the Board, it was announced at the end of February that agreement had been reached between the General Practitioners Committee (GPC) and NHS England (NHSE) on the key proposals for a contract settlement for 2025/26. The detail is yet to be published but key elements include £889 million of additional investment across the core practice contract and network contract directly enhanced service (DES). This is the equivalent of 7.2% cash growth on the contract envelope.

32 Quality and Outcomes Framework (QOF) indicators will be permanently 'retired' with income protected. A key part of the remaining QOF programme will focus on cardiovascular disease (CVD) prevention. Online consultation tools will need to be switched on for core practice hours. There is also the introduction of a new Directly Enhanced Service (DES) for advice and guidance that had been mooted which will require a significant and timely response from acute providers with the aim of improving patient experience and reducing referrals to outpatients as well as acute same day services.

British Medical Association (BMA) Collective Action – has been paused in lieu of the contract agreement reached for 2025/26.

However, the ICB continues working closely with stakeholders on the prescribing and safety monitoring for attention deficit hyperactivity disorder (ADHD) prescribing which formed part of the rationale for collective action.

The Connected Pathways Team continues to make significant progress in the implementation of the Primary Care Access Recovery Programme. Progress has been made on the use of digital tools with the majority of practices in mid and south Essex (MSE) regularly using tools such as AccuRx, eConsult and Patchs. The ICB Executive Team recently approved the continuation of investment in these tools, which are critical to delivery of modern general practice, via digital access funds.

The Primary Care Commissioning Committee (PCCC) approved several Primary Care Networks (PCN) reconfiguration requests received across three Alliances. These are being worked through in dialogue with the affected practices to achieve the most optimal outcome for local populations. Where approved, these will come into effect on 1 April 2025.

PCCC also considered an application to merge two practices within Billericay and subsequently close the branch surgery at South Green. Following review, this request was supported by the committee as there were no other facilities available to the practice and the landlord had service notice on the leaseholder. The ICB is working with local community leaders and assets, including the high street pharmacy, to ensure the community continues to have good access to services.

The ICB continues to support the establishment and formation of the General Practice Provider Collaborative (GPPC) - a critical part of the system infrastructure to support the 'Left Shift' of services closer to the residents of MSE – through the innovative and dynamic model of primary care. At present wider general practice is being engaged on the establishment of the governance and as an ICB a set of strategic commissioning intentions at being developed aligning to the medium term financial (MTP).

Primary Care – Pharmacy

As of 1 February 2025, there are 196 Community Pharmacies across the 26 PCNs in MSE (no change since November 2024).

Latest reporting in December 2024 saw the highest level of 'Pharmacy First' consultations to-date. For the first time, there were over 10k consultations in one month across MSE. There has been significant growth in the number of patients accessing the service through self-referral alongside being signposted by NHS 111.

Primary Care – Dentistry

NHS England recently published 'Arrangements for NHS urgent primary dental care during 2025/26'. This includes a requirement of all Integrated Care Boards (ICBs) to deliver a contribution towards 700k additional urgent dental care appointments per annum (commencing 2025/26). The ICB is reviewing the detail of this requirement to ensure we are able to deliver the 6,098 appointments allocated to MSE ICB. We have an established access scheme that aligns with the requirements of this development which will form the basis for our intended delivery during the next financial year.

At February's PCCC meeting, it was noted that over 20k patients had been seen through the dental access pilot. The service is now fully integrated into the NHS 111 Directory of Services enabling call handlers to directly book appointments for patients when they contact NHS 111. This pilot scheme has been extended for two years with an increase in overall capacity during that period. Work is being undertaken with Emergency Departments to enable them to directly book into this service.

Estates

Alliance Teams have been progressing several smaller Section 106 estates developments working with a range of practices across MSE.

Focus of Alliance Teams

There has been a relentless focus on all Alliances on the support to MTP in the form of the at-scale delivery of frailty and improved end of life identification via Integrated Neighbourhood Teams (INTs). A programme structure has been established and clear delivery goals and data sources defined for the scaling of the approach.

Priorities work for 2024/25 is being concluded and health inequalities funding continues to be distributed through trusted partners.

South East Alliance - have appointed a new clinical lead, Dr Jose Garcia, and Basildon and Brentwood have now appointed an independent chair whose name will be announced shortly.

Thurrock continues to build on its long history of joined up working, re-setting its arrangements through the development of the Place Based Partnership under

Thurrock Integrated Care Alliance (TICA), including refreshing ambitions and priorities, a leadership development programme for system leaders, and facilitating delivery of joined up service provision to meet the needs of our communities.

The Alliance summary reports highlight the breadth of partnership work being undertaken, with health, social care, councils and voluntary sector all working together to improve issues such as increasing the number of health checks in targeted populations, consulting on the NHS 10 year plan, using technology to better understand outcomes from signposting between services, energy grants for those most in need and the Sport England place based partnership, supporting healthy neighbourhoods and emphasising the benefits of physical activity.

Better Care Fund (BCF)

The better care teams have completed the Q3 reporting to the national team following an evaluation session for the ICB Discharge Fund with all three local authority partners and provider teams, where successes from the last nine months were reviewed and the planning for 2025/26 allocation was started.

The teams are currently focused on the 2025/26 planning for the BCF return, including refreshing the intermediate care capacity and demand plan for MSE, updating and conforming the financial allocations and, where possible, planning for service continuity for the next two years.

The routine timetable of meetings in all localities has been maintained. Within the ECC facing part of the system, the focus of the recent meeting was on the evaluation of the Home to Assess Service.

Transfer of Care Hubs (TOCH)

Our focus on TOCHs has been to maintain ‘business as usual’ while further developing links to INTs to facilitate improved discharges and more streamlined aftercare. Each hub is sharing learning to improve effectiveness and outcome. The first year of the TOCH development evaluation is being planned and will be supported by our health economist. Close links to the discharge cell are being maintained and the learning from both TOCH and the discharge cell will form part of the 2025/26 work plans.

Operational performance remains focused on the discharge from hospital metrics to ensure flow is supported by TOCH developments. We are starting to see some positive developments within the metrics supporting discharge and reducing length of stay. The discharge cell will measure many of the same metrics because such close links to the two evaluations are important.

2. Recommendation

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

3. Appendices

Appendix A - Primary Care and Alliances Highlight Report, March 2025

NHS
Mid and South Essex

MSE ICB - Primary Care and Alliances Highlight Report

March 2025

www.midandsouthessex.ics.nhs.uk

We are collaborative
We are compassionate
We are innovative
We are living well

Case Study – Post Discharge Welfare calls

Case Study
A gentleman who had a hospital stay of less that 5 days for minor investigations left hospital on pathway 0 (home with no follow up needs) after advising staff he was managing OK at home and declined any further support offered.

Intervention:

Once home he was contacted by the welfare service for a telephone follow up call.

He advised that prior to hospital he had been mostly housebound since Covid and that he lived alone.

He found the hospital noisy and overwhelming which was why he was keen to leave and declined support at home.

He advised that he was struggling to cope with both his physical health decline and emotional challenges, including low mood. And he had no food in the house yet.

Actions:

The welfare service team provided practical help (arranging a food shopping support to prevent readmission).

Contacted the GP practice to arrange a social prescribing contact to ensure other needs meet in relation to his emotional challenges and to follow up his other physical health needs with the GP team.

He was referred to a local Voluntary and Community Sector team for support to identify support to increase his confidence going out of the house to reduce his isolation.

Supporting a Patient's Transition to Wellness

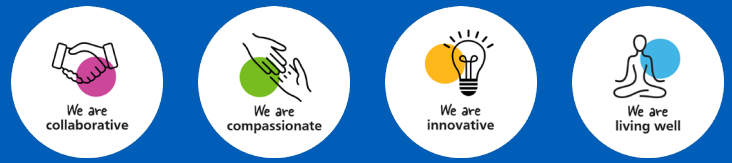
Outcome:

The gentleman was supported to remain at home, his immediate support needs were met, to prevent a readmission to hospital which was not what he wanted, he can start to gain confidence to leave the house improving his mental health support and reducing his isolation.

NHS
Mid and South Essex

Primary Care

www.midandsouthessex.ics.nhs.uk



Primary Care - General Practice 1

Reporting Month	March 2025	Executive Lead	Pam Green	SRO	William Guy/Jenni Speller	RAG	Amber

Overall Summary

- Primary Care Networks (PCN) Reconfiguration Requests
    - The Alliances and Primary Care Team have received a number of PCN reconfiguration requests across three Alliances. These are being worked through in dialogue with the affected practices to try and ensure the most optimal outcome for the local population.
    - Where approved, these will come into effect on 1st April 2025.

- New Contract Settlement for 25/26. It was announced at the end of February that agreement had been reached between the General Practitioners Committee (GPC) and NHS England on the key proposals for a contract settlement for 25/26. The detail of this is yet to be published but key elements include £889m of additional investment across the core practice contract and Network Directed Enhanced Service (DES) . This is the equivalent of 7.2% cash growth on the contract envelop. 32 QOF indicators will be permanently "retired" with income protected. A key part of the remaining QOF programme will focus on CVD prevention. Online consultation tools will need to be switched on for core practice hours. The introduction of a new directly enhanced service for advice and guidance.

- British Medical Association (BMA) Collective Action – has been paused in lieu of the above contract agreement has been reached for now
    - However the ICB continues to work with partners to put in place alternative arrangements for patients ADHD prescribing where practices have opted out of shared care. This is not entirely linked to Collective Action, it is thought to be a contributory factor.
    - The ICB is working with the LMC (local medical committees) and other partners regarding other areas of concern including some elements of prescribing medication and the undertaking of ECGs (electrocardiogram). The ICB is working with service providers to ensure that referral processes are efficient and effective and do not place a significant bureaucratic burden on practices.

-Enhanced Services – the ICB commissions a range of Locally Enhanced Services from primary medical contract holders in Mid and South Essex. This includes: Shared Care arrangements for a number of specific complex medications, wound care management, 24 hr ECGs, 24 hr BP monitoring, women's health hub, anti coag, DVT, Phlebotomy, Minor Surgery, Vasectomy services. These services are optional for practices to deliver

- The ICB is supporting the ongoing development of the GP Provider Collaborative. A key part of their current focus is the development of their organisational governance.

-Financial Recovery Programme
    - The Primary Care Team are continuing to make progress on Financial Recovery Programme schemes including a review of APMS (alternative provider medical services) project, a review of Local Primary Care Schemes and NHS Property Service arrangements
    - A number of savings have been secured both in year (24/25) and 25/26.

- The January 2025 Primary Care Commissioning Committee considered an application to merge two practices within Billericay and subsequently close the branch surgery at South Green. Following review, this request was supported by the Committee.
- The ICB is supporting the local implementation of NHS England's Primary Care Utilisation and Modernisation Fund 25/26. This scheme aims to enable investment in small estates improvement schemes to expand/convert capacity within practices before the end of December 25. Expressions of interest have been received from practices. We will work closely with practices to ensure that we maximise the benefit of this programme. The ICB is also seeking to invest up to £1m of local capital in practice schemes alongside improved utilisation of Section 106 monies.

Primary Care - General Practice 2

Reporting Month	March 2025	Executive Lead	Pam Green	SRO	William Guy/Jenni Speller	RAG	Amber

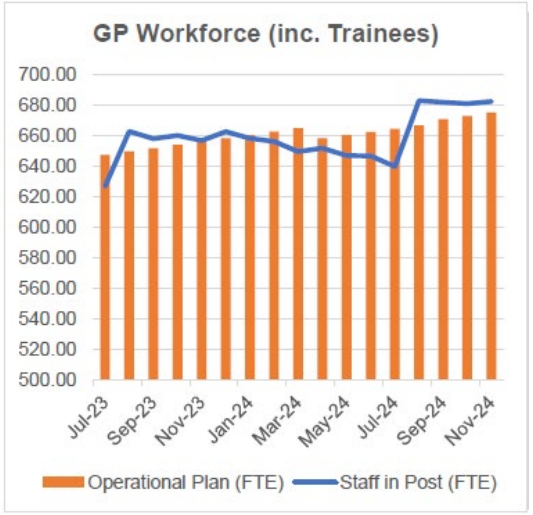
Overall Summary

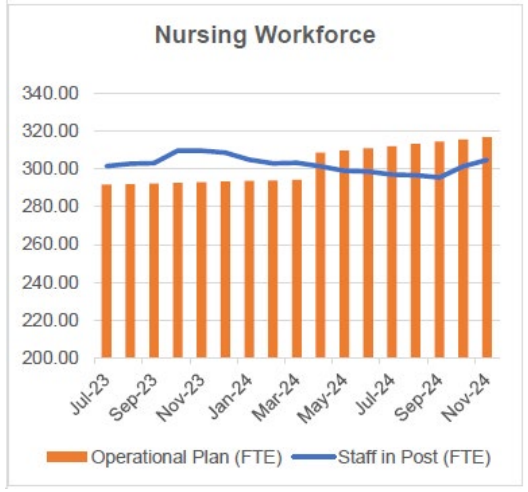
- At the February meeting, the Primary Care Commissioning Committee received an update from the Primary Care Workforce Hub

Overall GP workforce numbers including trainee numbers are ahead of plan. This has been driven in part by the expansion of Learning Organisations and Educators (previously called training practices) in Mid and South Essex. Through taking on the coordination of GP educator training and approval of educators, the Primary Care Hub have expanded the number of Educators to 232 and Learning Organisations to 87.

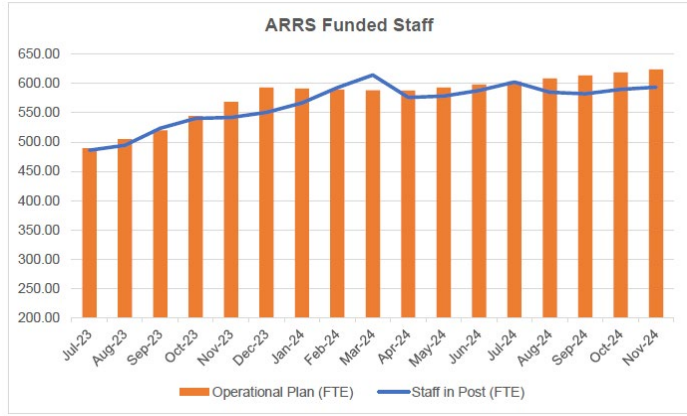
A number of further initiatives such as fellowships have also helped bolster numbers.

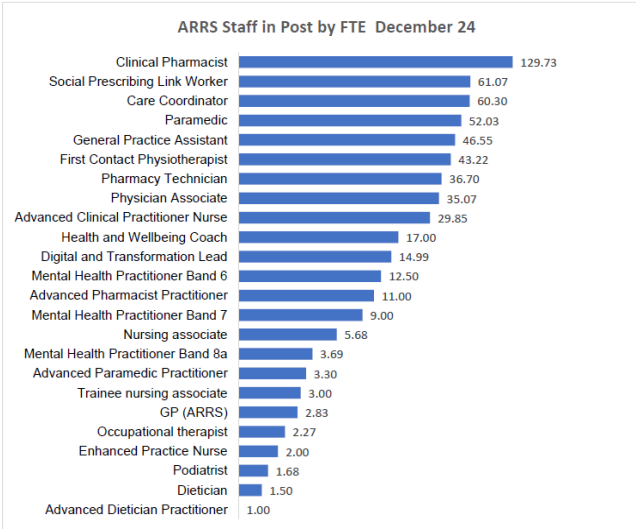
Nursing workforce numbers in primary care remain slightly behind plan. We have a number of schemes to support nurse development, recruitment and retention in Mid and South Essex including Nursing Pathway opportunities and CPD programmes





ARRS numbers have steadily grown by remain slightly below planned levels. There are now nearly 600 FTE staff employed across PCNs in Mid and South Essex. Over 20% of these are clinical pharmacists with other significant roles being social prescribers, care coordinators, paramedics, general practice assistants and first contact physios.





Primary Care – Access Recovery Programme/Connected Pathways

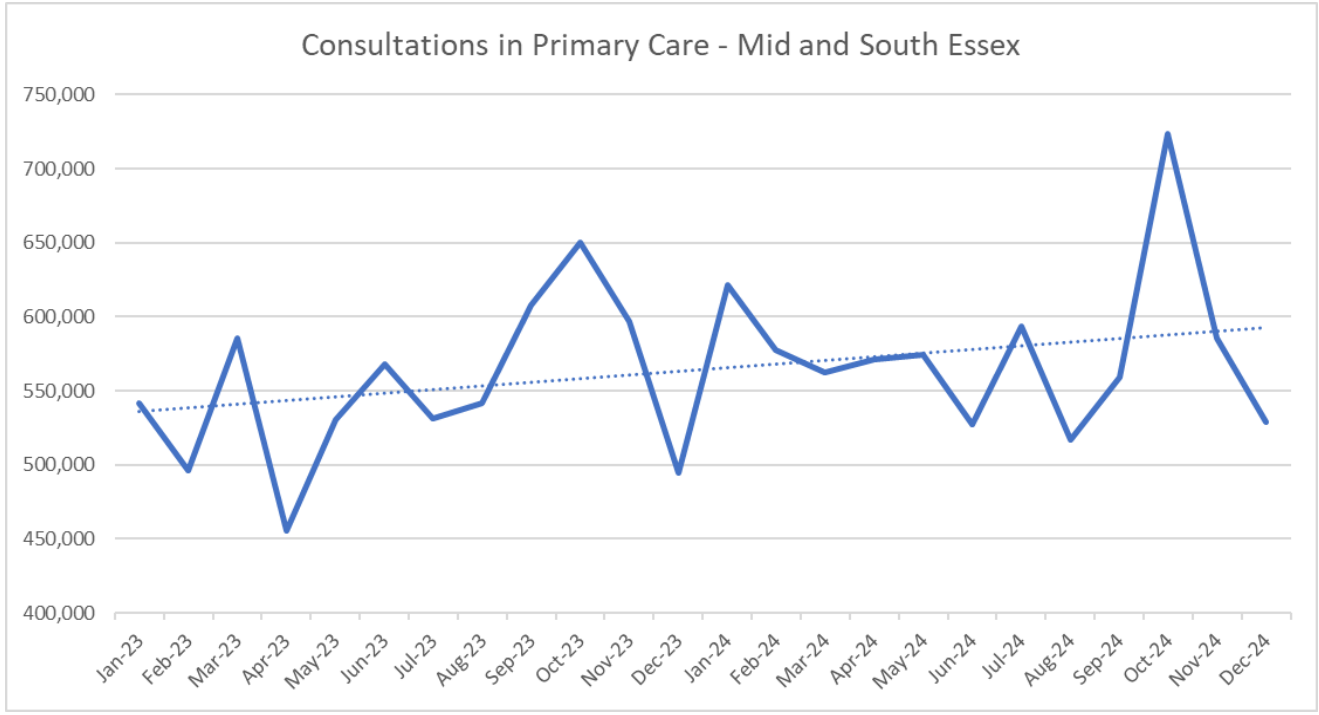
Reporting Month	March 2025	Executive Lead	Pam Green	SRO	Jenni Speller/Ali Birch	RAG	Amber

Overall Summary

The February Primary Care Commissioning Committee received a comprehensive update on the work of the Connected Pathways Team in delivering the Primary Care Access Recovery Programme.

The team is focused on the following projects:

1. Cloud Based Telephony – Achieved
2. Communications – On track
3. Digital tools – On track
4. Patient experience – On track
5. Pharmacy / Optom / Dental – On track
6. Self- Referral Pathways - Achieved
7. Staff Satisfaction – On Track
8. Total Triage – Achieved



Key achievements include:

- Roll out of cloud based telephony to ensure all practices have a compliant system in place
- Comprehensive comms campaign over winter including radio, newspaper and news website coverage of Modern General Practice across Mid and South Essex
- Implementation of Digital Tools across Primary Care. 142 practices now regularly use 1 or more digital tools to support the management of patients. Utilisation has significantly increased in 24/25
- Development of "Frontline" a tool to help direct patients to other local services that may better meet their needs including community and voluntary organisations. In January 2025, there were over 3,000 patients signposted or referred using the Frontline tool.
- Increases in use of Friends and Family Tools to track feedback from service users
- Expansion of self referral pathways including increased use of optometry, pharmacy and dental services. We are now operating 12 pathways and have the 12th highest levels of self referral of any ICB in England.
- Ensuring the use of transitional support funding to roll out Total Triage models across practices in Mid and South Essex. 69 practices have had their applications for funding approved.

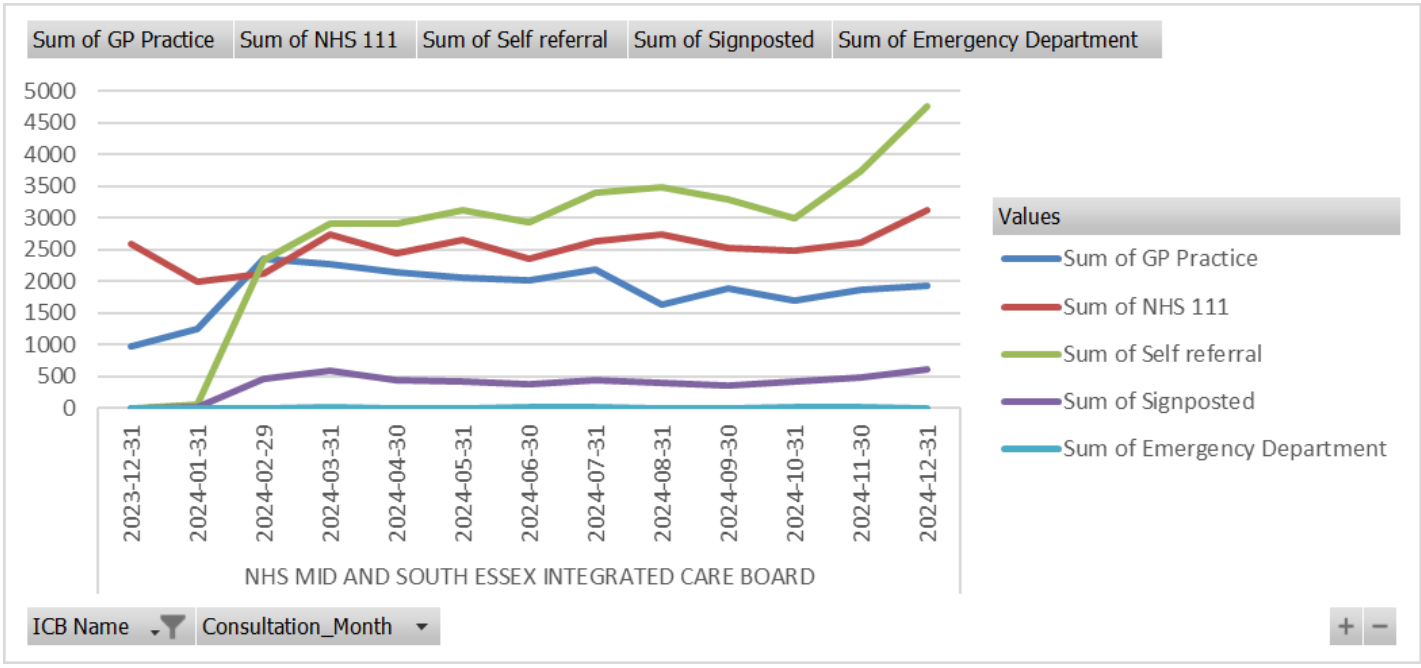
Primary Care – Community Pharmacy & Optometry

Reporting Month	March 2025	Executive Lead	Pam Green	SRO	William Guy/Paula Wilkinson	RAG	Amber

Community Pharmacy

As of 1st February 2025, there are 196 Community Pharmacies across the 26 PCNs in Mid and South Essex (no change on November 24).
December 2024 (latest reporting) saw the highest level of Pharmacy First consultations to date. For the first time, there were over 10k consultations in one month across Mid and South Essex. There has been significant growth in the number of patients that access the service through self-referral alongside being signposted by 111.
Common presentations to Pharmacy First include sore throats, uncomplicated UTIs and Otitis Media.
Alongside the development of Pharmacy First, pharmacies are continuing to undertake blood pressure checks to support the prevention of CVD. Typically, 3000 people are seen in this service every month across Mid and South Essex.
Through working with Essex Sexual Health Services, there is a growing level of contraception provision through community pharmacies in Mid and South Essex
Providers and the ICBs await guidance on the national community pharmacy contractual framework for 25/26.

A graph showing sources of referral to Pharmacy First by month (Mid and South Essex)



Community Optometry

The Primary Care Commissioning Committee received an update for quarter 2 Optometry Contracting produced by the Herts and West Essex hosted Pharmacy and Optometry Team. The ICB currently has 107 Mandatory Services Contract Holders and 22 Additional Services Contract Holders. A key programme of work being take forward by the contracting team is the reissuing of contracts to ensure that all current Ts and Cs are in place. 74 or 78 contracts have been finalised.
The ICB gave an update on a number of local issues relating to optometric services. Self-referral to Optometry practices is being prioritised within the Connected Pathways comms campaign this winter. Progress has been made on prescribing under FP10 to ensure that where available, patients do not have to be referred back to their GP or HES for further prescriptions.

Primary Care – Dentistry

Reporting Month	March 2025	Executive Lead	Pam Green	SRO	William Guy	RAG	Amber

Dentistry

- NHS England have recently published "Arrangements for NHS urgent primary dental care during 2025/26". This includes a requirement of all ICBs to deliver a contribution towards 700k additional urgent dental care appointments per annum (commencing in 25/26). The ICB is currently reviewing the detail of this requirement to ensure we are able to deliver the 6,098 appointments that are allocated to Mid and South Essex ICB. We have an established access scheme that aligns with the requirements of this development. This will be the basis for our intended delivery in 25/26.

- As of February's Primary Care Commissioning Committee, it was noted that over 20k patients have been seen through the dental access pilot. The service is now fully integrated into the 111 Directory of Service (DOS) enabling 111 call handlers to directly book appointments for patients when they contact. This pilot scheme has been extended for two years with an increase in overall capacity during that period. Work is being undertaken with Emergency Departments to enable them to directly book into this service.

- The Care Homes pilot has now treated 4,165 patients with positive feedback from patients and homes alike. Through improvements in access, there has been a subsequent reduction in the waiting times for domiciliary visits provided by the Community Dental Service. Waits have reduced from 100 weeks at the start of the pilot to 12 weeks currently.

- The new Children and Young Peoples Pilot has gained momentum with 140 schools now covered under the scheme and a further 100 schools lined up for coverage. We have received 24 expressions of interest from providers to participate in this pilot.

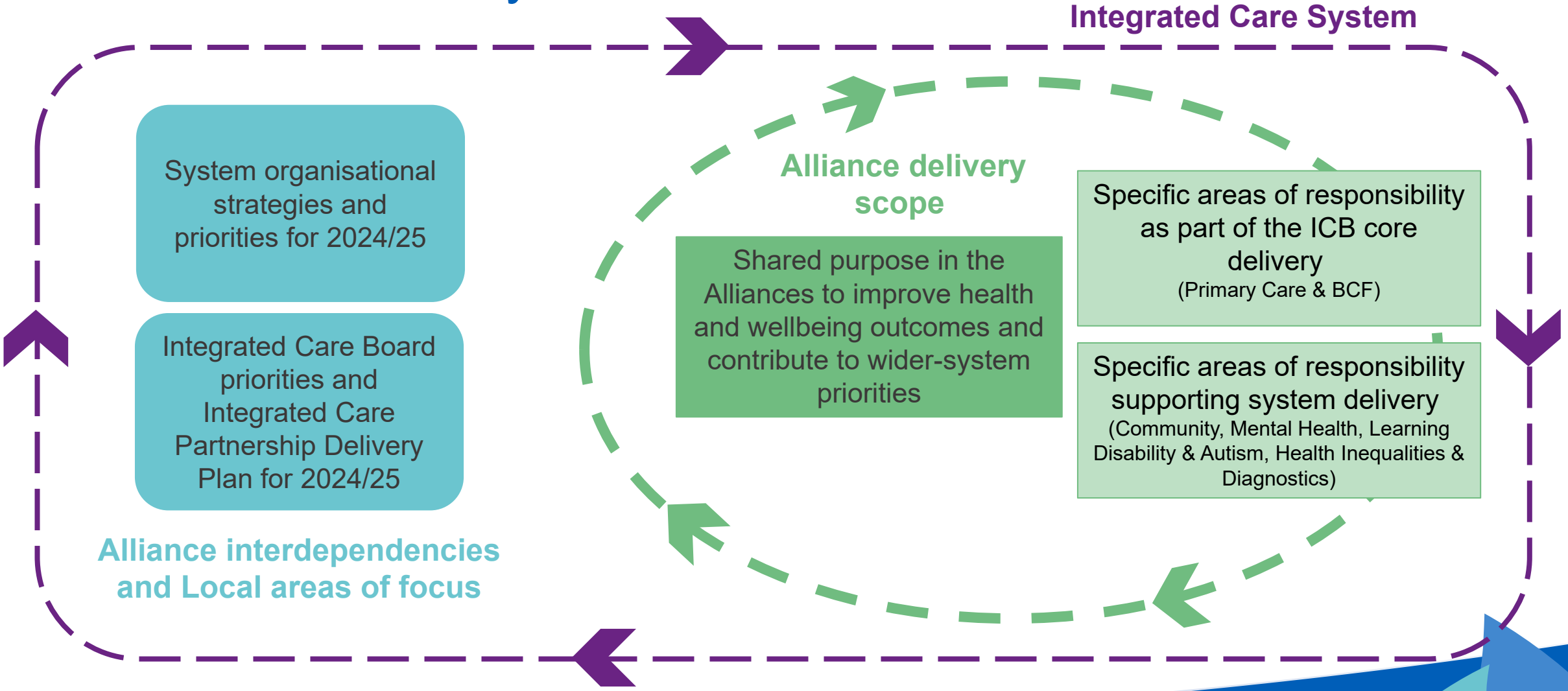
- The dental team have been continuing their contract rebasing reviews. This aims to improve delivery of the contracted levels of activity within our locally held dental contracts.

NHS
Mid and South Essex

Alliances

www.midandsouthessex.ics.nhs.uk

The Alliance Delivery Model



Priority Work Areas- Alliances 1

Work Area	*Aim*	*Update on actions*
Diabetes	To support people with diabetes to live well, and to address inequities in diabetes care across MSE by delivering an optimised, consistent and locally integrated model of diabetes care for MSE.	Focus on left shift and delivery of diabetes care in primary care. Working with Stewardship to take forward. Testing and developing through GP Provider Collaborative. Stakeholder workshop 30th January.
End of Life (EOL) Registers	To Improve identification of EOL in the last 24 months of life and the effective utilisation of the EOL registers to support proactive, personalised and anticipatory planning and delivery of care. Inclusive of promoting the Frail+ training resources on Our People, Your Future with a focus on compassionate conversations, evidenced approaches and techniques.	The national EOL Ambitions self-assessment review is complete, using a multi-agency approach the ICB will have a single view of EOL service maturity. This will provide key insight and direction to all plans. Data intelligence is strong in this area and bespoke data packs are available at Alliance level enabling targeted approaches with system partners and GP practices to improve performance. Action orientated plans are being developed to direct activity through INT's.
FrEDA roll out	Roll out of best-practice, proactive, personalised and frailty-focussed assessment and care delivery tool, based on all 5 domains of a comprehensive geriatric assessment (CGA). Permitting delivery of CGA, identifying persons with frailty/Dementia or any adult with end of life care needs significantly earlier, measuring and recording frailty more accurately in our population. Identify and share good practice and approaches	A Community of Practice is being developed to support the roll out of FrEDA, enabling staff at operational level to share learning and experience, highlighting the benefits and impact. Recruitment for the Band 7 support role is underway, providing both technical and engagement support.
Dementia Diagnosis Rate	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rates across MSE to meet the national target. The NHS has a goal of diagnosing 66.7% of people who are estimated to have dementia within the population by March 2025.	A new working group has been established, and a new work plan is being drawn up. This will be finalised in January 2025. Data to be used to highlight outliers in delivery of diagnosis rates and plans developed with outliers to deliver actions to achieve the target.
SMI Health checks	Improve quality of life, effectiveness of treatment, and care by increasing the SMI rates to meet the national target.	Review underway of current achievement and trajectory to this point last year. Targeted visits to outliers to support in developing delivery plans to increase performance. Working with NHSE regional team to apply new business rules under GPES. All GP practices signed up to GPES. New SOP developed and step-by-step guide for primary care to be sent out in March.
LD Health checks	Improve quality of life, effectiveness of treatment, and care by increasing the SMI rates to meet the national target	Continued review of current achievement and trajectory to this point last year. Targeted visits to outliers.

Priority Work Areas- Alliances 2

Work Area	*Aim*	*Update on actions*
Integrated Neighbourhood Teams (INT)	The aim is to deliver more joined up preventative care at a neighbourhood level. By sharing resources and information, understanding and utilising local assets, teams can work together more collaboratively to simplify and streamline access to services.	Concept to focus all 24 INTs on frailty and end of life being socialised across all stakeholders. Also presented to all directorates internally with broad support fo rdirection of travel. Operational group established across Alliances to mobilise plans See slides 15 and 16 for more detail.
Health Inequalities funding	To reduce health inequalities at place level through dedicated place based funding. Trusted partner arrangements in place with process for allocation of funding in line with local priorities	Mobilisation plans for the 2025/26 Trusted Partner programme are in development in each Alliance area, mobilisation expected in March 2025.
Health inequalities targets- focus on Cardiovascular Disease and Hypertension	To develop, test and implement a community health intervention that supports improved outcomes for people at risk of or living with CVD. As well as supporting prevention and treatments in primary care. Hypertension identification and management.	All areas are meeting the targets for lipid lowering medications. The CVD Community Outreach Grant programme is underway, PCNs and local partners are delivering community events focussed on CVD case finding, health literacy and medicines optimisation. CVD Place based partnership pilot mobilised in Canvey Island, focused on working age males who do not regularly attend health settings. The pilot engages the group through physical activity with aim of improving health literacy.
Medicines Optimisation	To provide Alliance based staff with key information and messages that can be delivered locally to support the Medicines Optimisation recovery plan.	Plans to advertise for Alliance based Clinical Leads for meds supported
VCSFE Discharge Spend	Embed VCSFE provision into the discharge process, supporting safe and sustainable transition back into the home environment. Taking forward the learning from 2024/25 into planning and further development in 2025/26	Framework reporting template shared for Qtr 4 completion. Review of model and planning for 25/26 continues. The emerging model includes navigation, social prescribing and community provided wrap around support.

Priority Work Areas- Process and Flow

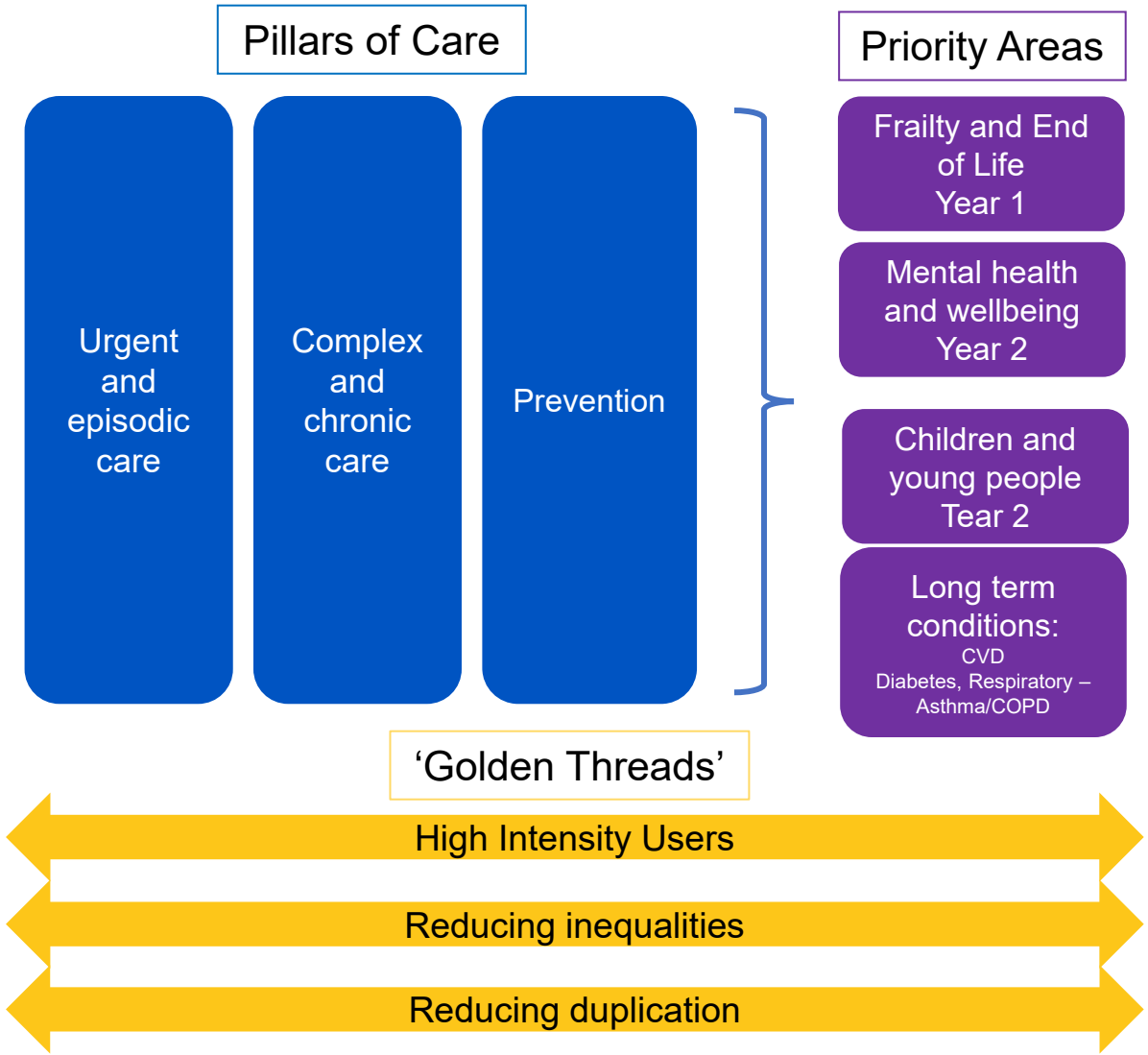
Work Area	*Aim*	*Update on actions*
Transfer of care hub (TOCH)	To Support effective identification of the most supporting of discharge pathways and to support 'pull' from assessment areas. To utilise metrics to support maturity of TOCHs	The transfer of care hubs work is integrating with the discharge cell to support flow over winter, both areas will be evaluated to support next steps planning. The evaluation's will be supported by the ICBs health economist and are likely to commence in the new financial year.
Intermediate Care Model	To support the development of an integrated IMC model for people using reablement services. Reviewing Southend Enhanced Discharge Service (SEDs), and bridging models in ECC and Thurrock.	In ECC the bridging model evaluation has been published and is being used to support the transition of the model in April 2025. The SEDs model is operating well in the capacity aligned, this is now being monitored with operational teams. Work to link the P1 pathway changes to the developing work on the wider Pathway 2 Beds (not IMC) is in progress.
Better Care Fund (BCF) **iBCF** **Discharge Fund**	Oversight and monitoring of all projects linked to the BCF and related projects including evaluation and reporting. Supporting the BCF Policy objectives to • Enable people to stay well, safe and independent at home for longer. • Provide the right care in the right place at the right time • Capacity and demand planning for intermediate care services, including discharge.	All 4 Alliances maintained partnership BCF governance groups with LA partners. The ICB discharge fund spend remains on target currently to be fully utilised by year end. The Q3 BCF report was submitted in Feb 24 The 25/26 planning for national submission is underway including a refresh of the demand and capacity model.
High Intensity Users	Identification and proactive, multi-agency approaches to support and develop interventions for high frequency users of services and high frequency admissions to support in managing demand across the system. Initial focus on delivery through Integrated Neighbourhood Teams.	Mapping of existing HIU schemes at place level across each Alliance. Agreement from INT Programme Board that HIU will sit under INT development and part of the INT delivery plan will be to support HIU in the frailty/EOL cohort.
Southend ABSS transition plan	Working with partners to understand and mitigate the impact of the National Lottery funded A Better Start Southend programme (ABBS), coming to an end. Supporting transitional arrangements.	The ABSS program and its funding will come to an end on 31st March 2025. Transition plans are embedded, facilitating both continuation and signposting to alternative services, minimizing the impact on families. Partners at Alliance level will continue to assess needs with a clear focus on outcomes based service development to give parents, babies, and children the best possible start in life.

Priority Work Areas- Estates

Work Area	***Aim***	***Update on actions***
Estates	To ensure the most effective utilisation of the MSE primary care and community estate including the most cost effective use of funding opportunities. Alliance Level estates plans to be drawn-up to inform the access to available Section 106 (S106) and Community Infrastructure Levy (CIL) funding.	Review of available S106 funding completed per Alliance area. A draft pilot of Primary Care Estates Plan produced for Rochford and to be rolled out across Alliances. Expression of Interest (EOI) and decision making framework in development to provide effective and transparent governance processes to support S106 and estates investment.

Integrated Neighbourhood Teams (INTs)

Integrated Neighbourhood Teams are fundamental to our plans to improve access and outcomes across health and social care, providing more proactive, joined up care and reducing health inequalities



Overview

- 23 of 24 INTs are now live with varying levels of maturity. Remaining 1 to be live by March 2025.
- ICB agreement to progress in sync, more supportive direction to providers, all 24 INTs focussing on same area, year 1 frailty
- Renewed focus to align to Medium Term Plan and establish new system governance

Work over the last period has included:

- ICB Executive agreement to adopt concept of focussing on 1 priority area and all 24 INTs moving together
- Based upon local success, development of an INT Frailty playbook, proposing a "how to guide" to mobilise an INT.
- Refinement of a frailty model with Ageing Well stewardship group.
- Stakeholder mapping, socialising new concept. Support form ICB Operational Group, focussed discussion with Health Inequality Teams, Babies, Children and Young People Teams.

Update on INT work programme

- Whilst there are 23 INTs "live" across the ICB it is recognised that they have varying levels of maturity. To date they have been grown organically with some steer relating to the Fuller Stocktake report and using the foundation of existing relationships.
- Aligned to the development of the Medium Term Plan it has been debated and agreed that stronger direction will be provided, with a clear message to all providers that all 24 INTs will be prioritising the same area.
- The NHSE Planning Guidance for 2025-26 includes specific reference to Neighbourhood Health Guidelines which has been cross referenced with our plans.
- For year 1 the priority will be Frailty and End of Life. Recognised that if this is the focus across our system, we will be able to make significant changes in terms of quality, capacity and finances.
- Stakeholder mapping and a clear narrative has commenced through January and February so that providers are aware and can consider training requirements and current alignment of staff.
- An INT Frailty playbook has been developed to assist INTs with taking the work forward (e.g. identifying appropriate patients, setting up a core leadership group, measuring success)
- Work with the Ageing Well stewardship group has commenced with a plan to agree the 5 key measures that will make a difference to patients and work force.
- An INT data dashboard is being trialed in 1 INT in order to establish baselines and to be able to measure success.
- The Community Collaborative have started to roll out FrEDA training, an award winning framework that captures essential information regarding patients in one place for different providers.

Alliance Summary 1

Reporting Month	March 2025	Executive Lead	Deputy Alliance Directors	SRO	Alliance Directors	RAG	Amber

Thurrock

Local Areas of focus:

Stop Smoking

VCFSE development

Healthy Weight EYOH programme

Thurrock Place-based Partnership update (Thurrock Integrated Care Alliance)

Thurrock continues to build on its long history of joined up working, re-setting its arrangements through the development of the Place Based Partnership under Thurrock Integrated Care Alliance (TICA), including refreshing ambitions and priorities, a leadership development programme for system leaders and facilitating delivery of joined up service provision to meet the needs of our communities.

Key delivery achievements since last Board report:

Work is underway to pull together a short annual report summarising the key pieces of place based delivery from 2024-2025, it is anticipated that this will be completed in April. A summary of the key achievements identified so far is outlined below. Review and refresh of neighbourhood working arrangements; In partnership with Healthwatch and Local Authority delivered broad stakeholder and resident engagement around NHS 10 year plan consultation; Supported approval of community diabetes service proposal and business case; Mobilisation of community mental health transformation programme – including collaboration on MSE ICB mental health commission for voluntary, community, faith and social enterprise services; Supported development of key ICB strategies – carers, learning disability and autism refresh, mental health wellbeing and suicide prevention; Led on public engagement to promote service awareness and gain insight into residents' needs and behaviours; Innovative delivery of flu vaccines; coordination of response to MMR vaccination; Supported a co-ordinated response to urgent and emergency care system pressures over winter; Development of successful funding bid – Work Well Programme;, which will support the delivery of innovative service models across Thurrock and broader MSE; Delivery in focus - agreed next steps for maturing our Integrated Neighbourhood Teams.

Basildon and Brentwood

Local Areas of focus:

Start well
Feel Well
Be well
Stay well
Age well
Die well

The Alliance committee discussed:

Integrated Neighbourhood Teams (INTs) – Presentation relating to concept of all 24 INTs across MSE working on frailty and end of life with a view to improving servcies to patients, more joined up working across organisations and creating capacity across all organisations by focusing on earlier identification and intervention to keep patients safe and well in their own homes.

Public Health and Essex Wellbeing Service – confirmation that equipment to enable health checks in non-traditional settings (e.g. large organisations/factories) going ahead with clear messaging to ensure high risk patients are identified and appropriate support provided.

Intermediate Care Services – Essex County Council provided an update on their Intermediate Care strategy. Recognition that lots of crossover with the INT work, with both streams looking to safely provide care for our population in their own homes. Focusing on those who access services frequently agreed to be an area of focus and an area to progress jointly across health and social care.

Technology – Discussion regarding platforms that enable both staff and members of the public to access information on local servcies or refer/self refer into services such as mental health support groups. Exciting opportunity to link with a proposed Council platform that will track the outcomes for individuals and help to identify gaps in our local provision. Agreed this work has significantly increased visibility of local assets and needs further promotion across all partners.

Medium Term Plan - Committee updated by Chair on progress with plan and addressing drivers of system deficit and support required from all partners.

- -

Alliance Summary 2

Reporting Month	March 2025	Executive Lead	Deputy Alliance Directors	SRO	Alliance Directors	RAG	Amber

Mid Essex

Local Areas of focus:

Thriving places Index priority areas:
Healthy Housing
Respiratory
Economic Wellbeing

The Alliance committee discussed: Representatives from the Mid and South Essex Foundation Trust/Essex County Council joined the meeting to brief the committee on the Greater Essex Connect to work Programme, explaining that the programme is about supporting those facing barriers to accessing employment. The work will start in April/May 2025 for a period of 2-5 years. ECC will be the Accountable Body for the programme leading the design and delivery for Greater Essex (Essex, Thurrock and Southend). The presentation highlighted the focus outcomes and cohorts that will be funded. Eligibility, suitability, together with willingness to work will be supported with provision, costs, and digital/IT infrastructure.

The committee also received an overview of the Home-Start Essex Public Health Accelerator Bid funding process, which provides services to those in the 20% most deprived communities, across Mid Essex, supporting with mental health, physical health, family support, asylum seekers and unpaid carers through funding schemes to support the health and wellbeing of these cohorts. The Alliance were asked to help with suggestions on next steps to support the sustainability of the project, which continues through to end of March 2026, The mid Children's and Young People's (CYP) partnership gave their regular update on work programmes happening in Mid Essex supporting the health and wellbeing of CYP and gave a number of case studies of good work and practice that is taking place. There was an ask of the Alliance to support representation in the sub groups developing the work plans and programmes to ensure momentum continues. The Integrated Care Board gave a further update on current planning work on priority areas and the new operational planning guidance for 25/26 for awareness.

Work on local areas of focus in the last period has included: continued progression of our Thriving Places Index programme, in which a broad cross-section of partners work together to understand and address factors impacting on whether a community thrives, bridging the gap between 'health' and those agencies able to influence the wider determinants of health:

- Healthy Housing/Respiratory. Work continues on the jointly identified priority projects, including reviewing eligibility criteria of new retrofit/energy grants for those most in need; layering data from multiple agencies to understand who/how to prioritise; improving awareness and pathways between agencies (e.g. front line clinical teams to housing teams, energy advisors and financial support). Agreement to fund an Enhanced Respiratory Service, providing the clinical component to support those at most risk and inform ongoing approach to our Healthy Housing strategy. Likely to start in April 25
- As our flagship approach to understanding and managing health inequalities in Mid Essex, TPI has also informed funding priorities for next year - providing evidence based rationale for where best to invest resources for the greatest impact

South East Essex

Local Areas of focus:

Healthy Neighbourhoods
Healthy Start
Healthy living
Healthy Mind
Healthy Aging

The first Alliance Committee meeting of 2025 welcomed the new Primary Care Clinical Lead, Dr Jose Garcia. Update reports from the Healthy Neighbourhood Partnership Group (HNPG) and Alliance Delivery Plan covered key challenges, including data access in the SEE mental health system, a small underspend in the Trusted Partner health inequality fund, and funding issues affecting voluntary, charity, faith and enterprise sector (VCSFE) services. Recognising the changes in the national policy landscape and ongoing financial challenges in the MSE system, concerns were raised about the sustainability of VCSFE sector funding. Members discussed the need for sustainable, ongoing financial support for VCSFE projects and proposed a further committee discussion to address the issue alongside notification of the concerns to the ICB Board..

The meeting also included updates on the Better Care Fund (BCF), where members discussed funding allocations, challenges in spending the Disabled Facilities Grant (DFG), and efforts to ensure effective use of resources. The A Better Start Southend transition and legacy planning were outlined, emphasizing collaboration to sustain key elements beyond its March 2025 conclusion. Discussions on mental health services highlighted governance changes, funding challenges, and agile commissioning models to improve patient access and equity. Additionally, updates on the Community Diagnostic Centres (CDC) detailed efforts to enhance diagnostic services in Southend and Pitsea. The Essex County Council VCSFE infrastructure programme was reviewed, focusing on place-based working and maximizing community resources. Members stressed the importance of leadership representation and integration with existing community networks, with a commitment to refining collaboration efforts across the region.

The investment plan for the Sport England Place Based Partnership work in Canvey Island was submitted in February, Healthy Neighbourhoods is a strong theme throughout with additional focus on physical activity and CVD, childhood asthma and social prescribing for children and young people.

NHS
Mid and South Essex

Alliance Directors

Dan DOHERTY
Pam GREEN
Aleksandra MECAN
Rebecca JARVIS

www.midandsouthessex.ics.nhs.uk

Key for project updates

G	On track, no intervention required
A	Project remains on track. However, there are a number of risks/issues that should be noted and monitored carefully
R	Off track, Diagnostic Implementation Working Group and/or Diagnostic Programme Board intervention required

Part I ICB Board meeting, 13 March 2025

Agenda Number: 12.1

Board Assurance Framework

Summary Report

1. Purpose of Report

To provide assurance to the Board regarding the management of strategic risks via the latest version of the Board Assurance Framework (BAF).

2. Executive Lead

Tom Abell, Chief Executive Officer and named Directors for each risk as set out on the BAF.

3. Report Author

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

Each sub-committee of the Board is responsible for their own areas of risk and receives risk reports to review on a bi-monthly basis.

5. Conflicts of Interest

None identified.

6. Recommendation/s

The Board is asked to consider the latest iteration of the BAF and seek any further assurances required.

Board Assurance Framework

1. Introduction

The ICB Board is responsible for ensuring that adequate measures are in place to manage its strategic risks. This is discharged through oversight of the Board Assurance Framework (BAF) by the Board itself supported by the Audit Committee which reviews the BAF and corporate risk register at each committee meeting. The ICB's main committees also receive excerpts from the BAF in relation to risks within their remit, alongside the full risk registers that relate to their committee remit.

2. Risks currently on the Board Assurance Framework

The current BAF, provided at **Appendix 1**, includes eight strategic risks, **all of which are rated red** (scored between 15 and 25), except Health Inequalities, which is currently scored 9/Amber (reduced from 12/Amber, January 2025).

- Workforce (score 20)
- Primary Care (score 16)
- Capital (score 16)
- Urgent Emergency Care (UEC) and System Co-ordination (score16)
- Diagnostics, Elective Care and Cancer Performance (score 20)
- System Financial Performance (score 16)
- Inequalities (score 9/Amber)
- Mental Health Services (score 16)

With the exception of Health Inequalities, the risk rating for each risk has remained the same since the last Board meeting.

Each BAF risk (and associated corporate risks on the ICB's corporate risk register recorded on Datix) is linked to one or more of the ICB's 7 strategic objectives, these being:

1. To ensure that the MSE ICB and ICS deliver good quality health care and services within financial resource limits.
2. To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
3. To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
4. To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement by March 2026.
5. To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.
6. To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.
7. To be an exemplary partner and leader across mid and south Essex ICS, working with our public, patients and partners in the ICP to jointly meet the health and care needs of our people.

*NB: An abbreviated version of these objectives is used in **Appendix 1**.*

The BAF also includes an updated summary of Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust's red risks as per BAF reports submitted to their most recent Trust Board meetings.

3. Assessment and Management of Risks across Integrated Care Systems

As highlighted in the January Board BAF report, the ICB is participating in a pilot with NHS England for the assessment and management of risks across integrated care systems in line with new National Quality Board guidance.

Two risks have been chosen to pilot the NHS England tools for assessing system risk: firstly relating to mental health patients who require urgent emergency care; secondly, the risk associated with inconsistencies in the service for end-of-life care.

The Associate Director of Corporate Services presented an overview of the pilot and its aims at the most recent System Quality Group meeting. The workshops to pilot the two risks, to be attended by appropriate representatives from relevant partner organisations, will be held mid-April 2025.

This pilot will run alongside the further development of the ICB's own risk framework including how the ICB collaborates with partners to manage risks. Included in this is a workshop with the Executive Team regarding the corporate objectives of the ICB and an in-depth review of the risks in the current BAF.

4. Recommendation

The Board is asked to consider the latest iteration of the BAF and seek any further assurances required.

5. Appendices

Appendix 1 - Board Assurance Framework, March 2025.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Board Assurance Framework

March 2025

www.midandsouthessex.ics.nhs.uk

Contents

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

BAF Risks – Summary Report

No	Risk and Key Elements	SRO(s)	Key Assurances (further information on individual risk slides)	RAG
1.	**WORKFORCE:** • Workforce Strategy • Primary Care Workforce Development (see Primary Care Risk) • Provider recruitment • Managing the care market	K Bonney	• Regular Workforce reporting to People Board • Regional Provider Workforce Return (PWR). • Reduction in unfilled vacancies and Improved attrition and turnover rates. • Reduction in bank and agency usage leading to positive impact on patient safety/quality. • Improved resilience of workforce.	**4 x 5 = 20** ⟺
2.	**PRIMARY CARE** • Primary Care Strategy • Workforce Development • Primary Care Network Development • Financial and contractual framework.	P Green	• Patient Survey Results. • Workforce Retention. • Improved Patient to GP Ratio. • Better patient access, experience and outcomes • Consultation data (volume, speed of access), digital tool data (engagement and usage)	**4 x 4 = 16** ⟺
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Infrastructure Strategy • Digital Priorities and Investment	J Kearton	• Reporting to ICB Finance and Performance Committee. • Delivery of system infrastructure strategy. • Progress reporting on investment pipeline. • Monthly reporting of capital expenditure as an ICS to NHSE.	**4 x 4 = 16** ⟺
4.	**UEC AND SYSTEM CO-ORDINATION ('Unblocking the Hospital')** • Managing 111 and Out-of-Hours • Flow, Discharge, Virtual Ward projects • Discharge to Assess	S Goldberg	• MSE UEC Board oversees programme. • Discharge Cell and enhanced Unscheduled Care Co-ordination Centre established. • Hospital discharges monitored hourly/daily and shared with social care and CHC teams via situational awareness system calls.	**4 x 4 = 16** ⟺
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Dr M Sweeting	• Finance & Performance Committee (F&P) maintains oversight of performance against all NHS Constitutional Standards. • Diagnostics: MSE Diagnostic Reporting to System Diagnostic Board & Diagnostic Performance Sub-Group. • Cancer: MSEFT Cancer performance report: Via Quality, Contract, Performance Meeting (QCPM) and fortnightly meetings with National Team as a Tier 1 Trust. • RTT: Via Quality, Contract, Performance Meeting (QCPM) and Tier One meetings held fortnightly: MSEFT RTT Long Wait Report. 52+ week waiting list size growth is the significant risk overseen via the two forums. • Quality, Contract, Performance Meetings between provider and ICB oversees performance not covered by the above.	**5 x 4 = 20** ⟺
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme • Use of Resources	J Kearton	• Preparation of plan position for Board, Regional and National Sign-off. • Development of financial insights through Medium Term Financial Plan. • Overseen by the ICB Finance and Performance Committee and Chief Executives Forum, also discussed at SLFG and Exec Committee. • Internal and External Audits planned.	**4 x 4 = 16** ⟺
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	R Jarvis	• Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE. • Improvement in access and reduction of health inequalities as shown in the performance metrics, of which our priorities are currently being developed. • Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.	**3 x 3 = 9** ↓
8.	**MENTAL HEALTH QUALITY ASSURANCE** • Workforce challenges • Demand and capacity • Performance against standards • External scrutiny • Addressing health inequalities/equitable offer across MSE.	Dr G Thorpe	• CQC action plan progression / Implement recommendations from CQC inspections and HM Coroner's PFDR. • Reporting to Clinical Quality Review Group. • Outcome of Quality Assurance visits. • Improved flow and capacity, reduction in out of area placements and reduced length of stay. • Mental Health Partnership Board & Whole System Transformation Group (WSTG). • Reports to F&P and Quality Committees to identify key quality/performance risks and action being taken. • Accountability review with focus on performance.	**4 x 4 = 16** ⟺

Risk Narrative:	**WORKFORCE:** Risks associated with the ICB and partner organisations not taking effective action to improve recruitment and retention of permanent staff to reduce reliance on bank/agency staff; and not taking effective action to ensure there is a reliable pipeline of staff to fill future vacancies. Inaccuracies in data reporting for HCAs has been identified as a concern. An additional risk has recently been identified regarding substantive recruitment to the Clinical Diagnostic Centres.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20 (based on highest rated risks on Datix which are rated between 16 and 20.) No change since January report.**
Risk Owner/Lead:	Kathy Bonney, Interim Chief People Officer.	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Good quality care within financial envelope; Develop and support workforce; System partnership working	Associated Risks on Datix:	ID Nos 4,53, 54, 55 and 56.

Current Performance v's Target and Trajectory

RECRUITMENT MSEFT: Against a target of 11.55%, overall vacancies have been declining month on month for 6 months down to 9.51% in Dec 2024 . Nursing and midwifery vacancies are down to 5.5% overall (from significant high of 9.9% for nurses & 10% for midwives Dec 23). Medical & Dental vacancies are also down to 6.7% in Dec 2024 against a target of 11.5%. **EPUT:** The overall vacancy rate is now at 13.3% against 12% target. For HCAs this figure is below 10%.
TURNOVER: **MSEFT:** Continued downward trend from a peak of 15.6% in August 2022 to 10.5% in July 2024, and in December 2024 turnover is 11.09% against an overall 13% target. Nursing turnover is down to 8.3%, midwifery 6% (8% in Dec 2023). For Medical and Dental the improvement is to 11.5% against target of 12% (This figure was 13.5% in December 2023 **). EPUT:** Staff Turnover is to 9.6% in December 2024, similar to November 2024 when turnover was 9.75% against 12% target.
BANK & AGENCY: Both EPUT and MSEFT remain on a significant downward trajectory for their bank spend, however, at M11 they remain below plan - EPUT 709 whole time equivalent (WTE) below plan and MSEFT 334 WTE below plan.

How is it being addressed? (Current Controls)

Whilst the trajectory of the reduction in Bank and Agency spend (despite some peaks and troughs) overall is going in the right direction, pace is an issue. Establishment Control Processes remain tight although there is an agreement to release all clinical posts for substantive recruitment. Overtime requests continue to be monitored. As previously reported MSEFT moved their temporary staffing service to Litmus for a 1-year period to run and manage the service. EPUT are currently in conversation with Litmus about following the same approach Delegated authorisation to fill shifts with bank and agency staff continues to be severely restricted. The ICB continues to scrutinise all vacancy fill (apart from substantive clinical roles), contract extension requests, against a set of predetermined criteria. Reducing substantive headcount remains a challenge for both MSEFT and EPUT as the move from temporary staff continues, so some peaks and troughs will naturally appear in their trajectories. Scrutiny for both organisations remains on the following areas.

- Substantive recruitment
- Admin & Clerical bank and agency requests
- Medical locum, bank and agency requests
- Nursing bank, agency and overtime requests
- Long term contracts / locums (non-clinical and medical)
- System and region agency price cap compliance pilot project.
- More recently there is additional scrutiny on sickness absence management .

EPUT also is moving in the right direction and is also subject to the same controls on all staffing spend. They are also looking at rostering where it is clear this is still not being done far enough in advance and results in gaps being filled with bank and agency. EPUT have continued to ban all bank spend for Health Care Assistants from 1 November 2024 and 200+ HCAs have been placed in the system by the Academy since July 2024. Both organisations are embarking on a corporate staffing review with a significant headcount reduction.

Barriers (Gaps)

- Compliance and controls will make a difference and is the right discipline.
- However, sustainable change will require significant decisions around size, shape and skill mix of future workforce aligned to priorities. The current operational planning (that is in progress) is an opportunity to achieve that.

How will we know controls are working? (Internal Groups and Independent Assurance)

- 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 morale.

Next Steps: (Actions)

1. Ongoing compliance and control tracking.
2. 2025/26 operational planning to agree affordable staffing levels and commitment to manage to that workforce plan Second submission due 27 March.
3. Scoping for system and region agency price cap compliance pilot project (April 2025).
4. Creation of a Workforce Intelligence Sub-Group to address data variations.
5. Creation of a Maximising Clinical Capacity Group as a regional pilot.

Risk Narrative:	**PRIMARY CARE:** As a result of workforce pressures and demand outstripping capacity, patient experience and pathways may not adequately meet the needs of our residents.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (no change since January BAF report)**
Risk Owner/Lead:	Pam Green – Basildon & Brentwood Alliance, Executive Lead for Primary Care William Guy, Director of Primary Care.	Directorate: Board Committee:	Basildon and Brentwood Alliance Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Patient Experience, Harm, Access, Additional Roles Reimbursement Scheme (ARRS), Hospital performance, reputational damage.	Associated Risks on Datix:	ID Nos 3, 21 and 52.

Current Performance v's Target and Trajectory

Workforce:

- National guidance now published on GP additional roles reimbursement scheme (ARRS) role – a growing number of PCNs are now utilising this initiative.
- Fellowship scheme: National funding ceased. Alternative local arrangements being considered.

Demand/Capacity:

- Available Appointments: Continued increase in overall consultation in primary care.
- Number of practices undertaking Total Triage has increased. ICB is promoting the use of transitional funding to support practices implement new approaches (ends March 25)

Barriers (Gaps)

- The period of Collective Action by the BMA has been paused in view of the 25/26 contractual settlement. The ICB will continue to address a number of issues identified with regard to prescribing and certain pathways e.g. electrocardiograms (ECGs), out of area providers with patients requiring continuous monitoring etc.
- 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.

How is it being addressed? (Current Controls)

- Access Recovery Plan – Over 50 practices have now been supported to move to the Modern General Practice model.
- Workforce development e.g. ARRS optimisation.
- Primary/Secondary Interface – programme of work to improve effectiveness.
- Initiatives for new GPs / Partners and to support other roles in practice teams.
- Refresh of the Mid and South Essex Primary Care Strategy.
- Development of services in other primary care disciplines (i.e. Pharmacy First, minor eye condition pathways, dental access pathway)

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

- 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.

Next Steps (Actions)

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

Risk Narrative:	**CAPITAL:** Insufficient capital to support all system needs, necessitates prioritisation and reduces our ability to invest in new opportunities, for transformational impact.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (no change since January)**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer. Ashley King, Director of Finance and Estates	Directorate: Board Committee:	System Resources Finance & Performance Committee Primary Care Commissioning Committee
Impacted Strategic Objectives:	Good quality care within financial envelope. Improve standards of operational delivery.	Associated Risks on Datix:	ID 58

Current Performance v's Target and Trajectory

- Delivering the capital plans as per the investment plan (pipeline).
- Future decisions to be made based on available capital and revenue resources.

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).

How is it being addressed? (Current Controls)

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

How will we know it's working? (Assurance)

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

Next Steps: (Actions)

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

Risk Narrative:	**Urgent Emergency Care (UEC) and System coordination** Risk that ICB and providers organisations are unable to effectively manage / coordinate capacity across the system, impacting on the system's ability to deliver effective care to patients.	**Risk Score:** **(impact x likelihood)**	**4 x 4 = 16 (no change since January BAF report)**
Risk Owner/Lead:	Samantha Goldberg, Executive Director of Performance & Planning Alan Whitehead, Associate Director UEC & SCC.	Directorate: Committee:	Strategy & Corporate Services MSE Strategic UEC Board and Finance & Performance Committee
Impacted Strategic Objectives:	Good quality care within financial envelope; Improve standards of operational delivery, Effective oversight, assurance and compliance; System partnership working.	Datix Risks:	ID No 26 and 93.

Current Performance v's Target and Trajectory

Emergency Department (ED) performance below constitutional standard, as are ambulance response times at MSEFT. ED performance – Q1: 75.2% and Q2: 72.7%, Q3: 68.1% and Q4 Jan/Feb) 67.9%. YTD 71.3% . Ambulance handover performance – Q1 89.7%, Q2 84.4%, Q3: 76.6% and Q4 (Jan/Feb) 72.2%, YTD 67.9%
Please refer to performance pack for trajectories.

Barriers (Gaps)

- Health and Social Care capacity to facilitate discharge into the right pathway impacts on MSEFT flow and community.
- MSEFT constraints to increase non-elective activity into SDEC due to bedded as escalation overnight capacity, specifically at Basildon and Broomfield hospitals.
- Workforce challenges (See Workforce Risk slide).

How is it being addressed? (Current Controls)

- The strategic and operational approach to managing winter incorporates a comprehensive plan to ensure the system can handle fluctuations in increased demand, potential disruptions whilst maintaining patient flow across the system, ensuring timely care and treatment, and good patient experience. There are four pillars 1) Operational resilience, ensuring the MSE system can withstand and respond to increased pressures during winter. 2) Improving co-ordination and collaboration & streamlining patient flow and discharge, a joined-up approach to enhance operational resilience with the creation of a Discharge Cell and co-location of services. 3) Enhancing urgent emergency care, strengthening service to provide timely and effective care overseeing plans to improve increased demand into SDEC and the deployment of the Unscheduled Care Co-ordination Hub (UCCH) minimum viable product. 4) Promoting preventative measures in encouraging vaccinations and supporting people & staff to stay well with strategies and approaches by communications.
  The Bed Model and the OPEL framework are frequently utilised as triggers and actions for delivering flow across the system and maintaining the 66 core G&A bed closures in MSEFT and minimising risk to opening of escalation capacity.
- Minimise attendance at ED by maximising attendance avoidance with all alternative urgent care pathways.
- Maximise discharge opportunities within the Discharge Cell with out of hospital virtual and physical capacity.
- Delivery of ED and Ambulance handover targets with newly appointed and commenced in February 2025, MSEFT Managing Directors in post to drive quality and improvement in the UEC standards.

How will we know controls are working?

- Monthly MSE Urgent Emergency Care (UEC) Board oversees performance reports into F&P committee and ICB Board.
- Hospital discharges monitored hourly/daily, shared with social care and continuing health care teams via daily situation awareness system meeting.
- Discharge Cell monitoring discharges to increase volume and reduce delays.

Next Steps

- Continuous monitoring of daily operations across providers to ensure delivery against winter plan and adjust plan where require (*ongoing).*
- Quality Improvement programmes at MSEFT to improve ED performance and ambulance handover delays, reduce length of stay, improve flow and retain escalation bed and general and acute bed closures by focusing on: 1) Board and ward rounds, 2) Home before lunch, 3) Red 2 Green and 3+ LOS (length of stay) daily reviews. *Ongoing.*
- Same Day Emergency Care (SDEC) plans to increase streaming patients to SDEC to reduced contribute toward ED performance reduce admission avoidance by supporting same day interventions for patients. *Ongoing*
- Unscheduled Care Co-ordination Hub MDT expanding with UCRT and NHS111 GP presence to support greater reduction in ambulance conveyances. *March 2025.*
- MSE participating in system risk assessment pilot, commencing with mental health patients who require urgent emergency care (April 2025).

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional or Operational Performance Standards.	**Risk Score:** (impact x likelihood)	**5 x 4 = 20 (based on highest rated risk score for diagnostic risk). No change since January report.**
Risk Owner/ Lead:	Matt Sweeting, Executive Director of Clinical Leadership and Innovation Aleks Mecan, Alliance Director Thurrock, Diagnostic SRO Samantha Goldberg, Executive Director of Planning & Performance (Elective & Cancer)	Directorate: Committee:	Clinical Leadership and Innovation, Thurrock Alliance, F&P Committee, MSE ICS Cancer Committee, MSE Diagnostic Board
Impacted Strategic Objectives.	Good quality care within financial envelope; Reduce health inequalities; Improve standards of operational delivery; Effective oversight, assurance and compliance; System	Associated Risks on Datix:	ID Nos 1, 2 and 13.

Current Performance v's Target and Trajectory

Diagnostics: Current plans on track to deliver operational planning commitment, currently performance 63% (the ask is to increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)
Cancer: Cancer Plan currently off track for delivery against operational performance For December 2024: Faster Diagnostic Standard 68.4% vs plan 78.4%, 62-day performance 53% vs plan of %
Referral to Treatment:
65+ week wait: MSEFT missed the National Operational Plan ask of zero people waiting over 65 weeks at the end of September 2024, the Trust are now working on plans for recovery of this position to ensure patients are treated and not waiting over 65 weeks.

Barriers (Gaps)

- **Cancer -** requires best practice pathways in place – System Delivery Fund (SDF) funding approved, MSEFT recruiting to the posts to support pathway delivery, Pathway analyser being completed to identify where there are opportunities for pathway improvement .
- **Diagnostic Capacity –** capacity across diagnostics is impacting delivery of the Faster Diagnostic Standard, this is being reported and overseen in terms of actions taken via the Diagnostic Performance Sub-Group of the MSE System Diagnostic Board and the Tier 1 Cancer meeting.
- **Elective** – Delivery of capacity to achieve recovery plans for 65+ weeks, reported and overseen within the Tier 1 RTT meeting.

How is it being addressed? (Current Controls)

Diagnostics:
- MSEFT have revised recovery plans for all modalities and trajectories will be overseen via the Quality, Contract, Review Meeting (QCPM) and incorporated into the 2024/25 operational plan.

Cancer:
- Daily review of patient tracking list (PTL) and next steps with all tracking focused on trajectory compliance. Weekly "huddle", monthly Cancer Transformation and Improvement Board, Cancer Committee and via the National Tier 1 meetings. Cancer Service Development Fund (SDF) schemes for 2024/25 in place to support cancer performance recovery.

Referral to Treatment (RTT):
- MSEFT sites working to maximise capacity utilisation for long waits through optimal clinical prioritisation and chronological booking. Oversight via the National Tier 1 meetings.

How will we know controls are working? (Internal Groups and Independent Assurance)

- ICB maintains oversight of performance against all NHS Constitutional Standards/Operational Plan asks, this will show the impact of actions via the performance reporting.
- **Diagnostics:** MSE Diagnostic reports to System Diagnostic Board. Deep dive at SOAC 28/02/25.
- **Cancer:** MSEFT Cancer performance report: Monthly System Oversight via Cancer Committee and Monthly Transformation and Improvement Board held which tracks delivery against SDF commitments. Fortnightly meetings with National Team as a Tier 1 Trust.
- **RTT:** MSEFT RTT Long Wait Report. Fortnightly meetings with National Team as a Tier 1 Trust.

Next Steps (Actions)

RTT and Cancer:
- Fortnightly Tier 1 meetings with national / regional team with oversight of actions, recovery and performance position continue. MSE System Cancer Governance review being completed for implementation on 1 April 2025.
- MSEFT Insourcing to support recovery and progression of mutual aid ask.
- Independent Sector support being progressed to support RTT recovery.
- Quality, Contract, Performance Meeting will oversee operational performance delivery vs plan.

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** MSE is a system facing significant financial challenges, agreeing a £96m deficit plan with NHSE for 2024/25. As part of the M6 position NHSE provided repayable Deficit Allocation Funding which adjusts the £96m deficit to breakeven. At month 10 the system is forecasting a deficit of £32.5m against this breakeven position. Failure to deliver the financial plan will place increased pressures across the whole system, impacting on our ability to deliver our intended outcomes.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (based on highest risk score for Risk ID 7 (Efficiency Programme). No change since January report.**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer	Directorate: Committee:	System Resources Finance Committee
Impacted Strategic Objectives:	Good quality health care within financial envelope; Reduce health inequalities; Improve standards of operational delivery; Develop and support workforce; Effective oversight, assurance and compliance; Innovative service improvement; System partnership working.	Associated Risks on Datix	ID Nos 7, 10, 14, 42.

Current Performance v's Target and Trajectory

The System has agreed its plan for 2024/25 submitting a revised profile in June 2024. At month 10 the overall health system position is a year-to-date deficit of £27.9m, and a revised forecast of £32.5m deficit against the plan of breakeven.

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.

How is it being addressed? (Controls)

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

How will we know controls are working? (Internal Groups & Independent Assurance)

- Delivery of the agreed revised 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.

Next Steps: (Actions)

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

Risk Narrative:	**INEQUALITIES**: Identification of groups at most risk of experiencing health inequalities and taking action to reduce these by improving access and outcomes.	**Risk Score: (impact x likelihood)**	**3 x 3 = 9, based on score for Risk ID 18 (reduced from 12 since last report in January)**
Risk Owner/Lead:	Rebecca Jarvis, Alliance Director South-East Essex. Emma Timpson, Associate Director of Health Inequalities and Prevention .	**Directorate: Committee:**	South East Alliance. Quality Committee; Audit Committee; Population Health Improvement Board.
Impacted Strategic Objectives:	Reduce health inequalities; System partnership working.	**Associated Risks on Datix**	ID Nos 18 and 45

Current Performance v's Target and Trajectory

- Basildon, Southend-on-Sea and Thurrock identified as having lower life expectancy and a greater inequality in life expectancy within their populations (source ONS 2020) .
- Core20PLUS5 (Adult and Children & Young People) inequalities data packs are being actioned by the Alliances and via Growing Well Board.
- PLUS group insights from Population Health Management team that identifies inequalities in health outcomes for certain groups circulated to Alliances highlighting opportunities for improvement in data capture.
- Health Inequalities dashboard complete and in final sign off phase. Population Health Improvement Board (PHIB) reviewing system ambitions based on JSNAs and PHM data and insights.

Barriers (Gaps)

- Capacity and resources to support prevention and health inequalities programmes when ICB focused is on financial recovery.
- Availability of Business Intelligence/Population Health Management resource.
- Quality improvement support for interventions.
- Financial resources are not yet sufficiently adjusted to reflect needs of population groups (proportionate universalism).

How is it being addressed? (Current Controls)

- PHIB provides system wide co-ordination and oversight for reducing health inequalities. PHIB along with Alliances provide oversight and direct priorities for health inequalities funding.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project including those part of financial recovery programme. EHIIA panel embedded and meeting monthly. Digital EHIIA tool final testing completed and further revisions required by Provide Digital before launching, discussions underway with health partners regarding wider adoption.
- Equality Delivery System (EDS) report finalised for 2024/25 covering the services of Heart Failure, Diabetes and Paediatric services.
- Bi-annual reports to the MSE ICB Board and ICP undertaken, next report due May 2024 to include 2024/25 Health Inequalities annual statement.
- Health inequalities dashboard published on Athena to identify and track impact of HI work.
- Targeted health inequalities funding in 2024/25 is supported Alliance level investment through trusted partners and system-wide strategic initiatives to address health inequalities for agreed priorities groups. All investments are subject to appropriate financial controls and triple lock. HI funding programme for 2024/25 developed and being considered as part of financial planning round.

How will we know controls are working? (Internal Groups and Independent Assurance)

- Internal audit report on ICB health inequalities arrangements provides substantial assurance
- Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE.
- Improvement in access and reduction of health inequalities as shown in performance metrics within HI dashboard.
- Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.

Next Steps (Actions)

- Launch of digital EHIIA tool (June 2025)
- Development of MSE ICS Ambitions for improving Population Health (May 2025).
- Implementation of Health inequalities funded programmes for 2025/26 if supported in the financial planning round (May 2025)

Risk Narrative:	**MENTAL HEALTH QUALITY ASSURANCE:** MSE Mental Health (MH) services have been identified as experiencing significant issues impacting on patient safety, quality and access which could result in poor patient outcomes.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (based on the highest rated risk referred to below, rated between 12 and 16). No change since January.**
Risk Owner/Lead:	Dr Giles Thorpe, Executive Chief Nurse	Directorate: Committee(s):	Nursing & Quality Quality
Impacted Strategic Objectives:	Good quality health care within financial envelope; Reduce health inequalities; Improve standards of operational delivery; Develop and support workforce; Effective oversight, assurance and compliance; Innovative service improvement; System partnership working.	Risks on Datix:	ID Nos 5, 22, 23 and 93.

Current Performance v's Target and Trajectory

- Sub-Optimal performance against several quality and contract indicators including SMI health checks and Out of Area (OOA) placements with 37 people placed out of area against a plan of 5 as of 27 of December 2024 and SMI performance currently at 50% against 75% of achievement in 12 months to end of the period (total percentage to get full check)
- Demand, capacity and flow issues resulting in long length of stay and continued out of area (OOA) placements of patients above the Long-Term Plan (LTP) expectation.
- Ongoing external scrutiny from media, Care Quality Commission (CQC) / Regulators, Lampard Inquiry.
- Ongoing HM Coroners cases with possibility of Regulation 28 Prevention of Future Deaths Reports (PFDR).
- Lack of equitable offer of services across MSE e.g. Autistic Spectrum Disorder (ASD) and wider neuro divergent pathway (NDP).

Barriers (Gaps)

- Strategic approach to all age Mental Health service, however lack of delivery pan-Essex.
- Data Quality issues and IT systems.
- Workforce challenges impacting on all services (see Workforce Risk on slide 4).
- System pressures to manage delivery (capacity).
- Flow through inpatient services.

How is it being addressed? (Controls)

- Provider reports taken to Quality Committee, alongside monitoring via the Quality, Performance, Contracting Meeting (QCPM).
- Attendance with 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.
- Quality Assurance Visits (QAV) attended by EPUT and Pan Essex ICBs to promote continued collaborative working, check and challenge, assurance of quality and patient safety, and compliance with regulatory requirements.
- Ongoing dialogue with EPUT' inquest team and Patient safety team to ensure information flows of upcoming HM Coroner cases are provided, to allow for ICB communications and senior leadership notification, ICB patient safety specialist and quality team continue to work with EPUT.
- Continued re-procurement of services alongside review of service provision

How will we know controls are working? (Internal Groups & Independent Assurance)

- Improved quality and contract indicators which are embedded and sustained.
- Improved and sustained capacity and flow, reduced length of stay, and reduced OOA placements.
- Outcome of Quality Assurance visits with embedded culture, quality, patient safety, and compliance with all contractual and regulatory requirements.
- Oversight of PFDR with the provider ensuring that all actions are embedded into practice.
- Accountability review with focus on provision and performance.
- Recent CQC inspection of Adult wards and PICU.

Next Steps (Actions):

- MSE ICB to chair MADE events to ensure system attendance, compliance, and oversight (April 2025).
- Continued joint QAV with system partners. (Ongoing)
- Continue monthly update meetings with EPUT for PFDR horizon scanning and receive monthly HM Coroners cases information from EPUT (Ongoing).
- Implementation of the mental health learning disability autism (MHLDA) inpatient quality transformation with final plan submitted 28 June 2024 (March 2025).
- Await recent CQC visit report and action plan (April 2025).

Partner Organisation Self Identified Red Risks (and scores)

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

- Financial Sustainability (25)
- Constrained Capital Funding Programme (25)
- Workforce Instability (20)
- Capacity and Patient Flow Impacting on Quality and Safety (20)
- Estate Infrastructure (20)
- Planned Care and Cancer Capacity (20)
- Delivery of Clinical and Operational Systems to Support delivery of business objectives (16)
- Cyber security (15)
- Occupational Health and Wellbeing Resources (16)
- Organisational culture and engagement (16)

Partner Organisation Self Identified Red Risks

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

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

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Nicola Adams
Associate Director Corporate Services
Nicola.adams15@nhs.net

Sara O'Connor
Senior Manager Corporate Services
sara.oconnor@nhs.net

www.midandsouthessex.ics.nhs.uk

Part I ICB Board Meeting, 13 March 2025

Agenda Number: 12.2

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 Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.
Dr Kathy Bonney, Interim Chief People Officer.

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Quality Committee and Remuneration Committee

5. Link to the ICB's Strategic Objectives:

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement in staff survey results by March 2026.
- To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.

7. Conflicts of Interest

None identified.

8. Recommendation

The Board is asked to note the revised policies set out in this report.

Revised ICB Policies

1. Introduction

The purpose of this report is to update the Board on new and revised policies which have been approved by the relevant committees since the January Board meeting.

2. Revised Policies

The following policies were approved by the relevant committees, as per the authority set out in the relevant committee terms of reference.

Committee / date of approval	Policy Ref No and Name
Quality Committee 28 February 2025	The Quality Committee approved the following revised policy: • 074 Community Communicable Disease Outbreak Incident Management Policy
Remuneration Committee 7 February 2025	The Remuneration Committee approved the following revised policies: • 044 Absence Management Policy • 052 Fostering Policy • 056 Dignity at Work Policy • 078 Reimbursement of Staff Expenses Policy The following new policies were also approved: • 028 Sexual Misconduct Policy • 057 Car Leasing Policy • 090 Cycle to Work Policy • 094 Staff Volunteering Policy The committee also agreed to extend the review dates of the following policies until June 2025: • 023 Freedom to Speak Up (FTSU) Policy. • 065 Management of Allegations Against Staff The extensions were requested to allow for the current negotiations regarding external support for FTSU services to Primary Care (Policy Ref 023) and for joint work between the Safeguarding Team and HR to conclude (Policy Ref 065).

3. Findings/Conclusion

The above policies ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities. The approved policies will be published on the ICB's website.

4. Recommendation

The Board is asked to note the new and revised policies set out in this report.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, 13 March 2024

Agenda Number: 12.3

Committee Minutes

Summary Report

1. Purpose of Report

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

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

2. Chair of each Committee

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

3. Report Authors

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

5. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

6. Recommendation/s

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

Committee Minutes

1. Introduction

Committees of the Board are established to deliver specific functions on behalf of the Board as set out within their terms of reference. Minutes of the meetings held (once approved by the committee) are presented to the Board to provide assurance and feedback on the functions and decisions delivered on its behalf.

2. Main content of Report

The following summarises the key items that were discussed / decisions made by committees as recorded in the minutes that have been approved since the last Board meeting.

Audit Committee, 15 October 2024

The following items of business were considered:

- The committee received a copy of the Board Assurance Framework submitted to the September Board meeting and the full corporate risk register.
- A deep dive relating to risks within primary care was presented to members.
- Update on the status of ICB policies.
- Update on the ICB's Freedom to Speak Up (whistleblowing) arrangements.
- Update on the ICB's arrangements to manage conflicts of interest.
- Overview of work being undertaken for the Data Security Protection Toolkit submission.
- Emergency Planning, Resilience and Response update.
- Health & Safety update.
- Register of Procurement Decisions, waiver report and update on losses and special payments.
- Internal Audit, Local Counter Fraud Specialist and Local Security Management Specialist updates.
- External Audit update.
- Service Auditor reports referenced in the Annual Report
- Minutes of other main ICB committees.

Clinical and Multi-Professional Congress, 27 November 2024

The following items of business were considered:

- An update on progress of the Improving Value workstream and future plans.
- An overview of the current financial position and future plans including 2025/26 opportunities and work being undertaken on the Medium Term Plan (MTP).
- An update on the prioritisation work being undertaken between ICB officers and the ICB's Executive Team.
- Horizon scanning to identify areas of work for discussion at future meetings.

Finance and Performance Committee, 7 January 2025

The following items of business were considered:

- The proposed 'Time to Care' inpatient mental health programme.
- System finance and performance report for month 8.
- Update on progress of 2025/26 planning.
- System financial sustainability
- Contract awards for NHS General and Acute Services 2025/26.
- Provide Tier II Contract 2025/26.
- Finance and performance related risks on the Board Assurance Framework and other risks within the remit of the committee.

Finance and Performance Committee, 5 February 2025

The following items of business were considered:

- System Finance and performance report for month 9.
- Forecast outturn 2024/25
- Capital update.
- 10-year capital template (Infrastructure Strategy) update
- Update on progress of 2025/26 planning.
- System recovery report.
- TPP SystemOne GP Enhanced contract extension
- Time to Care – 2024/25 Trading Account and Benefits Realisation Framework
- Minutes of the System Finance Leaders Group (SFLG) and the System Investment Group (SIG) meetings both held on 25 November 2025, and minutes of the Extraordinary System Investment Group held on 16 December 2024 were noted.

Primary Care Commissioning Committee, 11 December 2024

The following items of business were considered:

- Medium Term Plan update
- South East Essex Surgery closure.
- Primary Care Network changes
- Premises update.
- Primary medical services contracts update.
- Primary/secondary care interface update.
- Community Optometry update
- Community Pharmacy update.
- Primary care risk register and relevant BAF risk.
- Primary care quality update.
- Minutes of the Dental Commissioning and Transformation Group meetings held on 4 September, 24 October and 6 November 2024.

Primary Care Commissioning Committee, 14 January 2025

The following items of business were considered:

- Primary Care Strategy.
- Primary Care Local Dispute Resolution paper

- Primary Care Network – Thurrock reconfiguration request.
- Surgery Merger (Basildon and Brentwood Alliance) which was approved.

Quality Committee, 20 December 2024

The following items of business were considered:

- A deep dive on the progress with implementation of the Patient Safety Incident Response Framework (PSIRF) was presented.
- The ICB's Executive Chief Nurse reported escalations from Safety Quality Group and provided an update on emerging safety concerns.
- EPUT provided a mental health services update.
- Maternity services improvement plan overview.
- Safeguarding adults update.
- Learning disabilities and autism update.
- Palliative and end of life care update.
- Babies, children and young people update.
- Quality Impact Assessments undertaken.
- Patient experience update, including an update on progress with addressing the complaints backlog.
- Proposal for Structured Judgement Reviews.
- Patient Safety and Quality Risks update.
- The Committee provided feedback on draft Terms of Reference for the Infection Prevention and Control Oversight Group.
- The committee approved the revised Defining the Boundaries Policy, PSIRF Policy, and extended the review date of one other policy.
- An update on the arrangements to undertake the annual review of the committee's effectiveness during 2024/25.

3. Recommendation

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

Minutes of the Audit Committee Meeting

Held on 15 October 2024 at 1.00pm

via MS Teams and Face to Face at Phoenix Court

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.

Other attendees

- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Nicola Adams (NAd), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Head of Financial Services, MSE ICB.
- Jane King (JKi), Corporate Services and Governance Support Manager (minute taker), MSE ICB.
- Sara O'Connor (SOC), Senior Corporate Services Manager, MSE ICB (for Items 4-6).
- Iain Gear (IGe), Information Governance Manager, MSE ICB.
- William Guy (WG), Director of Primary Care, MSE ICB (for Item 5 only).
- Janette Joshi (JJ), Deputy Director System Purchase of Healthcare, MSE ICB (for Items 12-13).
- Barry Frostick (BF), Chief Digital & Information Officer, MSE ICB (for Item 11).
- Emma Larcombe (EL), Director, KPMG.
- Karen Swainson (KS), Head of Internal Audit, TIAA.
- Hannah Wenlock (HW), Anti-Crime Specialist, TIAA.
- Inge Damiaens (ID), Anti-Crime Manager, TIAA.

Apologies

- Jim Cook (JC), Deputy Director of EPRR and Operational Resilience, MSE ICB.

1. Welcome and Apologies

GW welcomed everyone to the meeting. Apologies were noted, as listed above.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the

meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

There were no further declarations raised.

3. Minutes and Action Log

The minutes of the ICB Audit Committee on 23 July 2024 were received.

It was highlighted that Melanie Alflatt did not attend the meeting on 23 July 2024 and should be removed from the list of attendees.

The action log was discussed and noted that all actions were complete.

Under Matters Arising, NA advised that following the recent committee effectiveness reviews, the Executive Committee agreed that the Individual Funding Request (IFR) process would transfer from the Quality Committee to the Audit Committee, to provide assurance that the process was followed robustly and consistently. There would be no requirement for the Audit Committee to be involved in arbitration and IFR trends would be shared with Alliance teams.

ACTION: The Audit Committee Terms of Reference should be updated to reflect the Individual Funding Request as a responsibility of the Audit Committee.

Outcome: The minutes of the meeting held on 23 July 2024 were approved as an accurate record, subject to the amendment highlighted.

4. Board Assurance Framework & Corporate Risk Register

SOC presented the latest iteration of the Board Assurance Framework (BAF) which was submitted to the Part I ICB Board meeting on 12 September 2024. An updated BAF would be submitted to the next Part I ICB Board meeting on 14 November 2024.

There were 8 ICB red rated risks outlined in the BAF. A summary of Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust's (EPUT) red rated risks were also included.

A copy of the Corporate Risk Register was also presented to the committee, which detailed 58 active directorate level risks. At the time of writing, updates for 13 risks remained outstanding. Members were asked to note that several of these risks were reported to the Quality Committee (QC) and would be updated prior to the next QC meeting on 25 October 2024.

Since the last committee meeting 3 risks had been closed and 6 new risks had been opened.

Outstanding risks would be reported to the ICB Operational Group on a monthly basis and the concerns would be taken back to the appropriate directorates. Any issues would be escalated to the Executive Team. It had been agreed that manual reminders would no longer be sent and reliance placed on automatic Datix reminders. Risk leads would be reminded that clear explanations of the actions taken to mitigate risks were necessary in updates.

A pilot was underway with the Business Intelligence & Data team to use Datix to record project risks.

GO noted that some assurances around risks were several months old and the delay made it difficult to pick out any slippage and address issues in a timely manner. NA highlighted that using Datix for risk management was a new way of working for the organisation and the Governance Team were working with directorates on the risk update process. It was hopeful that reporting outstanding risk updates to IOG and the Executive Committee would improve the timeliness of the process.

MH raised concerns around the wording of the controls outlined within the Court of Protection and Deprivation of Liberty Safeguards (CoPDoLS) risk relating to risk appetite. NA agreed and would arrange for the control wording to be reviewed.

ACTION: Review and update wording of the controls outlined within the Court of Protection and Deprivation of Liberty Safeguards (CoPDoLS) risk relating to risk appetite.

Outcome: The Committee NOTED the Board Assurance Framework and Corporate Risk Register update.

5. Primary Care Risk Deep Dive

GW welcomed WG to the meeting to present a deep dive into the BAF Primary Care risk. The purpose was to provide assurance to the Audit Committee that there was a clear plan to manage the risk, with metrics and milestones in place, provide understanding of the resources required and expected timing/resolution to mitigate the risk.

WG presented the actions being taken in Primary Care to address the risks and the effect the actions were having on patients, acute services, and the wider system. The challenges remained increased demand on primary care, workforce pressures and poor patient experience.

Following a question from GO WG advised that newly qualified GPs could now be recruited under the Additional Roles Reimbursement Scheme (ARRS).

GO enquired what action had been taken to improve patient experience. WG explained that poor patient experience was generally linked to difficulties in obtaining primary medical appointments. The introduction of Cloud Based Telephony systems provided improved GP access to patients and offered practices the functionality to manage calls more effectively.

GW enquired whether the number of acute patients turning up in A&E that should be seen in primary care or the community were known. WG explained that a recent one off audit undertaken by acute services of 450 presenting patients, between 50-80 were suitable cases for primary care.

JKe advised that MSEFT had been asked to look at the return on investment of having a GP service located in A&E. JKe added that there would always be an element of non-urgent cases presenting at A&E.

WG advised that a GP practice located close to Basildon Hospital found many of their patients were visiting acute services between 5-8pm when the practice was closed. The

practice was undertaking a pilot to extend their operating hours to manage these cohorts and to avoid presentation at the hospital.

Outcome: The Committee NOTED the presentation on the Primary Care risk deep dive.

6. Policy Update

SOC provided a progress update on the review of ICB Policies, including those within the remit of the Audit Committee, and requested the committee to extend the review date of the Incident Reporting Policy (Ref 024) until January 2025, while the new Datix incident reporting module was implemented.

Outcome: The Committee NOTED the update on progress with the review of existing ICB policies, including those within the remit of Audit Committee.

Outcome: The Committee APPROVED the extension of the review date of the Incident Reporting Policy (Ref 024) until January 2025.

7. Whistleblowing / Freedom to Speak Up update

NA invited GW, as the ICB's Freedom to Speak Up Guardian, to give an update on Whistleblowing / Freedom To Speak Up (FTSU).

GW advised that many of the issues received to date were around operational matters, particularly in areas affected by workforce reduction, and not issues covered by the FTSU policy, e.g. bullying and harassment issues.

FTSU training was now included in staff induction sessions and had been well received. The latest Pulse staff survey results also indicated the FTSU work undertaken by the ICB was positively received. It would be necessary, however, to establish the best way to support Primary Care Networks with FTSU.

GO enquired whether there was a coordinated approach towards FTSU at ICS level. GW explained that individual providers were required to submit their own data but agreed that a coordinated approach was needed across the system.

KS suggested that TIAA could support the ICB with FTSU, if required.

Outcome: The Committee NOTED the Whistleblowing / Freedom To Speak Up update.

8. Conflicts of Interest

NA presented the Conflicts of Interest update which provided an overview of the work being undertaken to obtain declarations of interest and manage conflicts of interest.

Following approval of the updated Management of Conflicts of Interest Policy in July 2024, new guidance on the management of conflicts of interest within ICBs had since been issued and consequently the ICB policy was under review again. Additionally, a policy / guidance document to better guide staff in managing potential conflicts when working with commercial organisations was being drafted to strengthen ICB processes.

The report provided the Audit Committee with assurance that processes to update the declarations of interest register and manage conflicts of interest were robust. However, independent assurance would be provided on these processes as part of the internal audit on counter fraud and conflicts of interest which was due to commence.

The governance team would be reviewing how best to develop its processes for gathering conflict of interest information and producing registers in the future in order to maximise efficient use of resources within the team. A copy of the ICB Board Register of Interests was included.

SOC confirmed the ICB had a robust new starters process in place which included automatic notifications from the NHS Electronic Staff Record (ESR). Following the reorganisation, a updated staff list was received which would support work on outstanding forms. SOC thanked the Governance Officer for working with the Business Managers to increase the number of forms returned.

In response to GO, NA confirmed that new appointees were asked to complete a declaration of interest at the beginning of the recruitment process. Although the onus was on employees to declare any new interests or changes to interests, the Governance Team also undertook an annual declaration of interest update.

Outcome: The Committee NOTED the update on Conflicts of Interest.

9. Information Governance Update

IGe provided the committee with an overview of the work undertaken towards the Data Security Protection Toolkit (DSPT) submission, the associated DSPT audit, and wider Information Governance (IG) related work across the ICB and ICS.

JM gave an update on the work the ICB was undertaking to deal with the changes to the DSPT required to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF). The ICB was working towards DSPT completion and submission at the end of June 2025, as required. The ICB was also looking at how it could work with ICS partners on the CAF.

GO noted the concerns the impact of the DSPT changes would have on resource and enquired what was needed to achieve the submission deadlines. JM explained that workforce capacity first needed to be understood. The main concern was that the impact on other teams' capacity to support was unknown, e.g. there would be a big impact on the Emergency Planning Team.

In response to GW, JM explained that ICBs were looking at common issues and themes together and how these may be resolved, the IG team were already linked in with ICBs across the East of England to share learning and ideas. The changes to the DSPT had also impacted ICS partners and issues were discussed at the Information Governance Steering Group.

JKe said there was capacity to undertake the work within the IG team but reiterated that it was unclear what the impact would be for other teams.

KS advised that TIAA were working through DSPT toolkit requirements and would be issuing guidance in due course. TIAA were also working with other ICBs across the country on DSPT and could link the ICB in with other ICBs if required.

Minutes of the Information Governance Steering Group held on 4 July 2024 were presented to the committee for information.

Outcome: The Committee NOTED the quarterly report on Information Governance.

10. Emergency Planning, Resilience and Response Update

NA presented the Emergency Planning, Resilience & Response (EPRR) and the System Co-ordination Centre (SCC) report on behalf of the Deputy Director of EPRR and Operational Resilience who was unable to attend the meeting.

The Urgent and Emergency Care (UEC) Team had submitted an SCC maturity index to NHS England (NHSE) with an initial rating of 'benchmarkable maturity', meaning the ICB's model was likely to be at the forefront of its kind and other organisations could learn from our approach.

The ICB was working with ICS partners on winter planning preparations, informed by national guidance published by NHSE in September 2024. There was no national winter funding available this year to support winter capacity schemes.

The ICB had submitted its annual NHSE EPRR Core Standards self-assessment with a provisional rating for 2024 of 'substantial compliance' which was subject to a 'confirm and challenge' session with the regional NHSE team in November 2024. Provider assurance would be presented in January 2025. A copy of the self-assessment submission was provided to the committee for information.

In response to GO's query on the impact of collective action, NA explained that an update paper had recently been presented to the Executive Committee and no major issues were flagged, additionally no issues had been raised at the Primary Care Commissioning Committee. JKe suggested sharing the Executive Committee paper with the Audit Members for information.

ACTION: Circulate Executive Committee GP Collective Action paper to Audit Committee Members.

Outcome: The Committee NOTED the quarterly EPRR Update and NHSE EPRR Core Standards submission.

11. Health & Safety Update

BF presented the Health and Safety (H&S) report to the Audit Committee. Since the creation of the Health and Safety Working Group (H&SWG) in early 2024, progress continued to be made to enhance the organisations approach to health and safety however work was still required to improve compliance levels for the annual working from home / Display Screen Equipment (DSE) risk assessment which was approximately 45%. The low compliance rates had been shared with the ICB Executive.

Staff were regularly reminded of the organisations [manual] Incident Reporting arrangements and work would take place later in the year to move the process onto Datix.

NA advised that work was taking place with Business Managers to improve the poor level of compliance with completion of DSE assessments, which had a positive impact. NA expected the ICB to be fully compliant with DSE assessments by the next Audit Committee.

GW took the opportunity to ask BF about the recommendations made in the TIAA Security Management report (included under Item 16) as he was concerned about delay in implementing the recommendations. NA assured GW that the recommendations made within the report would be addressed by the next Audit Committee.

It was noted that the responsibility for Health & Safety was moving to the Governance team. BF would continue to chair the H&SWG.

Minutes of the Health & Safety for 4 July 2024 were presented to the Audit Committee for information.

Outcome: The Committee NOTED the Health & Safety update.

12. Contract Governance & Procurement Register

JJ presented the Register of Procurement Decisions detailing the 30 decisions (which had a published Contract Award Notice (CAN) on the Find a Tender service, for Mid and South Essex Integrated Care Board) for contracts awarded between 16 July 2024 and 1 October 2024. From 1 April 2024, the ICB's procurement specialists, Attain, had taken over the responsibility of maintaining and producing the Register of Procurement Decisions.

MH enquired whether there was a reason for the high volume of short contracts awarded. JJ explained the length of contracts depended on the service and nature of contract but it was often to align contract end dates.

The latest Procurement Register would be published on the ICB website following review by the Audit Committee.

Outcome: The Committee NOTED the Contract Governance update and the latest iteration of the Procurement Register.

13. Waiver Report

JJ presented the Waiver Report. There were 11 procurement waivers signed since the last Committee totalling £1,629,978. Members held a brief discussion on the nature of the waivers, but gained assurance that due process was being followed.

Outcome: The Committee NOTED the Waiver Report.

14. Losses & Special Payments

The ICB Board approved the payment of a settlement invoice in relation to a Clinicabin, the cost of which had been recovered from North East London NHS Foundation Trust (NELFT).

Outcome: The Committee NOTED the special payment.

15. Internal Audit

KS presented the Internal Audit Progress Report, detailing the progress of work undertaken against the 2024/25 Internal Audit Plan. The report highlighted a new Internal Audit Code of Practice.

Three final audit reports had been issued, with the Health Inequalities and Population Health Management rated as 'Substantial' and Primary Care Estates (Part 1) and Collaboration and Partnerships with 'Reasonable' assurance.

There were proposed changes to the audit plan. It was suggested that the Data Security Protection Toolkit (DSPT) was moved to next year's plan to align with national submission timescales and, as the Continuing Health Care team had recently undergone significant operational changes, it was proposed to move the audit to the next financial year once new processes were in place and embedded.

A Governance and Board Assurance/Risk Management audit was due to commence in November 2024 and a Conflicts of Interest audit would follow, undertaken jointly by Internal Audit and Counter Fraud.

In response to GW, JKe agreed to discuss audit priorities with the team and identify a suitable time for the CHC audit next year. Any unused plan days would be moved to contingency.

It was noted that there were three outstanding audit recommendations and that revised due dates had been issued for each.

In response to GO, NA advised that risk management was incorporated into each of the alliances but did not cover provider risk. There was a difference across alliances in maturity but all operated within the ICB's Risk Management framework and had slightly different governance in place. In time, each alliance would have their own individual risk register.

GW suggested a Board development session on health inequalities funding and how funding was spent.

ACTION: Schedule a Board development session on health inequalities funding and how funding was spent.

Outcome: The Committee NOTED the Internal Audit update.

16. LCFS/LSMS

HW presented the Anti-Crime progress report which summarised the proactive work completed against the 2024/25 work plan. The report also included a summary of the status of investigations and referrals since the last paper presented to the committee, noting that the one open case was pending closure.

JKe enquired whether there was still a high number of primary care referrals being received. HW reported numbers had levelled off.

ID provided an update on the Security Management work plan for quarter 2.

GW enquired whether the recommendations made in the Site Security Review for the ICB Headquarters would be completed by the end of November 2024. NA advised the ICB would respond to the recommendations by the end November 2024.

Outcome: The Committee NOTED the update from the Local Counter Fraud and Security Management Services.

17. External Audit

EL confirmed that planning for 2024/25 audit cycle was due to commence which included the Mental Health Investment Standard work.

Outcome: The Committee NOTED the update from External Audit.

18. Service Auditor Reports

NA noted that the Service Auditor Reports, referenced in the Annual Report, were provided to the committee for information.

Outcome: The Committee NOTED the Service Auditor Reports.

19. Minutes of other ICB Committees

The following minutes were presented to the committee:

- Finance & Investment Committee – 4 June 2024, 2 July 2024, 6 August 2024.
- Quality Committee – 28 June 2024.
- Primary Care Commissioning Committee – 12 June 2024, 10 July 2024.
- Clinical & Multi Professional Congress – 26 June 2024.

Outcome: The Committee NOTED the minutes of the sub-committees.

20. Any other Business

There was no other business to discuss.

21. Items to escalate

No items to escalate

22. Date of Next Meeting

1.00pm–3.00pm, Tuesday 21 January 2025.

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 27 November 2024 at 09.30 am – 11.00 am

Via MS Teams

Members

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Fatemah Leedham (FL), Pharmacy.
- Sarah Zaidi (SZ), Primary Care.
- Donald McGeachy (DM), Urgent and Emergency Care.
- Owen Richards (OR), Resident Engagement.
- Simon Griffiths (SG), Social Care.
- Krishna Ramkhelawon (KR), Public Health.
- Feena Sebastian (FS), Mental Health.
- Ronan Fenton (RF), Acute Care.
- Gerdalize Du Toit (GDT), Community Care.

Attendees

- Helen Chasney (HC), Corporate Services & Governance Support Officer (Minutes).
- Scott Baker (SB), Director of Allied Health Professionals and Leadership, MSE ICB.
- Philip Read (PR), Associate Director of Central PMO, MSE ICB.
- Ashley King (AK), Director of Finance and Estates, MSE ICB.

Apologies

- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Holly Middleditch (HM), Senior Clinical Fellow, MSE ICB.
- Rachael Marchant (RM), Primary Care.
- Babafemi Salako (BS), Primary Care.
- Odutola Olugbenga (OO), Primary Care

1. Welcome and Apologies

MS welcomed everyone to the meeting and apologies were noted as listed above. It was confirmed that the meeting was quorate. A round table of introductions was provided.

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 meeting held on 28 August 2024 were approved.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 28 August 2024 were approved.

4. Matters Arising/Action Log

Action 5 – Further information would be sought and brought back to Congress for final sing off. Action to be closed.

Action 6 – The agreed governance structure for Service Restriction Policies was for Congress to provide expert clinical advice, then Executive Committee for sign off where minimal change was required. For significant changes, a formal business case or consultation would be required. Action to be closed.

There were no further matters arising.

5. Improving Value workstream

SB provided an update on the progress on the improving value workstream and future plans, including the possibility for Congress members to support with specific questions and guidance.

It was previously reported that the Service Restriction Policies (SRPs) and the Evidence Based Interventions (EBIs) were separate and a process to join them together had been completed. The key focus were the financial challenges so opportunities were identified that could make financial savings or improve productivity and value through the either EBIs or SRPs. The Procedures of Limited Clinical Effectiveness (POLCE) had four interventions in category 1 and 13 interventions in category 2 and the difference in effectiveness level and whether they were recommended to be utilised for treatment modalities was noted.

The identification of opportunities with EBIs was a challenge due to the complexity of unintended consequences with patient outcomes and experience, so a data methodology was utilised to identify different areas where opportunities could be proceeded. A further complexity was the decision making on whether or not to proceed.

An example was provided of injections for nonspecific low back pain without sciatica (category 1 procedure), with a value of £3 million per year, so consideration should be given to whether diagnostic scans were required, the impact on the treatment and care provided and also whether a guided injection was vital or could this be given blinded. The evidence suggested that the outcomes were the same. Consideration should also be given with regards to moving care closer to home and upskilling current resources in primary care and the Additional Roles Reimbursement Scheme (ARRS) roles and whether guided injections could be given using ultrasound scanners. Further work was required to determine whether activity was being carried out outside of secondary care.

Further work was required on data validation and conversations had begun on the possibility of coding issues. A cross directorate group would consider the unintended consequences, and support was provided by colleagues from the quality workstream to understand the

impact if a certain activity was reduced or ceased. Congress could be involved to stress test a particular intervention to ascertain whether it would be a good idea to proceed or not. Good clinical engagement and wider public engagement would be required for any significant changes.

MS highlighted that the withdrawal of value-based healthcare did not always release source because of the infrastructure.

SZ welcomed the approach and commented that the challenge would be how to complete an analysis based on value as some national bodies had not yet evolved to doing value-based analysis. The ICB could be leaders in the methodology and seek stewardship expertise.

RF commented that the logic was obvious, both financially and clinically. However, the practicality of deployment and how it would be received would be a challenge. It would need to be communicated that it was not just about finances but also logical management of health care resource which ultimately benefitted everyone, and the stewardship route would most appropriate to provide the support.

GDT commented that the system was in a position where lots of activities were potentially not adding value, not doing activities that adds value and drives additional activity that would not add value, so a solution was required that if an activity was ceased, what value-based activity could be done to provide better outcomes for the population. The challenge and benefit of engagement should not be underestimated.

RF commented that the alternative must have benefit and needed to be communicated positively.

SG requested consideration of what the alternative treatment and the prevention intervention would be as something clinical could be ceased notwithstanding the patients' needs and not linked to the strategic aims across mid and south Essex (MSE) and the alliances. The alternative could be the social model to reduce costs and reinvest as there could be an increase in people experiencing more pain.

KR commented that clear communication to the public would be important and clinical signoff should be through the stewardship work, but consideration should also be given to the political dimension that could be faced. The expectation was that radical change was needed for the system to restore a good financial position. A simple approach was required, and the principles should include how clinical would be utilised to demonstrate the position comparatively. The utilisation of stewardship to inform some of these conversations was important and engagement with the population should be tangible and meaningful.

OR referred to compliance with NICE and Getting it Right First Time (GIRFT) and asked if the system were aware of all the evidence-based recommendations and whether all opportunities had been undertaken before considering starting something new. Consideration should be given to the patients' perception of effectiveness. The public might see on social media that they should be getting a certain treatment but when they see the consultant they might be offered something different. Work was happening in the system on shared decision making and personalisation which could impact on this. There were system responsibilities about socio-economic wellbeing and consideration was required on whether unintended consequences would be impacted which would link into the alternative question.

FL advised that the role of the dexa scan was currently being reviewed in the management

of osteoporosis and requested that alternatives were considered.

SZ agreed with SG that the public should be involved and felt empowered which would support myth busting. If the evidence base was strong and there were other more effective alternatives that would result in a better outcome or carry a lower risk of harm, then this should be communicated to the public in a way that they would then recognise that this was about improving standards of care received in a value based way that offered less risk of harm and made them better informed. High quality shared decision making was the national challenge which was not yet embedded within the culture of frontline clinical practice.

DM agreed with SG about the need to provide alternatives which could provide temporary relief. The challenge with looking at value was that it may be more expensive, so would need to carefully review the changes being made in case activities were being removed without having alternatives in place. The complexity of the NHS coding system required expertise to interpret the coding. When activities were stopped several codes would be stopped, however other codes could also indicate that an activity should not be done anymore.

FS asked whether other ICBs were offering similar treatments, as there were issues when services were provided in one area and not in another. SB gave category 1 procedures as an example and advised that it was compared nationally, and MSE were an outlier for lower back pain. FS suggested the inclusion of that narrative to support acceptance. All interventions were nationally benchmarked.

GDT commented that some activities would support left shift and investment in alternatives could be costly. The benefit to the economic outcome for the population needed to be harnessed, so a review was required of the population health management and wider determinants that added real value to people, such as work, home and family and would evidence how well the system partnership worked to evidence decisions in health.

MS advised that Congress would receive further updates in the future and summarised the following key points of discussion, how this should be structured, the narrative, clear communication, stewardship principles, left shift, benchmarking with other systems, the complications with the detail when audits were completed and that clinical expertise would be needed to complete those audits as they had a better understanding of the service.

Outcome: The committee noted the verbal update on improving value workstream.

6. Financial Recovery Overview

PR provided an overview of current financial position and the future plans including 2025/26 opportunities and the work on the Medium-Term Plan (MTP).

The plan agreed with NHS England (NHSE) for 2024/25 was for a £168 million financial efficiency programme which moved the system to a £95 million deficit position. At month 7, the system was £32 million deficit to plan. The ICB was experiencing some pressures around All Age Continuing Care (AACC) but were aiming for a break-even position. Across the system, EPUT were currently £6 million off plan and MSEFT were £23 million off plan. A slight upward trend was noted due to the Investigation and Intervention work, supported by Price Waterhouse Cooper, so plans had started to impact, however, there was more to do to reach the year end deficit position.

MSEICB was not the only system with a challenged financial position. Two East of England

systems were in the top 8 most challenged systems across the country with MSE sitting at number 8 and Norfolk and Waveney at number 4. The regional position at month 7 demonstrated all ICBs were extremely challenged in terms of their financial position. Most of the East of England systems efficiency plans had started to deliver, however MSE were 70% in terms of confidence with the in-year delivery of efficiency, so there was more work required in year.

The ICB had an ambitious programme of £48 million target for 2024/25 and there was a significant risk with delivery. Work was underway with finance business partners and directorate leads to prioritise spending, release budgets where possible and make improvements. Congress members were asked to feedback any ideas to the Programme Management Office email address which would be taken through due diligence and reviewed to ascertain if opportunities could be realised in the current financial year or come to fruition next year.

The mobilisation of large change programmes that could deliver in year efficiencies in months 7 and 8 was a challenge, so the focus was on what significant change could be brought forward into next year. MSEFT and EPUT were also reviewing their efficiency targets for next year. Within the ICB, the working principle was that the efficiency target would be similar to this year, however confirmation would be received nearer to the end of the financial year. Some schemes in primary care were planned to be mobilised this year and would be transferred into next year and also several procurements underway that would be delivered next year. Several system opportunities and functions were being reviewed and would be included in the Medium-Term Plan. Conversations were being held on how service redesign could be delivered and some significant large-scale change through collaborative working. Also reviewing activities in scope and several opportunities were underway to potentially redesign or have a different service offer moving into 2025/26.

There were some key principles for the remainder months of the year, such as the continuation of triple and triple lock and vacancy freezes, the service development funding (SDF) and additional funding, however additional capacity and capability constraints would be required to deliver those programmes of work so the ICB and system would need to provide an overhead contribution. Budget spend was being reviewed and as there would be no reserve for 2025/26, there would be focus on holding budget conversations.

The Medium-Term Plan (MTP) process had commenced. PA Consulting had joined the organisation for eight weeks with an ambitious programme of work, phased into three areas. The current phase (Phase 1) was undertaking a diagnosis of the real challenges in the system to fully understand the forecast position. Phase 2 would be prioritisation and understanding the large-scale programmes that would move the system to a more sustainable position and Phase 3 would be the system wide delivery plan. The scope needed to be strategic and focused on 3–5-year routes to financial sustainability across all organisations in the system, with a set of 8-10 key prioritised collaborative strategic options and objectives. Conversations on an agreed financial model had started and solutions needed to be delivered by providers in the system.

The principles were in line with national principles such as treatment to prevention, acute to community care and analogue to digital and a suite of activities were being reviewed from population, patient, people, providers, and partners perspectives. Several key conversations were being held, and included clinical congress and clinical engagement and the PMO team would be linking in with stakeholders across the system to ensure that those conversations

were happening as part of this strategic programme of work.

The 8-week programme should be delivered mid-January 2025 with MSEICB Board signoff and ultimately the MTP would go live for April 2025/26.

GDT suggested for the stewardship forums to be involved in the early scoping phase of the MTP as they would have the knowledge of how to radically transform services.

KR suggested that the high-level plan and proposals were shared with the Chair of the Health and Wellbeing Board and Leader of the Councils, and that early engagement was required.

SZ commented that the aim was to move to left shift, sickness to prevention model and acute to community, but would need to prioritise to achieve this. An intelligent analysis was required of the activities modelled as quick result and quick impact to transfer the resource to activities with longer term benefits. MS explained that the model would be optimised in the next few weeks with PA Consulting.

RF commented on the lack of clinical engagement in secondary care, which could have happened in other areas of expertise, so could take 2 years for them to take ownership and responsibility. SZ commented that time should be dedicated to engaging and empowering the front-line staff.

SG commented that a cultural shift in ownership across the whole workforce and people in receipt of care was required. A practical suggestion was made for the ICB to review activities which could be double funded. MS advised that joint brokerage with local authorities was currently being reviewed.

OR commented that the narrative needed to be presented collaboratively with system partners with opportunities for the local population to contribute.

PR confirmed that wider system and clinical engagement would be discussed with PA Consulting colleagues. John Walter, Director of Operations for AACC, was working on the Discharge to Assess pathways and reviewing current frameworks system wide so assurance was provided that system wide collaboration was being undertaken.

Outcome: The committee noted the verbal update on financial recovery.

7. ICB Prioritisation work

AK provided an update on the prioritisation work undertaken between the ICB Officers and ICB Executive team.

The ICB were currently operating with resource constraints following the restructure process, which did not include a review of the work undertaken, therefore, a prioritisation process was required to identify areas of focus. Teams were asked to consider what could be done over and above their business-as-usual requirements within existing resource over the next four months, and the Medium-Term Plan (MTP) would focus on priorities from April 2025 onwards.

The Executive Team had identified 18 key areas of focus which mainly consisted of functions within the ICB, such as alliances, mental health and learning disabilities and quality. Each team were asked to identify key areas of focus and if these areas delivered specific improvements, what areas could be stopped or paused.

The alliances were provided as an example who had identified key areas of focus such as FREDA rollout and to increase uptake with a targeted approach and improvement in uptake of end-of-life register. The alliances identified activities to pause, such as carers and veterans where an annual return would only be required. They had also identified several areas where they had input or impacted other workstreams, such as supporting community equipment, MSK procurement and interface work.

The delivery team identified musculoskeletal (MSK) and pain as a priority, along with dermatology, eye care, women's health, Community Diagnostic Centre programme, some specific areas of cancer and Tier 2 service reviews. Areas to be stepped down included additional transformational redesign works for cancer, Ears Nose and Throat (ENT) although prioritisation for this would need to be fluid. Key areas for the primary care commissioning team were GP collective action, roll out of vaccination programmes, dental services and redefining the primary care strategy.

The next steps were for Business Informatics (BI) colleagues and central programme management office (PMO) to review the data currently available to use as proxy measures for improvement, which would be monitored through a commissioning forum due to commence in December.

SZ commented that the areas of focus should be where differences could be made and referred to the end-of-life registers as an example where the focus on Advanced Care Planning could be more appropriate and was measurable on Athena. Engagement was required from the front line, with an inductive approach to drive this in every part of the system. AK explained that the right metrics might be captured now but better ones could be extracted and whether the right metrics were being captured to move the dial and were activities being done at the right time for that metric to be meaningful. Culture change would not be achieved in four months and should be considered as part of the MTP work. MS commented that the number of people trained for an activity could be monitored but would not count the cultural movement in some respects.

RF commented that cultural change was difficult and complex with regards to promotion and needed expertise, possibly beyond Congress and would be a long-term approach. MS commented that some cultural change work had been completed through educational grant funding, such as end of life and frailty.

OR commented that culture change was also about the community and how people's perceptions could be changed on what could or couldn't be done. OR asked whether some inequalities could be increased through this process and what risk assurance mechanisms were in place. Patient choice was currently a challenge which could be cultural, but also linked in with patient safety issues due to delays in the pathway, so for a patient to have the opportunity to go somewhere else to have that diagnosis and treatment also contributed.

MS commented that the culture of patient choice would be fed into the MTP. The number of people on registers could be counted but it would be the clinical intervention that would move the dial and would be where clinicians could support and potentially the system could help target areas that were not doing well.

GDT commented that FREDA would make a difference to the MSE population as evidenced

by the previous initiative 'Connect with Neighbourhoods'. With regards to OR comment, with the 30% reduction in resource, difficult decisions needed to be made from a purely health perspective but keen to understand how other partners could support that work. The importance of prioritising cultural and engagement with colleagues in secondary care, community and primary care, and the MSE population should not be underestimated. If the perspective could be changed to be a collective effort on agreed outcomes for the population, then that's what should be aimed for. MS confirmed that the feedback on engagement would be provided at the forthcoming MTP meeting.

Outcome: The Committee noted the verbal update on the ICB Prioritisation work.

8. Horizon Scanning

MS confirmed that areas of work for discussion at future meetings would be:

- MTP work
- POLCE/EBI work
- Business Case for Community Beds Update
- Potentially merger opportunities and estate changes within the system

9. Any other Business

MS thanked Donald for his contribution over many years in various roles.

There were no further items of any other business raised.

10. Date of Next Meeting

Wednesday 18 December 2024 at 9.30am – 11.30am via MS Teams.

Minutes of the ICB Finance and Performance Committee

Held on 7 January 2025 at 2.00pm

ICB Headquarters and Microsoft Teams meeting

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, MSE ICB, **Chair**
- Tom Abell (TA) Chief Executive Officer, MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member and Vice Chair, MSE ICB
- Jo Cripps (JC) Executive Director of System Recovery, MSE ICB
- Laura Davis-Hughes (LDH) Local Authority representative, Essex County Council (ECC)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Diane Leacock, Non-Executive Director, Essex Partnership University Foundation Trust (EPUT)
- Julie Parker (JP) Mid and South Essex NHS Foundation Trust (MSEFT)
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Sam Goldberg (SG) Urgent Emergency Care System Director, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB (part) via Microsoft Teams
- Dawn Scrafield (DS) Chief Finance Officer, MSEFT (agenda item 5.1 & 5.2) via Microsoft Teams
- Katie Arnold (KA) Programme Lead for Strategic Capital, MSEFT (agenda item 5.1 & 5.2) via Microsoft Teams
- Simon Covill (SC) Director of Operational Finance, EPUT (agenda item 5.3) via Microsoft Teams
- Elizabeth Wells (EW) Director of Mental Health Urgent Care & Inpatient Services, EPUT (agenda item 5.3) via Microsoft Teams
- Janette Joshi (JJ) Deputy Director of Contracting, MSE ICB (agenda item 9) via Microsoft Teams
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes) via Microsoft Teams

1. Welcome and apologies

JF welcomed everyone to the meeting in particular new members Laura Davis-Hughes, local authority representative and Diane Leacock, Non-Executive Director, EPUT.
Introductions were conducted and the meeting was confirmed quorate. There were no apologies.

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 had a potential conflict for agenda item 9 (Contract Awards for NHS General & Acute Services 2025/26) as an employee of MSEFT. JP and DL had a potential conflict for agenda item 10 (Provide Tier II Contract 2025/26) and recused themselves from the meeting at the point the agenda items were discussed.

DL declaration had not been included within the register (as a new member), but clarified she had no further conflicts with remaining agenda items. NA confirmed an updated Register of Interests would be available for the February meeting.

Outcome: The Register of Interests was noted.

ACTION: An updated Committee Register of Interest was to be provided at the February meeting.

3. Minutes of previous meetings

The minutes of 3 December 2024 were agreed as an accurate record.

Outcome: The minutes of 3 December 2024 were approved.

4. Action Log / Matters arising

Following a query from JF, NA advised assurances were being sought on the business case for Hybrid Closed Loop (HCL) systems for managing blood glucose levels in Type 1 Diabetes, in readiness of progressing a paper to Board.

Outcome: The action log was noted.

5. Business Cases

5.1 This item has been minuted confidentially.

5.2 This item has been minuted confidentially.

5.3 Time to Care

The paper was originally presented to the Finance and Performance Committee on 5 November 2024 providing an overview of the proposed Time to Care (TTC) inpatient mental health programme. The paper had since been updated to include key financial details and outlined an ask for ICB investment of £11.3m over a four-year period.

The case assumed a 35% reduction in out of area placements and would reduce pressure on urgent and emergency care beds. The case aimed to reduce length of stay from 60 to 30 days and provide patients with therapeutic intervention from day 1. The primary benefits of the staffing model would improve the quality and safety of the care delivered, a key area of focus of the Lampard Inquiry, creating consistency across wards in Essex. A small surplus was outlined in Year 5.

Following a query from LDH on recruitment to posts, EW confirmed a number of posts had already been recruited, recruitment of student placements was also underway.

It was noted that a large proportion of the core allocation of the Mental Health Investment Standard would be used to fund the case. There was a wider discussion on the funding ask and the rationale to prioritise the case over other areas. The Committee recognised the challenges and agreed the

proposal was the right approach for MSE. The need to capture the case into Medium Term Plan was highlighted.

The Committee asked for some amendments to the paper in readiness for presentation to the ICB Board, namely that the paper clearly articulated how benefits would be tracked and the requirement to use a high proportion of the Mental Health Investment Standard and the risk this posed limiting the ability to invest elsewhere.

SC agreed to implement a tracker to capture and monitor the intended benefits.

The Committee agreed the principle that funding of the case was on an actual incurred basis or that funding was redirected back into the Mental Health Investment Standard.

Outcome: The Finance and Performance Committee supported progression of the Time to Care Business Case to the Part two ICB Board.

Assurance

6. System Finance and Performance Report – Month 8

JK presented the Month 8 report and highlighted a £1m in-month improvement to the System deficit. The Month 8 year to date position was £31m off plan. It was corrected MSEFT delivered a surplus in Month 8 of £0.5m, not £0.8m as shown in the paper.

JK highlighted the level of risk within the System position was high. The cost of all age continuing care continued to present as a pressure and had seen an increase in activity in the Month 7 position.

The cost of Mental Health inpatients and out of area placements continued to be a significant pressure within EPUT as did the significant provision made for the Lampard Inquiry.

MSEFT had identified the likely forecast based on current interventions was a deficit of £19m. This figure included Deficit Support Funding received from NHS England. The position for EPUT was being worked through.

JK highlighted sustained operational pressures over recent weeks within the trust and reported high numbers of flu and the associated costs would likely impact the Month 9 position.

MB asked that a review be undertaken to ensure spend was delivering as intended. JK explained the productivity plan would highlight specific areas MSE was an outlier in terms of output compared to other Systems. The productivity plan would help to identify areas of focus, this formed part of operational planning for 2025/26. Nationally, it was anticipated Corporate was an area where productivity gains could be made.

The Committee welcomed the improvement in the Month 8 System position but recognised the challenge for 2025/26.

It was suggested there was a focus on risks associated to cancer and elective care at a future meeting. The Committee welcomed more narrative in the Performance section of the report to explain actions being taken to improve performance.

Outcome: The Committee noted the Month 8 Finance and Performance Report.

Action: It was agreed there would be a focus on Cancer and Elective care at a future meeting.

7. Planning

Despite a delay to 2025/26 planning guidance, planning continued to progress. It was anticipated guidance would stipulate a reduction in performance measures and there would be an enhanced focus on delivery of the 18-week trajectory until March 2029. It was believed this would impact payment mechanisms such as the Elective Recovery Fund.

It was not anticipated there would be an uplift in the core allocation for MSE for 2025/26, as such MSE would need to reduce its cost base significantly.

JK asked that a separate session on the ICB and System plan was scheduled to a future agenda.

Outcome: The Committee noted the verbal update on planning.

Action: An additional session on the ICB and System plan be scheduled once the planning guidance is released.

8. System Financial Sustainability Board Report

Engagement with PA Consulting to support medium term planning was due to conclude in the next two weeks. PA Consulting had worked on a long list of priorities to identify significant items that would support the future financial position. Some comparison work had also been undertaken to assess MSE against its peers.

Key areas included prevention, urgent and emergency care, flow, acute re-configuration and pharmacy.

Outcome: The Committee noted the verbal update on System Financial Sustainability.

9. Contract Awards for NHS General & Acute Services 2025/26

JP had a potential conflict of interest and left the meeting whilst the agenda item was discussed.

The Committee received a paper regarding 8 contracts with NHS providers of General and Acute services (with a contract value in excess of £5m) that were due to expire on 31 March 2025. The Committee were satisfied with the recommended contract renewal approach.

Outcome: The Committee:

- **Agreed to award a 3-year contract to MSEFT for General and Acute Services from 1 April 2025 under PSR Direct Award Process (DAP) A.**
- **Agreed to award 1-year contacts to the NHS Acute providers specified in the paper, for General and Acute Services from 1 April 2025 under PSR Direct Award Process A.**
- **Supported the move to an Associate arrangement for Barking, Havering & Redbridge NHS Trust from April 2025.**
- **Noted that contract values for 2025/26 would be calculated in line with national guidance and using the ICB's planning principles.**

10. Provide Tier II Contract 2025/26

JP and DL had a potential conflict and left the meeting whilst the agenda item was discussed.

The paper proposed an approach for the commissioning of Tier II services as the existing contract was due to expire on 31 March 2025. JC reported the commissioning responsibility for direct access

diagnostics had been passed back to the ICB due to capacity constraints within MSEFT. The ICB had enacted a direct award to the current tier 2 diagnostic provider to ensure continuity in service provision for the next 12 months whilst future commissioning arrangements were considered.

JJ confirmed a review was being undertaken of expenditure to ensure it was as expected.

Outcome: The Committee approved the proposal to award a 12-month contract to Provide CIC for Tier II services, noting the variable service line end dates.

11. Board Assurance Framework / Finance Risk Register

The Committee were presented with the Finance Risk Register and the finance and performance related risks on the Board Assurance Framework.

Work had commenced to embed risk management within the Committee including referencing risks on the agenda. Further work was required to improve the transfer of risks between Committees and embed risk management within reports to the Committee. MB welcomed a fuller update at meetings when presenting new risks (transferring from another committee).

Following a query from JP on the need to triangulate risk appetite across the System, NA clarified this formed part of the system risk pilot with NHSE on the system approach to risk management.

JP suggested greater inclusion of population health within the Board Assurance Framework to enable the ICB to deliver its strategic objectives.

Outcome: The Committee:

- **Noted the most recent updates on risks within the remit of the committee.**
- **Noted there are 10 risks currently rated red.**
- **Noted the 3 recently updated finance/performance related risks on the ICB's Board Assurance Framework (BAF).**

12. Triple lock ratification

No items presented for this meeting.

13. Feedback from System groups

No items presented for this meeting.

14. Any other Business

There were no items raised under any other business.

15. Items for Escalation

To seek Board endorsement of the decision made by the Committee to support submission of the following business cases:

- Acute Service Reconfiguration - 3 storey Southend development.
- Acute Service Reconfiguration – Acute Kidney Unit.
- EPUT Time to Care business case.

The improvement in the financial position was noted, there was concern on the ability to maintain the position for 2024/25. The Committee were mindful of challenges anticipated in 2025/26. The Committee noted the current position on Performance and agreed this was an area escalated to Board.

16. Date of Next Meeting

Wednesday 5 February 2025
2.00pm - 4.30pm
Microsoft Teams Meeting

Minutes of the ICB Finance and Performance Committee

Held on 5 February 2025 at 1.30pm

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
- Laura Davis-Hughes (LDH) Local Authority representative, Essex County Council (ECC)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Julie Parker (JP) Non-Executive Director, Mid and South Essex NHS Foundation Trust (MSEFT)
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Sam Goldberg (SG) Urgent Emergency Care System Director, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB (part)
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Barry Frostick (BF) Chief Digital and Information Officer, MSE ICB (agenda item 11 and 12)
- Les Sweetman (LS) Deputy Director - Programme Delivery, MSE ICB (agenda item 11 and 12)
- Dawn Scrafield (DS) Chief Finance Officer, MSEFT (agenda item 5)
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Jenny Davis (JD) Director of Finance – Strategy & Commercial, EPUT (agenda 7 and 8)
- Simon Covill (SC) Director of Operational Finance, EPUT (agenda item 5 and 15)
- Elizabeth Wells (EW) Director of Mental Health Urgent Care & Inpatient Services, EPUT (agenda item 15)
- Angela Wade (AW) Director of Nursing, Infection Prevention & Control, EPUT (agenda item 15)
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and apologies

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

Apologies were received from Tom Abell (TA) Chief Executive Officer, MSE ICB and Diane Leacock, Non-Executive Director, EPUT.

2. Declarations of interest

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

There were no declarations of interest in relation to the agenda items.

Outcome: The Register of Interests was noted.

3. Minutes of previous meetings

The minutes of 7 January 2025 were agreed as an accurate record.

Outcome: The minutes of 7 January 2025 were approved.

4. Action Log / Matters arising

SG clarified a deep dive (scheduled for a future meeting) on Non-Elective and the Urgent and Emergency Care (UEC) would focus on delivery against the performance standards and the action plan in place to achieve trajectory in quarter 4 as well as the 2025/26 baseline and actions to aid delivery.

Work was underway with MSEFT on Cancer and Elective performance to assess the contribution to the overarching trajectory for improvement in each of the pathways using an analyser tool. Neurology, skin and breast cancer were the main speciality areas of focus.

MS suggested, as Cancer and Elective performance was a high priority area, an update was provided quarterly to assess if performance was improving with the actions that had been put in place.

Outcome: The action log was noted.

ACTION: An update on Cancer and Elective performance to be provided to the Committee on a quarterly basis.

5. System Finance and Performance Report – Month 9

JK presented the Month 9 report and confirmed a continued improvement to the run rate into Month 9. The Month 9 year-to-date position was £27.6m off plan, this was an improvement of £3.5m from the previous month. The ICB delivered a £1.1m improvement, MSEFT a £3.5m improvement and EPUT a £1m deficit.

Since the introduction of the investigation and intervention work in Month 5, there had been an improvement to the “Do Nothing” scenario by £55m.

JK reported pressures over the winter period would be visible in Month 10. Should spend continue as it was, it was anticipated MSE might deliver a System deficit between £130m - £140m against the planned deficit of £96m. Work continued to bring this closer to the agreed £96m planned System deficit.

EPUT continued to liaise with NHS England in relation to the ongoing costs associated with the Lampard Inquiry. Anticipated costs of £12m-£15m were outside of the reporting position.

In response to the Investigation and Intervention work, JP asked if any learning could be gained from the implementation of controls elsewhere in the System. MB queried the level of interventions that had been applied and asked if there were further benefits to be gained. JK confirmed a PMO tracker was in place to monitor benefits and a paper was being prepared by way of update for the March Board. JK took an action to share the PMO tracker showing the level of interventions.

SC highlighted a number of interventions enacted within EPUT including pay controls and a vacancy freeze. There was also dedicated support to improve the flow of patients. EPUT were engaging with an external provider to replicate the benefits MSEFT gained on improving bank and agency usage.

DS said a number of interventions within MSEFT were in progress and raised further opportunities to be gained in areas such as medicines management, procurement and digital transformation. Although there had been improvements in pay costs, this was also highlighted as an area of further opportunity. It was noted non-pay costs had not benefitted the same reduction.

DS confirmed work was taking place with services to challenge productivity and assess core budget against the level of demand and time required to recover waiting times. MB suggested a risk-based approach to maximise resource in the areas of the greatest risk.

The restriction to the level of activity that could be undertaken whilst maximising Elective Recovery Funding was raised as an area of risk, this was being managed collectively as a System.

SG noted that early reporting of Month 11 suggested a 23% improvement for Accident and Emergency (A&E) and Ambulance performance, it was hoped performance would be sustained as the System exit the winter period.

JP encouraged early planning for Winter 2025 to ensure MSE were in good stead. SG confirmed the Winter Vaccination Group had stepped down the frequency of meetings but continued to meet. Focus was on Spring vaccinations and utilisation of the vaccination bus.

Outcome: The Finance and Performance Committee noted the Month 9 System Finance and Performance report.

ACTION: PMO tracker showing the level of interventions and associated benefits to be shared with the Committee.

6. Forecast outturn 2024/25

At Month 9, it was anticipated MSE would be unable to deliver the planned year-end deficit of £96m. MSE were forecasting to deliver a system deficit between £130m-£140m for 2024/25. The System would be required to move its position [agree a new year-end position with NHS England] no later than Month 10.

In previous years, the System had enacted the Forecast Outturn Protocol [process to agree a new year-end position]. JK explained the approach had differed this year due to the investigation and intervention work that had already taken place.

The Month 9 Finance and Performance report presented to this Committee was presented to NHS England to support discussion at monthly financial review meetings. The report did not show the underlying exit run rate as the report mirrored what was reported in the Integrated Financial Report (IFR) that was submitted nationally to NHS England.

JK highlighted the deficit would be repayable in future years.

Outcome: The Finance and Performance Committee noted the verbal update on Forecast Outturn 2024/25.

Assurance

7. Capital update

Capital spend for MSE for 2024/25 was £62m year-to-date. The System was £24k behind plan on 'local capital programmes' but largely on track to deliver in line with the year-end forecast. This was in line with agreed changes made to the forecast during the year including the reprofiling of the Electronic Patient Record (EPR) funding of £9.6m and Community Diagnostic Centre (CDC) funding of £4m into future years.

The forecast reflected a reduction of £2.7m for International Financial Reporting Standards 16 (IFRS 16) leases within EPUT and accounted for an ongoing dispute.

JD highlighted slippage for the go live date for the Thurrock CDC from July 2025 to August 2025. Discussions were taking place with NHS England and NHS Property Services on the cost and timeline for the Braintree CDC. The Pitsea CDC cost pressure had been mitigated by £6m.

The Acute Service Reconfiguration business cases presented at the January meeting (3 storey Southend development and Acute Kidney Unit) were with NHS England for approval.

Outcome: The Committee noted the verbal update on Capital.

8. 10-year Capital Template (Infrastructure Strategy) - Update

During 2024 the System were asked to develop an Infrastructure Strategy alongside a 10-year capital 'plan'. The initial submission was made in August 2024 with a further submission in December 2024. The paper provided the revised Capital template that formed part of the Infrastructure Strategy national submission in December 2024.

The Committee were advised the System Capital template was submitted at a point in time to support dialogue with HM Treasury on NHS capital requirements.

The submission covered a range of investment areas to enhance primary care estates with the majority of investment directed to maintenance and infrastructure improvements to ensure the estate was safe. The total requirement across MSE was £2.4bn.

The Committee discussed the extensive challenge and the scale of the requirement within what was considered an inadequate funding envelope. JD raised EPUT had the highest level of critical infrastructure risk and received 19% of the funding envelope in previous years.

The visibility of capturing risks within the Board Assurance Framework and Risk Register was flagged key. The Committee noted the need for the System to work collaboratively to prioritise areas of spend.

JK reported an increase to the Capital settlement for 2025/26 but recognised the challenge.

Outcome: The Committee noted the December 2024 Capital Template and the implications of the information within it.

9. Planning 2025/26

The awaited Planning Guidance and allocations for 2025/26 had been received from NHS England. Allocations for 2025/26 had received a minimal increase. There had been a reduction to Service Development Funding (SDF) and the majority of funding had moved to the core baseline. The allocation for Elective Recovery Funding had also seen a reduction. Ringfences continued to be in place for the Mental Health Investment Standard (MHIS), Childrens Hospice, Better Care Fund (BCF) and Dental funding.

The System Operational Planning Group had been set up to facilitate the collective delivery of the MSE Operational Plan for 2025/26. The group would receive updates from each of the separate workstreams including finance, activity, efficiencies and workforce.
The System had been notified a Productivity submission was required in 2025/26. Organisations had received Productivity packs from NHS England identifying areas of opportunity.

There had been a number of planning workshops established. A workshop had taken place with MSEFT activity planners to look at the core activity required and areas of pressure. This would enable discussions to take place on demand management, waiting list initiatives and independent sector provision.

Outcome: The Committee noted the update on Planning 2025/26.

10. System Recovery Report

The System Recovery Report captured the amalgamation of work undertaken across the System.

The Medium-Term Plan (MTP) due to be presented at the ICB Board Seminar on 13 February 2025 identified £160m of opportunities for strategic change. The majority of opportunities were based on benchmarking and best practice. JC explained the MTP would be a live model. Programme Delivery groups would be established with clear Senior Responsible Officers (SROs) and Executive leadership to aid the development of business cases. The groups would report to an overarching programme Board / joint Committee between organisations and held accountable.

An output from the plan was for the ICB to issue its strategic intent over the next 5 years, this would be discussed further at the ICB Board Seminar.

JP flagged engagement from primary care was key and raised the need to be aware of dependencies between organisations in decision making.

Outcome: The Committee noted the System Recovery Report.

AK left the meeting.

Business Cases

11. This item has been minuted confidentially

12. TPP SystmOne GP Enhanced contract extension

BF explained there was no contractual provision to extend the SystmOne contract as it had already been fully extended, any further extension would effectively be ‘non-compliant’ with procurement regulations. It was noted the current framework had expired and all ICBs were in the same position. It was anticipated NHS England would procure the national digital pathway framework at the end of

February 2025.

The Committee were asked to approve the non-compliant extension of TPP SystmOne which was a Primary Care core clinical system, provided to all 146 MSE GP practices. The extension would be for an additional 15-month period (1 April 2025 – 30 June 2026) at a cost of £3,024,951 fully funded by the NHS England GP IT futures notional allocation.

There was recognition of the associated risk and detrimental impact on Primary Care should the service not be extended. The Committee requested clarity on where the accountability fell by approving a non-compliant extension as directed by NHS England. BF took an action to raise with NHS England and provide assurance to the Committee the ICB would not be held accountable should any financial consequence arise.

Outcome: The Committee approved the non-compliant 15-month contract extension for TPP SystmOne effective 1 April 2025 – 30 June 2026 and the indicative cost of £3,024,951 fully funded by NHS England GP IT futures notional allocation.

ACTION: Query on where the accountability fell by approving a non-compliant extension to be raised with NHS England to provide assurance to the Committee the ICB would not be held accountable should any financial consequence arise.

13. Financial Governance

No items presented for this meeting.

14. Triple lock ratification

No items presented for this meeting.

15. Time to Care–2024/25 Trading Account and Benefits Realisation Framework

Following presentation of the Time to Care business case at the January ICB Board, there was recognition as this was a significant investment of the Mental Health Investment Standard it required oversight by the Finance and Performance Committee to ensure the investment was having the desired impact. The purpose of the paper was to provide the 2024/25 forecast outturn and trading account position and the benefits realisation evaluation framework.

AW advised a dashboard was under development (balance scorecard approach) to provide assurance on delivery. MB welcomed the inclusion of trends to monitor how Time to Care was progressing over time.

SC reported the use of a tracker to monitor new posts coming into the service mapped against temporary posts exiting the organisation.

EW highlighted investment into Time to Care for in-patient Mental Health services adhered to priorities within the NHS England Operational Plan including to reduce the average length of stay, furthermore it addressed key findings of the Lampard Inquiry.

AW advised the quality and evaluation framework was under development and would be triangulated with key performance indicator (KPI) data. MS would liaise with AW in relation to the tracking of quality and patient experience and reporting this to the Quality Committee.

Outcome: The Committee noted the report and inclusion of the 2024/25 TTC financial

forecast and benefits framework requested at the January ICB Board.

The Committee noted 2025/26 financial updates and actions with progress would be monitored via the System Investment Group into the Finance and Performance Committee.

16. Feedback from System groups

The minutes of the System Finance Leaders Group (SFLG) and System Investment Group (SIG) both held on 25 November 2024 and minutes of the Extraordinary System Investment Group on 16th December 2024 were presented for information.

Outcome: The minutes of the System Finance Leaders Group were noted

17. Any other Business

NA advised the review of Committee effectiveness for the Finance and Performance Committee would be undertaken shortly.

18. Items for Escalation

TPP SystmOne GP Enhanced contract extension – should adequate assurance not be provided at the March meeting on where the accountability fell by approving the non-compliant extension, this would be escalated to the ICB Board.

19. Date of Next Meeting

Tuesday 4 March 2025, 1.30pm - 4.00pm
Boardroom, ICB Headquarters.

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 11 December 2024, 9.30am–11.30am

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex (nominated deputy for Dan Doherty).
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Vicky Cline (VC), Senior Nurse for Acute/Community (nominated deputy for Viv Barker).
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleksandra Mecan).
- Ashley King (AK), Director of Finance and Estates (nominated deputy for Jennifer Kearton).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Head of Commissioning.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Jane King (JKi), Corporate Services and Governance Support Manager.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Sarah Cansell (SC), Contracts Manager (Primary Care).
- Jo Cripps (JC), Executive Director System Recovery (Item 5 only).
- 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.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Marion Barritt (MB), Alliance Administrator, Basildon and Brentwood.
- Jennifer Knight (JKn), Primary Care Account Manager, Mid Essex.
- Tom Perry (TP), PA Consulting (Item 5 only).
- Ellis Greenhalgh (EG), PA Consulting (Item 5 only).

Apologies

- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Viv Barker (VB), Director of Nursing.
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.

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 October 2024 were received.

KSS highlighted that she attended the meeting and should be added to the list of attendees.

Outcome: The minutes of the ICB PCCC meeting on 9 October 2024 were approved, subject to the amendment highlighted.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (136, 141, 153, 157, 159) were all within timescales for completion.

Outcome: The updates on actions were noted.

5. Medium Term Plan

JC attended the meeting to provide context around the requirement for the ICB to develop and deliver a Medium Term Plan (MTP) which would set out an overarching direction for the Mid and South Essex Integrated Care System's strategic route to financial sustainability.

PA Consulting had been commissioned to lead the MTP work on behalf of the System.

TP and EG explained that ambitious shifts in the delivery of care were required to continue to deliver high quality, sustainable healthcare that met the needs of the mid and south Essex population. The three main areas of shift were around treatment to prevention, hospital to community and analogue to digital. A presentation was given setting out

different hypotheses for clinical transformation across the system and how these could be delivered through organisational transformation and enablers.

SA commented that the hypothesis for acute and community care required a commitment to look into existing acute service provision, rather than it be repackaged.

In response to BB, JC confirmed aim of the MTP was for the system to work together and reduce silos in healthcare. JC added that a small number of priorities would be identified that would have the biggest impact on our population, workforce and financial sustainability.

WG stated that investment into overarching capacity in primary care needed to be the right generalist model.

JS stressed and TP agreed that engagement should be widespread to ensure views from all providers (including primary care) were considered, not just acute providers.

ES highlighted that primary eye care and community eye care services needed to be included in the MTP as well as acute ophthalmology services and added that digitalisation would support a joined up approach to healthcare.

AD stated that pathways for frailty and cancer patients experiencing complications needed to be considered to avoid unnecessary admissions to accident and emergency (A&E). TP agreed and that current pathways did not serve as well as they should for these cohorts.

PW suggested that the term 'urgent' needed to be clearly defined, as a patient's perspective of 'urgent' was often different to a medical urgency. Pathways should also be reviewed to help patients understand how community pharmacy and community ophthalmology could be the first point of contact for a broad range of services.

PG advised that the Executive Committee had recently met with PA Consulting and had agreed for them to document historic investment in primary care across mid and south Essex to benchmark against areas who had historically invested more in primary care.

WG commented that any shift from acute to community care must make logical and economic sense. WG added that there had been over-specialisation in treatments in previous years and investment was needed to revert to generalist care models.

TP thanked the committee for their contribution to the discussion and confirmed the comments made aligned with the approach taken by PA Consulting.

SA enquired whether a feasibility test was built into the MTP decision-making process and gave an example whereby PA Consulting and a partner organisation may consider an option to transfer work from secondary care into primary care, pending the views of primary care colleagues. Additional discussion was held regarding the transfer of funding in that regard.

TP confirmed, when narrowing down potential options, consideration would be given as to whether the change could be delivered in 3-5 years, it's feasibility and impact across the system.

PG said that when looking at reprovision costs, the ICB must be critical about the pre-existing level of funding to ensure there was the capacity and sustainability of primary care.

JH commented that without investment into primary care, system improvements would not be seen and recommended there should be more freedom for general practice to use available resources to meet local demands.

The committee agreed that clarification was required on the terminology used to describe a collection of services which included cardio vascular, respiratory and diabetes (Metabolic Syndrome, Metabolic Systems or other).

SA requested that JC and PA Consulting bring an update on the MTP work to a future PCCC meeting when available.

ACTION: The committee workplan to include an update on progress with the MTP work being brought back to the committee at an appropriate time.

6. South East Essex Surgery closure

JS presented the paper seeking formal approval for a branch closure request in South East Essex Alliance, noting the closure was effective from 30 August 2024 and due to the premises no longer being available for the delivery of primary medical services, as notice to vacate was served by the landlord.

The Practice conducted patient engagement via a Patient Participation Group (PPG) meeting, patient texts/letters, questionnaire, Frequently Asked Questions (FAQs), engagement meeting, posters and social media for patients across all three surgery sites. An Equality and Health Inequalities Impact Assessment (EHIIA) was completed.

VC noted that a Quality Impact Assessment (QIA) had not been received from the practice. SC confirmed this was outstanding and had been chased.

JH enquired whether there were any alternative solutions available to mitigate any risk to patient care. JS explained that alternative options were very limited, however there was very little risk to patients due to the closure. Patients were offered appointments across other sites and could also register with other practices in the area if they chose.

Outcome: The Committee retrospectively APPROVED the closure of the branch site in South East Essex Alliance, effective 30 August 2024, following the submission of an application to close the site.

7. Primary Care Network changes

JS presented the paper setting out a number of Primary Care Network (PCN) reconfiguration requests (within the Thurrock Alliance and South East Essex Alliance areas) received by the ICB, including the formation of a new PCN in South East Essex Alliance. Details of each of the requests were reviewed by the committee. It was noted that work was underway with the providers affected to complete Equality Impact Assessments (EIA), as part of the ICB's assurance processes.

Should approval be given to the formation of a new PCN, there may be financial implications for the GP Information Technology (GPIT) budget. Due to the recent notification, the request had not yet been reviewed or processed.

PW enquired whether prescribing arrangements had been factored into the changes proposed. JS confirmed that if reconfiguration changes were approved by the committee, an overarching project group would be established to support implementation.

JH enquired whether there were any risks associated with the proposed PCN reconfigurations and asked that risks be included in future papers.

JS explained the proposed changes were largely in relation to governance and there would be minimal change to patient care. There was a risk that stakeholders may not understand the rationale behind the changes and therefore there would be communications plan.

ACTION: All future PCCC papers to include a section on associated Risks.

KSS and PW were both concerned about the impact the changes would have on other stakeholders, including community pharmacies. PW added that changes to PCN configurations could affect relationships that were already established and impact the progress of INTs. JS suggested this could be discussed by the reconfiguration project group and that some thought would be given to future plans regarding PCNs.

SA highlighted that contractual processes allowed for PCN changes. It was important that Alliances were supportive of any changes proposed to PCNs.

In response to KSS regarding the impact of costs and resource from the changes, JS advised that any costs would be in relation to a new SystmOne implementation and would come from the GPIT budget. PCNs would be required to meet any other costs, e.g., professional fees and professional advice, themselves. JS acknowledged there would be a challenge to ICB staff capacity that would need to be managed.

AK requested that the Finance team were involved in next phase of the PCN reconfiguration work to ensure they were sighted on the costs involved.

MA confirmed that Thurrock Alliance had no concerns with the requests made and had welcomed the changes. RJ said in respect of the proposed changes in South East Essex, the ambitions and principles remained around neighbourhood working and believed that by supporting these PCN changes, this would accelerate progress in collaborative working.

Outcome: The Committee **APPROVED** the five PCN reconfigurations set out in the paper.

8. Premises update

JS set out the proposed approach to utilising the ICB's capital allocation to expand premises capacity across general practice in mid and south Essex.

Estates capacity was a key constraint for the expansion of GP led services within local communities. Recent rises in premises running costs and business operating costs in general mean there were further challenges in achieving expansion in premises capacity due to the impact on affordability and risk appetite of individual contract holders.

There were three suggested actions to build premises capacity alongside existing programmes. Review whether any surplus Primary Care capital was available to support the work undertaken by individual practice landlords using their own funding, implement MSE Expand programme and longer term to work with the Local Medical Council, GP Provider Collaborative and system partners to create a better system for the development

and management of GP premises within MSE, where system-wide service transformation was not reliant on the finances and risk appetite of individual contract holders.

MSE Expand would look to invest £500k of the ICBs £2m capital allocation into multiple small scale premises expansions across the ICS, to provide a minimum of 26 extra consultation/treatment/examination rooms (1 per PCN). The remainder of the ICB allocation was required to meet GPIT requirements. It was proposed that a further £500k was requested from our two NHS system partners from their Capital allocations on the basis that additional capacity would support the 'left shift' agenda by enabling more care to be delivered in the community. The provision of NHS capital would also support extensions/ reconfigurations of existing premises to provide the facilities required for a training practice.

The proposed approach had been endorsed by the ICB Operational Group (IOG) who report into the Executive Committee. IOG confirmed that consideration must be given during implementation to how the programme can support our ambitions to address health inequalities within the system.

AK highlighted that the programme would allow investment in areas unable to access other investment and was supportive of the proposal.

Outcome: The Committee ENDORSED the proposed approach to expand premises capacity in primary care.

9. Primary Medical Services

JS provided an update on primary medical service contract activity since the update in August 2024.

It was highlighted that one CQC report was awaited, following inspection.

The planned number of practices supported by the Connected Pathways team with the move to modern general practice had been achieved.

Winter Access Scheme and APMS Update

WG gave the committee the opportunity to discuss or raise any questions in relation to the papers circulated for noting, in between the October and December meetings, regarding the Winter Access Scheme (which outlined how the ICB was commissioning additional capacity to support winter resilience) and APMS reprovision update.

No questions were raised on either paper.

Outcome: The Committee NOTED the Primary Medical Services update

10. Primary / Secondary Care interface update

JS gave a presentation on the Interface Improvement Programme. The interface, pathways of care between primary care (general practice) and secondary (acute), was a critical part of the Primary Care Access Recovery Plan.

A Clinical Fellow recently undertook a strategic review of the overarching issues affecting the mid and south Essex healthcare system which were placed under 6 headings: governance frameworks and operational inconsistencies, experiential deficit and lack of

workforce mobility, poor visibility between sectors, poor communication mechanisms, strained relationships and poor IT and systems integration.

The main drivers identified to address the issues focussed on strategic leadership, an operational framework for continuous development and prioritisation of ongoing professional development.

The committee agreed the improvement work undertaken would have real impact on the healthcare system and make a difference to people's working lives.

PW commented that discussion was required on prescribing responsibilities/shared care protocols.

SA highlighted the need for the destination of work coming from secondary care into primary and community care to be carefully considered and managed through the transition process to avoid the risk of any gaps in care.

PG commented that there was a big task ahead, however the programme had the potential to change the culture across the system. With the underlying principle of respect, the programme would encourage better behaviours, reduce cost and improve the quality of care. The programme would be a new way of working and PG requested that an infographic flow chart was brought to a future meeting to demonstrate ownership and how the ICB can support localised resolution through alliances as a feedback loop.

ACTION: An Interface Improvement Programme infographic flow chart to be presented to a future PCCC to demonstrate ownership and how the ICB can support localised resolution through alliances as a feedback loop.

Outcome: The Committee NOTED the Primary / Secondary Care interface update.

11. Community Optometry update

The Community Optometry update was presented to the committee which provided an update of the contractual activities in relation to primary care optometry services and local development issues in optometry services. Ophthalmology Transformation was overseen by the Mid and South Essex Ophthalmology Transformation Board.

There were no questions raised.

Outcome: The Committee NOTED the Community Optometry update.

12. Community Pharmacy update

The Community Pharmacy update was presented to the committee which provided an overview of recent changes and developments in community pharmacy and service provision.

There were no questions raised.

Outcome: The Committee NOTED the Community Pharmacy update.

13. 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 10 active risks relevant to the work of the Committee. There was 1 red rated risk related to Primary Care Demand and Capacity and 7 rated amber. Since the last risk report, no further risks had been opened and no risks had been closed.

SA referred to the branch closure discussion under item 6 and suggested there were cases of primary care practice premises being lost because landlords were pulling out of contracts. SA sought opinion on whether this risk should be flagged to the Board.

WG agreed this was an issue, there had been shift in the change of ownership model of general practice buildings away from premises being actively owned by surgeries and being owned by former partners or other bodies not involved in providing medical services. The concerns had been flagged with NHS England. The Committee noted that although a parachute framework was in place, should there be a contract hand-back, any practice would require premises to deliver services from.

PG stated that the ICB was not alone with this issue and agreed the risk should be raised at Board level and escalated to NHSE to look at further mitigations. SW suggested the risk should also be raised with partners for awareness to understand situation.

SA requested an update on management of this risk within the next risk report to the committee.

ACTION: Market failure risk due to primary care premises issues to be added to the risk register as a Board level risk.

Outcome: The Committee NOTED the Primary Care risk update.

14. Primary Care Quality Updates

The ICB Quality Committee was responsible for oversight of Primary Care quality issues and received a report on a quarterly basis for Primary Medical Services, and bi-annual basis for Pharmacy, Optometry and Dentistry Services. The Primary Care Quality Committee papers were provided to the Committee for information.

There were no questions raised.

Outcome: The Committee NOTED the Primary Care Quality updates.

15. Minutes of the Dental Commissioning and Transformation Group

The minutes of the Dental Commissioning and Transformation Group meeting held on 4 September 2024, 2 October 2024 and 6 November 2024 were received.

Outcome: The Committee NOTED the minutes of the Dental Commissioning and Transformation Group.

16. Items to Escalate

Escalate to BAF - Risk of market failure due to primary care premises issues to be added as a Board level risk.

17. Any Other Business

There was no other business to discuss.

18. Date of Next Meeting

1.00pm-3.00pm, Tuesday, 14 January 2025
Via Microsoft Teams

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 14 January 2024, 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
- Viv Barker (VB), Director of Nursing.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleksandra Mecan).
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Ashley King (AK), Director of Finance and Estates (nominated deputy for Jennifer Kearton).

Other attendees

- Tom Abell (TA), Chief Executive Officer.
- David Barter (DBa), Head of Commissioning.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Emma Spofforth (ES), Clinical Lead, Local Optical Committee.
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Michelle Cleary (MC), SEE Alliance Delivery and Engagement Lead
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality.

Apologies

- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.
- Sheila Purser (SP), Chair, Local Optical Committee.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Jane King (JKi), Corporate Services and Governance Support Manager.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- Sarah Cansell (SC), Contracts Manager (Primary Care).

- Dr Matt Sweeting (MS), Executive Medical Director.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.

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.

PG advised she was now an honorary lecturer at the University of Essex and SA noted that it would be added to the log.

AD advised her practice in the Colne Valley was adjacent to the Braintree PCN which has an item on the agenda around reconfiguration.

Members noted the register of interests. No issues were raised.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 11 December 2024 were received.

Outcome: The minutes of the ICB PCCC meeting on 11 December 2024 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (136, 157, 165, 166) were all within timescales for completion.

Outcome: The updates on actions were noted.

5. Primary Care Strategy

WG provided a presentation updating on the Primary Care Strategy covering a review of GP numbers, the commissioning approach within the system and some focus areas the committee needed to be aware of.

The following key points were noted:

- There was a shortfall in GPs compared to the national average that fell disproportionately across Alliances, with Thurrock and Basildon & Brentwood having a higher need.
- MSE had an ageing workforce with a high proportion of GPs aged 55 or over.
- A local approach to ‘left-shift’ was being piloted by volunteering Primary Care Networks.

- Groups of additional services included core tasks, supporting recovery, transformation and fundholding.
- There would be a longer-term impact of GP Collective Action.
- The reforming elective care for patients guidance had implications for primary care to improve efficiencies.
- The following focus areas were starting to become an issue in the system and would need to be addressed:
    - Focus area 1 – ADHD – The impact of GPs ceasing to prescribe medication.
    - Focus Area 2 - Community Pharmacy – The closure of pharmacies as a result of a shortfall in funding.
    - Focus Area 3 – Advice and Guidance (A&G) – Achieving the goal of increasing requests**.**

Following the presentation, WG invited discussion around the commissioning implications of local and national issues within the MSE ICB.

WG assured PG that the feedback from the face-to-face session at the university would be used to shape the strategy, noting that the key issues highlighted provided a focus for the commissioning approach in 2025/26.

TA explained that the Medium-Term Plan supported 'left-shift'. Reshaping out-of-hospital services, including primary care, would require a fundamental change from a transactional approach to a more holistic, outcomes-based approach, whilst using existing resources.

JH advised that the priority for GP numbers should be aligning Thurrock and Basildon & Brentwood with the local average, followed by raising the entire ICB to the national average. The long-term goal should be to exceed the national average.

JH acknowledged the risks associated with A&G, including the potential for incentives that could lead to unnecessary requests. JH suggested implementing a more regulated referral system that ensures all referrals meet the service restriction policy criteria.

KSS reassured the committee that pharmacies were not expected to engage in collective action and proposed exploring innovative approaches, such as creating services similar to the COVID prescribing hub, specifically for ADHD medications.

ES explained that in optometry, the referral pathway includes a funded A&G function, but it was ineffective because it was not set up for MSEFT clinicians to respond. Data showed that if optometrists had access to a functional A&G portal, referrals to ophthalmology might decrease significantly.

AD advised of the need to consider the whole balance of the primary care workforce including additional roles and other support staff, rather than assessing GP numbers alone.

AD questioned the effectiveness of GP payments for A&G, as local experience showed the system was only set up to be effective for a small number of specialties where the hospital staff provided a timely response. Long waits for responses could lead to delays in patient referrals, A&G would only work when it was properly embedded. SA shared reservations regarding this

SA agreed with JH that referral management was an approach that was important to consider. JH clarified that his suggestion was not to revisit the previous referral management approach, but instead use Ardens forms with clearly defined referral criteria.

WG noted the appetite from primary care providers to work differently reducing the current transactional model, but without creating additional cost pressures.

WG advised that the next step was to identify priority schemes for 2025-26 which included a new model for diabetes.

ACTION: A document setting out the immediate actions for 2025-26 with strategy principles be presented to the Committee in March.

ACTION: A more detailed strategy document (2-5 years) be presented in Q1 25/26 (Apr-Jun) with details on principles, extent of innovation and areas covered.

Outcome: The Committee supported the approach to developing the Primary Care Strategy.

6. Primary Care Local Dispute Resolution Paper

WG presented the Primary Care Local Dispute Resolution paper, produced following several disputes raised by local providers regarding the application of the national contract. The disputes were raised ahead of the delegation of responsibility to the ICB.

The proposed process included the creation of a dispute resolution panel for which a terms of reference was included. NA requested that should the committee approve the proposal, the PCCC Committee terms of reference would also need to be updated to include the panel as it's sub-committee.

PW requested confirmation that although the ICB was the delegated commissioner that the contract for the services were still held by NHS England. WG advised this was the case and agreed to amend the wording.

ES requested clarification that the enhanced services cited within the dispute resolution panel terms of reference did not include those commissioned by the Trust. The wording should also be updated to clarify that specialist representatives were only required for disputes relevant to their services e.g. you don't need an optometrist on the panel for a dispute with a dentist.

JH clarified that the panel could only make a recommendation to the PCCC rather than being an independent decision-making panel.

KSS advised that Community Pharmacy Essex was still functioning as the Local Pharmaceutical Committee with the new trading name aimed at improving the public's understanding of their function. They welcomed the move for a local dispute resolution panel as this was currently absent outside of the management of performance issues within the contract.

Outcome: The Committee approved the local dispute resolution process, subject to the changes discussed, approved the terms of reference for the dispute resolution panel and approved for the PCCC terms of reference to be updated to reflect the new sub-committee.

Action: The PCCC terms of reference be updated to include the dispute resolution panel as a sub-committee of the PCCC.

7. Primary Care Network - Thurrock

WG presented the paper setting out a Primary Care Network (PCN) reconfiguration request within the Thurrock Alliance. Several PCN changes had been requested for 2025/26.

The paper recommended assignment of the practice to their former PCN for their patients to access their network Direct Enhanced Services (DES) as a non-member practice. The practice would cease to be a provider of these network DES services.

JH agreed with this suggestion, but questioned whether the financial impact on the practice of losing their provision of DES services was significant, and considered in the decision. WG advised that any potential financial mitigations would be discussed with the practice.

DD added there was a need to monitor the impact on patients of orphaned practices to ensure they do not experience inequalities in service delivery.

PW requested assurance that patients from orphaned practices would get access to the Additional Roles Reimbursement Service (ARRS) roles as these were now fundamental to service provision, and raised the risk that if many more practices were orphaned the effective delivery of these roles through PCNs would be reduced.

JH suggested specific patient engagement was undertaken to ensure patients were aware of services available.

MA agreed on the importance of protecting patients access to services. Discussions with clinical directors from a neighbouring PCN, ruled out the practice joining due to the physical distance creating logistical difficulties in the provision of ARRS staff.

MA assured that in addition to their former PCN, the practice had a large practice nearby from another PCN that could also provide ARRS.

Despite risks identified, WG reassured SA that this was the most appropriate solution.

SA requested that this would be initially contracted for one year and reviewed ahead of any agreement for these arrangements to become long-term.

ACTION: VK to complete a Quality Impact Assessment and EHIIA for the changes to PCN reconfiguration in Thurrock.

Outcome: The Committee supported the proposal for PCN reconfiguration with the identified mitigations in place for a period of one year, at which it is to be reviewed before becoming long-term.

8. Surgery Merger (Basildon and Brentwood Alliance)

WG presented the paper, which detailed the recommendation to merge a branch Surgery with another Surgery, and subsequently closing the Branch Surgery and transferring the patient list.

The change was proposed as a result of the branch surgery lease not being renewed by the landlord.

Patient engagement highlighted issues such as the removal of a local resource in a relatively deprived area, additional travel time for patients and access concerns with new

housing developments being proposed in the area. The existing contract holders intended to create additional capacity at the new premises with the conversion of administration space to new clinical rooms and moving the administration functions to unused space in the adjacent medical centre.

The Alliance supported this proposal as the best option to provide continuity of access to primary care services within the area.

PW highlighted the opportunity that the surgery closure provided to test new commissioning arrangements, with local pharmacies delivering ARRS roles nearer to the population.

WG advised the partnership were looking to implement a total triage system across their remaining practices with a Pharmacy first option in place.

VK advised that the condition of Surgery was poor and that the CQC stated they wouldn't approve the existing premises, without the current safety risks being addressed. A Quality Impact Assessment has been completed (and Equalities and Health Inequalities Impact Assessment (EHIIA)) for the proposed change and would be approved as a desk-top exercise.

Outcome: The Committee approved the proposed surgery merger within the Basildon and Brentwood Alliance.

9. Items to Escalate

No Items to escalate.

10. Any Other Business

There was no other business to discuss.

11. Date of Next Meeting

9.30am-11.30am, Wednesday, 12 February 2025
Via Microsoft Teams

Minutes of MSE ICB Quality Committee Meeting

Held on 20 December 2024 at 10.00 am – 1.00 pm

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB) and Chair of Quality Committee.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB (present up to item 13).
- 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).
- Dr Milind Karale (MK), Executive Medical Director, EPUT.
- Christine Blanshard (CB), Chief Medical Officer, Mid and South Essex NHS Foundation Trust (MSEFT) (present up to item 6).
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company (present up to item 11).

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience, MSE ICB.
- Viv Barker (VB), Director of Nursing for Patient Safety, MSE ICB, up to item 7.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB, for item 19.1.
- John Swanson (JS), Lead Nurse for Infection Prevention and Control, MSE ICB (present up to item 10).
- Dawn Osborne (DO), Associate Director of Patient Safety, MSEFT (deputising for Diane Sarkar).
- Karen Flitton (KF), Patient Safety Specialist, MSE ICB.
- Sara O'Connor (SOC), Senior Manager Corporate Services, MSE ICB.
- Yvonne Anarfi (YA), Deputy Director for Nursing for Safeguarding, MSE ICB.
- Clare Angell (CA), Deputy Director for Babies, Children and Young People, MSE ICB.
- Carolyn Lowe (CL), Deputy Director for All Age Continuing Care (AACC), MSE ICB (present up to item 15).
- Julie Davis (JD), Complaints Clinical Support Officer, MSE ICB.
- Dr Sarah Zaidi (SZ), System Clinical Lead for End of Life Care, MSE ICB (present for item 12.
- Lucy Millard (LM), Lead Patient Safety Specialist, North East London NHS Foundation Trust, NELFT(present up to item 12).

- Bridgette Beal (BB), Director of Nursing & Allied Health Professionals, Provide (present for item 6).
- Rebekah Baillie (RB), Associate Director for the Learning Disability and Autism Health Equalities Programme, Hertfordshire & West Essex ICB.
- Samantha Nesbit (SN), Governance Coordinator, MSEFT(present for item 6).
- Deborah Goldsmith (DG), Director of Midwifery, MSEFT.
- Tracy Rodgers (TR), Deputy Director of Nursing and Quality, Provide (present for item 6).
- Edward Barrett (EB), Implementation Manager, UCL Partners (present for item 6).
- Bethan Simpson (BS), EPUT(present for item 6).
- Roshini Patel (RP), Head of Patient Safety Incidents Management, EPUT (present for item 6).
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.
- Wendy Dodds (WD), Healthwatch Southend.
- Alix McMahon (AM), Complaints and Support Manager, MSE ICB.
- Eleanor Sherwen (ES), Deputy Director of Nursing, MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex, MSE ICB.
- Diane Sarkar (DS), Chief Nursing and Quality Officer, MSEFT.

1. Welcome and Apologies

NIB welcomed everyone to the meeting. Apologies were noted as listed above. The meeting was confirmed as quorate.

2. Declarations of Interest

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

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 25 October 2024 were reviewed and approved.

Resolved: The minutes of the Quality Committee meeting held on 25 October 2024 were approved without amendment.

4. Review of Action log

The action log was reviewed, and updates were noted.

Resolved: The Committee noted the Action Log.

5. Lived Experience Story

NIB advised that unfortunately there was no lived experience story available to be presented.

6. Deep Dive – Patient Safety Incident Response Framework (PSIRF)

KF advised that NHS East of England was the first NHS region in the country to go live with the Patient Safety Incident Response Framework (PSIRF). One of the key successes was building a culture of collaboration across the region. PSIRF peer review meetings were well attended and enabled insights to be shared to enhance patient safety. The meeting scope would be expanded to include primary care colleagues and the frequency would be increased to six times a year. Monthly 'lunch and learn' sessions were offered and supported by UCL Partners. PSIRF and Just Culture training had been delivered system wide. The MSE Patient Safety Summit held received positive feedback.

Out of the 72 smaller providers in the system, 4 were non-compliant with PSIRF and assistance was therefore being provided with the final processes through the contracting team. The next steps were to ensure that all providers remained compliant with PSIRF and to work with All Age Continuing Care (AACC) providers to develop policies to support adherence to PSIRF principles.

Fourteen general practitioners in primary care had signed up as early adopters and six remained actively engaged. Tools were being tested to ensure the needs of GP providers were met with the rollout of PSIRF.

The challenges of implementing PSIRF were detailed in the report and included: embedding PSIRF over a diverse range of providers; provision of resource and support; the change in cultural shift in encouraging the transition from a reactive to a proactive response; and sustaining engagement and collaboration.

The next steps would be to conduct annual PSIRF self-assessment reviews with a heatmap to determine areas of focus for the system and whether any additional help to providers was required; and the expansion of PSIRF into primary care; and embedding PSIRF into the Safety Management System. The implementation of PSIRF Phase 7 which was supported by UCL Partners, would improve system communication around care of patients with pressure ulcers in the community within the last three months of their life.

The proposed patient safety governance framework was more robust and would be adopted in early 2025. Within mid and south Essex (MSE), a strong foundation had been laid for PSIRF with notable successes in collaboration, training, and system-wide implementation.

An update was provided by the four providers, as follows:

Provide – TR advised that Provide went live with PSIRF on 4 October 2023. A review of the past year demonstrated that PSIRF had made a positive impact and resulted in a healthy reporting culture. The four aims of PSIRF had been considered in the review and further detail of each was provided in the report. A PSIRF plan was in place, however the approach was flexible. The plans for next year were set against three strategic aims

(Insight, Involvement and Improvement) in the Patient Safety Strategy. Provide had signed up to work with the system and UCL partners on Phase 7.

MSEFT – DO advised that MSEFT transferred to PSIRF in November 2023. Since transition, 31 Patient Safety Incident Investigations (PSIIs) had been commissioned, of which nine were against local priorities and the remaining 22 against national priorities. The highlights of PSIRF implementation were provided in the report and included the implementation of DCIQ (Datix) which supported accurate reporting of staff involved in or affected by patient safety incidents. As an early adopter of Datix, MSEFT were supporting the testing of new changes being implemented next year. A quarterly review of the Learning From Patient Safety Events (LFPSE) system had been completed and evidenced a positive shift in how incidents were being reviewed with learning identified and included changes to systems and processes. The challenges were highlighted in the report and the next steps included the launch of updated tools, guidance and educational packages and attendance of patient safety representatives at multi-disciplinary team (MDT) reviews.

NELFT – LM reported that the challenges of PSIRF for NELFT included embedding the changes trust wide due to the size of the organisation, facilitating training across the organisation and embedding a different way of working. The cultural shift remained a challenge. The positives were noted as similar to the challenges, with the addition of engagement from colleagues and a fully implemented Patient Safety Incident Response Plan (PSIRP) was in place, with 10 workstreams set up, following a review of common themes in safety incidents to support a targeted approach.

EPUT - AS confirmed that EPUT were early adopters of the PSIRF in May 2021. As part of the Lampard Inquiry, all incidents over the 23 years period were being reviewed and safety improvement areas had been identified. The challenges were similar to other system partners with the addition of ensuring that reports were appropriate for HM Coroners and families and managing expectations. The highlights were ensuring PSIRF patient safety and learning was embedded at a local level and that incidents were being reported. Dedicated staff had been placed in each Care Unit to support cultural change. Work was ongoing on how to better engage with family members and having the correct structure in place from 'Ward to Board'. Physical health and discharge processes had been added to the Safety Improvement Plan.

SP commented that primary care should also be taking a lead on this. KF confirmed that this would be the focus for quarter 1 in 2025/26 following the patient safety strategy for primary care. Two primary care representatives had joined the Patient Safety Collaborative Group.

In response to a question raised by MS, TR confirmed that there had been a cultural shift amongst clinicians and ownership at every level. PSIRF was more about learning and shared learning and After Action Reviews (AARs) had been requested for events that were unrelated to PSIIs due to the positive results. DO confirmed that there had been positive engagement, particularly with MDTs and positive feedback on thematic reviews had been received from nurses and clinicians. MK explained that the two main purposes for an investigation were learning and streamlining of processes. PSIRF had created a category of investigations, and it was necessary to be mindful that families were assured, and any findings shared for investigations that were not reviewed under the PSIRF categories.

NIB referred to the impact of Martha's Rule and that it would be beneficial for the data to

evidence improvement and that learning had been embedded and sustained. GT commented that a positive reporting culture was required, and it was more important to see reductions in the levels of harm in relation to patient safety incidents. The ambition of the Safety 2 movement was to have a culture in our healthcare system to focus on those near miss events and for people to feel confident to report on where harm was avoided to learn from those. A reduction in the number of PSIIs but an increase in incident reporting was preferred. A bigger focus was required on the continuing involvement of patients, families and carers in investigations as partners.

7. Executive Chief Nurse Update

7.1 Safety Quality Group - Escalations

There were no escalations from Safety Quality Group.

7.2 Emerging Safety Concerns/National Update

GT advised that the new NHS Quality strategy was being proposed and would align with the development of the 10-year plan. Quality would be a key theme in the enabler workstreams, including finance and contracting, data and technology, and accountability and oversight. A proposal and consultation would be published shortly on the roles and responsibilities for oversight and assurance for health services at a system level. GT urged partners to be involved in the development of the national strategy.

The number of seasonal influenza cases had increased and remained highest in children, but COVID admissions had stabilised, respiratory syncytial virus (RSV) positivity and admissions continued to increase and were higher than the two previous seasons' peaks. Infection prevention and control impacted flow and operational demand across the system and there had been an 80% increase in admissions for norovirus, which resulted in bed closures, compared to the same time last year.

Outcome: The committee noted the verbal update on Emerging Concerns and National update.

7.3 ICB Board/SOAC concerns and actions

There were no escalations.

8. EPUT / Mental Health Update

AS highlighted the following key issues.

The incident trends over the last 12 months demonstrated appropriate levels of no or low harm incidents. The decline in September was due to the alignment of Datix to ensure that the Care Units were being captured.

Physical health was a focus and one of the safety improvement plans would be extended to the patient's pathway in acute trusts to ensure learning.

Patient flow remained a challenge with system delays and work was ongoing with system partners to move patients on in a timely fashion. Length of stay was an area of focus, and a catchment area meeting was being set up between community and inpatient teams to support better patient flow.

The Trust was part of the Early Warning Signs Framework for inpatient mental health, learning disability and autism inpatient settings to identify early warning signs and prevent issues from escalating. The national team were providing support to refine the quality dashboard.

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

9. Maternity Services Improvement Plan Overview

DG advised that following a suggestion from the national team to move to a perinatal improvement programme rather than a maternity improvement board, work was ongoing to support that transition and included a review of key priorities.

DG gave an overview of each workstream within the Perinatal Improvement Programme as follows:

Foetal Medicine: A new consultant had been recently recruited on the Southend site who would support the services in the future. A new Small for Gestational Age (SGA) policy was being introduced from 1 February 2025 to ensure compliance with 'Saving Babies Lives'.

Preterm Birth: Significant improvement had been made in all the key performance indicators (KPIs) within Saving Babies Lives in the Clinical Negligence Scheme for Trusts (CNST) compliance.

Diabetes: Within MSE, work was ongoing to transition to one guideline as two sites followed National Institute of Clinical Excellence (NICE) guidelines and the other site followed the World Health Organisation (WHO) guideline.

Patient Experience: The Care Quality Commission (CQC) survey report had been received and an action plan response was being formulated. Work was ongoing with Maternity and Neonatal Voices Partnership (MNVP) to improve patient experience.

Regulatory and National Standards: 9 of the 10 safety actions under CNST had been signed off and would be following governance processes for formal sign off. The actions arising from the Ockenden report were being progressed. Broomfield Hospital was subject to a Section 31 Notice following a CQC inspection. The draft CQC reports for Southend and Basildon had been responded to and the final report was awaited. The report from the second CQC inspection on the Broomfield site was also awaited.

Flow, Demand and Capacity: This was a key priority, particularly on the Broomfield site, where capacity does not meet the demand and flow. Discharge processes were being streamlined and caesarean section rates were being reviewed.

Maternity Safety Support Programme (MSSP): Meetings were being held to consider how the MSSP could be exited.

Quality and Safety: The governance framework and subsequent action plan required revisiting along with the remaining actions from the governance deep dive on stillbirths and neonatal deaths conducted in 2022/23.

Team Health: To review how culture could be improved within MSE. The vacancy rates were being reviewed and it was noted that turnover rates were below the Trust KPI. All

student midwives had been fully recruited across MSE, as well as external midwives from the Basildon site.

Neonatal Improvement Redesignation: There had been meetings held to agree the redesignation of the Southend Hospital Neonatal Service, which had proved challenging.

In response to a query from NIB, DG confirmed that the timeline for the conclusion of the Broomfield CQC report was currently unknown, however regular engagement meetings with the CQC were being held.

Resolved: The Committee noted the Maternity Services Improvement Plan Overview report.

10. Safeguarding Adults Update

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

There was a risk across the system with regards to vacancies in the safeguarding teams but recruitment processes were in place. The ICB had recently successfully recruited a social worker into the Safeguarding Team. There were vacancies collectively across the system and the ICB Safeguarding Team were supporting as much as they could.

Safeguarding Children in Dental Health Teams

A flow chart had been designed following work with providers and dental health care teams which required the committee's approval before wider distribution. Nationally there had been a risk for dental care for children, particularly looked after children, and it was suggested that a visual safeguarding tool was designed to aid assessing and recognising dental health issues. The flowchart had been shared with the Primary Care Team and Dentistry Committee.

In response to a query from SP, YA confirmed that there was close partnership working with Thurrock and Essex alliances, and work was ongoing to engage Southend.

GT asked for the flowchart to be shared with the ICB Communications team to ensure that inclusive standards were being met.

Resolved: The Committee noted the safeguarding adults update report and approved the dental care flow chart.

Action: YA to share Safeguarding Children in Dental Health Teams flowchart with the communications team to ensure that inclusive standards were being met.

11. Learning Disabilities & Autism (LD&A) Update

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

The Southend Essex Thurrock (SET) Learning Disabilities (LD) and Autism Programme had delegated authority from the ICB to commission specialist LD healthcare services.

The function and purpose of the programme was detailed in the report and noted that the target of 41 adult inpatients had been increased to 43 because of pressures. However, the targets for both adults and children were significantly breached.

The risks and issues highlighted focused on adult mental health, but also impacted on children, and included compliance with NHS targets and how issues could be collectively addressed and completed in a more collaborative / integrated way. Detail of the risks, issues, mitigations and gaps were provided in the report.

The timeline for future programmes was provided, noting some programmes required integrated working. Further workshops would be held to review collective contributions, where discharged was enabled and viable, contributions to a patients journey and where the focus would be required for both adults and children.

MK commented that joint working would be required between EPUT, Hertfordshire Partnership University NHS Foundation Trust (HPFT - LD provider) and the local authority.

CA suggested that a children and young people (CYP) report should be included on the agenda for February's meeting to consider the missed opportunities, as the risk factors such as fractured education offer, poorer mental health, long waits to diagnosis and insufficient needs led support were known to influence admission.

In response to a query from NIB regarding outcomes and updates from future workshops, GT advised that the Adults and Children Steering Group and LDHE Board would receive the updates, which would then come through to Quality Committee. The government was currently reviewing all System Development Funding (SDF) as part of next year's planning, noting the only area protected was the mental health improvement standard. It would be difficult to identify areas of focus due to uncertainty regarding funding and would potentially not be ready for review until quarter 2 of 2025/26.

Resolved: The Committee noted the Learning Disabilities and Autism update report.

Action: HC to add children and young people report to the agenda of the Quality Committee meeting on 28 February 2025.

12. Palliative and End of Life Care/Hospice Update

SZ advised that a strategic delivery plan had been mapped across six national ambitions. The national direction was a population health management approach for improvement in recognising people with life limiting conditions and was a local and national challenge. The aim was to improve recognition, deliver timely personalised care and support planning 24/7 coordinated care and ensure an all provider focus with the inclusion of staff skills and competences.

Progress had been made with population registries which improved coordinated care. The full ICS data coverage supported a better understanding and recognised the needs of people in a life limiting stage of illness through the ongoing work with the population health management segmentation data model which has supported insight into the number of people likely to have a life limiting prognosis.

The highest prevalent conditions with end-of-life indicators were understood from the population health segmentation model. Long term health conditions, such as heart failure, Chronic Obstructive Pulmonary Disease (COPD) and dementia were most likely but there were significant high prevalence in other conditions. Activity data detailed the scale of the issue that affected Emergency Departments and ambulance calls. Across the ICS, 42% on inpatient mental health activity were likely to meet that life limiting prognosis category and

similarly significant proportions of outpatient activity were people in this category and included mental health outpatient clinic activity.

A performance dashboard had been developed for end-of-life care and would be accessible to all providers, alliances and PCN networks to drive quality improvement. The highlight report had identified unwarranted variation, which should be reduced in recognition of people with end of life needs, timeliness of that support and measuring the delivery of best practice proactive personalised care inputs, personalised care and support planning and anticipatory medication prescribing.

The palliative care board had worked on the foundations key enablers to promote 'everybody's business' and an all provider cultural shift towards personalised and proactive care. A Macmillan post for 22 months had been fully funded across East of England ICB regions.

The HPAL MSE (Health and Palliative Care MSE) platform was accessible to all professionals and the public, to promote better information and resources. Generic care delivery tools, such as FrEDA (Frailty End of Life Dementia Assessment) tool was live across most providers and supported the promotion of early recognition and earlier personalised advanced care planning. Significant benefits were realised with significant reductions in people with unplanned admissions in their last 90 days of life and population deaths occurring in hospital were 20% better than the national average. The launch of EPaCCS (Electronic Palliative Care Coordination System) had provided equity across all alliances and providers and front line staff were encouraged to identify patients and upload details to the care coordination platforms. An area of focus was education, training and awareness for frontline staff as the comprehensive end of life needs assessment had identified training as a gap in most providers. Educational resources were available through a generic web platform and included immersive simulation training.

Work was ongoing with MSE Compassionate Communities campaign and that every community was prepared to help and the cultural shift to embrace and normalise the approach to death and dying.

MS commented that report showed why frailty and end of life would be a focus in the Medium-Term Plan (MTP), particularly the roll out of FrEDA and other tools to support recognition of those in the last few years of life. SZ advised that with the 24/7 component, it was recognising the enablers in the new care models that were being mobilised with single point of access for urgent and emergency care and virtual hospital, which were already showing benefits for this population to receive more personalised care and was a cultural shift to an all provider engagement.

Resolved: The Committee noted the End-of-Life Care/Hospice Update report.

13. Babies, Children and Young People Update

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

At the last committee meeting, there was discussion regarding the requirement for the ICB to understand the experiences of children with Special Educational Needs and Disabilities (SEND) in accessing health services, to evidence how outcomes were being achieved and how quickly identified needs were responded to. The ICB was providing funding to a young

person's forum called TRAVERSE, which sat alongside the multi-schools council, and would be providing support to measure the impact of health services. An annual touch-point survey would be designed through the virtual views platform to ascertain how healthy and safe young people were feeling, along with focused project engagement work.

The new joint commissioning group in Southend was being launched from January 2025 and would be a good opportunity to work with local authority colleagues, public health colleagues, police crime and commissioner officers on the shared ambition, shared areas of focus and collaborative working during 2025/26. The initial focus would be managing the transition from 'Better Start Southend' and reviewing the impact on health services, but also supporting the transformation activity, particularly with regards to therapies work. The aim was for a similar approach with Thurrock, with meetings scheduled for early 2025.

The joint data dashboard had been implemented linking all health equality data from three ICBs working within Essex County Council. Metrics from local authorities would be added in the future.

The paediatric hearing service improvement programme was going well, and the outcomes of the initial investigations had been included in the report. One of the unexpected benefits of visits with the provider trusts was understanding how changes that happened at a strategic level were impacting operational teams and careful consideration was required on how communications could be improved.

The challenges from the LD and autism programme were highlighted. There would potentially be some commissioning implications, particularly with regards to ensuring that 16 young peoples' needs were met following discharge.

Risks highlighted included the significant level of demand with right to choose assessments for Autism and Attention Deficit Hyperactivity Disorder (ADHD), and the quick mobilisation and provision of a framework in 2025/26 was being considered to set a quality threshold for MSE to manage activity better. There was a focus on waiting time recovery across acute and community services and ensuring that data received was accurate.

Resolved: The Committee noted the Babies, Children and Young People Update report.

14. Quality Impact Assessment Update

KF advised that this was the first quality impact assessment (QIA) report presented to the committee which summarised the robustness of the oversight and consistency of the ICB's QIA process.

Eight approved QIAs were detailed in the report. The QIAs mainly had a positive impact and mitigations and review processes were put in place for those which identified a negative impact. Most QIAs in Quarters 1 and 2 related to streamlining services and making them equitable across the health system.

An update report would be presented to Committee every six months.

NIB asked the Committee to consider if any further information was required in the next report.

MS welcomed the report as a check and challenge.

Resolved: The Committee noted the Quality Impact Assessment Update report.

15. Patient Experience Update

JD took the report and highlighted the key points.

The complaints team had received 1,113 new contacts from April to November which was similar to last year following the delegation of primary care complaints from NHS England to ICB, although a higher number of cases remain opened and response times had lengthened.

Staff vacancies and sickness had impacted the complaints backlog recovery, however temporary inhouse support had been provided and a six month post was currently out to internal advert. East of England Ambulance NHS Trust (EEAST) had been commissioned for a 12-week pilot to manage the initial contact to the Patient Advice and Liaison Service (PALS) and Complaints to provide a more robust service to meet higher demand. A longer-term solution was being explored to address the higher caseload.

To address the increase in complaints and prevent further backlog, the Primary Care Complaints Team would be transferred to the Alliances from January 2025 to facilitate closer working relationships and shared learning.

SM highlighted that there had been a reduction in the backlog of complaints and expectations were being managed.

Resolved: The Committee noted the Patient Experience Update report.

16. Proposal for Structured Judgement Reviews

MS advised that Structured Judgement Reviews (SJRs) were an evidence-based way of learning from deaths and MSEFT had requested support in managing the backlog of SJRs. It had been agreed that the most recent deaths would be prioritised for a review, rather than going back historically over a year ago. There had been good percentage uptake of SJRs the previous year and the learning had been included in action plans.

MS requested committee's approval of the methodology, and that clear timelines would be provided by the Trust on how targets would be achieved in the next year.

NIB asked when the outcomes of the new methodology would be realised. MS confirmed that the expectation was that a detailed breakdown would be received by the end of the month.

SP raised concern with reviewing the most recent and whether any learning or trends linked to earlier deaths could be missed. MS advised that due to the previous completion rate of 80-90% there was a grip on the top 5 causes, such as Sepsis, ward moves and handover of management plans and, as with PSIRF, action plans were being developed on the top 5 causes rather than each one to make it more effective. This was a pragmatic approach to support the Trust. SM advised that it would be helpful for the Trust to provide a robust framework of how the backlog would be reviewed and how the process would be sustained. MS to update the committee with the response from the Trust with the trajectories.

SM noted that it was only the acute provider that was challenged with SJRs.

Resolved: The Committee noted the Proposal for Structured Judgement Reviews.

Action: MS to provide an update on the Trust response to trajectories and how the process would be sustained.

17. Patient Safety & Quality Risks

SOC advised that 24 risks were currently within the remit of Quality Committee. Two risks related to Palliative Care had been transferred to the remit of Finance & Performance Committee. A discussion had been held with GT as to whether these risks should be reported to both committees and SOC welcomed views from the committee.

All risk updates had been completed in a timely manner and new arrangements had been implemented to ensure that the ICB Operational Group (IOG) and Executive Team received details of any outstanding updates.

There were currently 10 red risks and no new risks had been added since the last meeting. Work was ongoing to roll out team risk registers across the ICB and so additional risks would be added in due course.

Risk ID8 (Compliance with the Mental Capacity Act (MCA) 2005) was recommended for closure, the rationale was provided in the report and any residual risk was included within another relevant risk (Risk ID 63).

The six high level quality related risks currently included within the Board Assurance Framework (BAF) were highlighted within the report. The BAF would be updated prior to its presentation at the next Board meeting on 16 January 2025.

The ICB's risk management arrangements were currently being reviewed and proposals would be presented to the Executive Team and ICB Board. This could result in a new criterion for risks escalated to the BAF.

The committee confirmed that ideally risks should only be held within the remit of one committee.

SOC confirmed that the incident reporting module was currently being tested on Datix, which would be rolled out to all staff early 2025.

Resolved: The Committee noted the Patient Safety and Quality Risk report and approved closure of risk ID8 (Compliance with Mental Capacity Act (MCA) 2005.

18. Terms of Reference

18.1 Infection Prevention and Control Oversight Group

SM advised that the Terms of Reference for the Infection Prevention and Control Oversight Group were in draft form and requested feedback from the committee. The policies and process required updating and the final version would be brought back to committee for final ratification.

Resolved: The Committee noted the Terms of Reference for the Infection Prevention

and Control Oversight Group and that a final version would be presented at a later meeting for approval.

19. Nursing and Quality Policies and Procedures:

19.1 Review of Nursing and Quality Policies:

The committee were asked for comments on the following:

080 Defining the Boundaries Policy – The policy related to effectively managing the boundaries between NHS and private care. As movement between private care and NHS care had increased, it was important that staff and public understood the arrangements. The policy had been discussed at the Operational Group and had been adopted from a document produced by the East of England Priorities Advisory Committee and aligned with other ICBs in the region.

MS commented that the policy was detailed, clear and very helpful and each patient had their own individual circumstance.

SM commented that the policy could reduce the burden on a challenged NHS system. Each patient should be considered individually as there could be many reasons why the care had changed from private to NHS, such as work or financial, and the organisation could be criticised if a blanket approach was given for all. SM suggested a review or evaluation to be completed after 12 months to ascertain effectiveness as people on significant pathways should not be adversely impacted. PW agreed and understood the rationale for considering each case on its merits. The policy was constantly being reviewed to ensure wording was clear and issues were being picked up. There may be an increase in conversations with patients when the policy was published on the website. NIB suggested that a case study could be provided on the external website to ensure a clearer understanding.

SP commented that there were cases when complications arose and so the care would be transferred to NHS providers and asked whether the private organisations were quality governed for their work so that they could be held accountable. PW confirmed that any private provider should adhere to all the relevant quality standards to deliver services and some also had NHS contracts. There was a baseline quality of service to be delivered through CQC registration. SM advised that the majority of private providers, whether providing physical or mental health, had an agreed process for quality assurance, they were all managed and monitored to the same set of quality assurance standards and amount of scrutiny as an acute provider and would be logged and tracked. If sub-optimal care was identified, then services could be suspended. SM agreed with SP that a report on independent providers should be submitted to the committee and that it would be added to the workplan.

089 Patient Safety Incident Response Framework Policy (PSIRF) - The policy had initially been given a one year review date in anticipation of primary care going live with PSIRF, however this would not be mandated until 2026. There had been no amendments made to the policy and a review in 18 months was suggested to allow for the implementation of PSIRF within primary care.

Resolved: The committee approved the following revised documents:

- **080 Defining the Boundaries Policy**
- **089 Patient Safety Incident Response Framework Policy.**

Action: HC to add Independent Providers update to the workplan.
Action: PW to consider adding a case study of a patient moving from private to NHS care on the external website to ensure a clearer understanding of the process.

19.2 Extension of review dates of existing policies:

Committee members were asked to extend the review dates of the following policies:

074 Communicable Disease Outbreak and Incident Management Policy (to 28 February 2025) – SM requested a review date extension to February 2025 so that the policy could be aligned with the NHSE and ICB memorandum of understanding.

Resolved: The committee agreed to extend the review date of the Communicable Disease Outbreak and Incident Management Policy.

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

20.1 Escalations to:

- **Other ICB main committees (including SOAC)**

There were no escalations to other ICB main committees.

- **ICB Board**

There were no escalations to ICB Board .

- **Safety Quality Group**

The main subject area of complaint/concerns received was ‘care needs not adequately being met’ which was 68%.

20.2 Agreement on next deep dive

The next deep dives were confirmed as follows.

- February 2025 – Maternity Services
- April 2025 - Dental Services

SP suggested a further deep dive on End-of-Life Care to see the progress from last year with a Medium-Term Plan focus.

21. Any Other Business

SOC confirmed that a recent audit highlighted that all committees should be reviewing the effectiveness of each meeting so that any issues could be picked up during the year to supplement the annual committee effectiveness review.

Arrangements for the end of year effectiveness review process were being finalised and would consist of a desktop review undertaken by the governance team, which would be shared with members, along with a short questionnaire to be completed.

NIB advised that last year's Committee Effectiveness review highlighted that a review of the meeting day and time should be held to improve people's ability to attend which would be taken into account during 2025/26.

NIB invited members to comment on the effectiveness of the meeting.

MS commented that there should be assumption that papers had been read and only key points should be highlighted, and that presentations could be shorter to allow for more focused discussion.

22. Date of Next Meeting

Friday, 28 February 2025 at 10.00 am to 1.00 pm via MS Teams.