MID AND SOUTH ESSEX JOINT COMMITTEE - PART I - IN PUBLIC

MID AND SOUTH ESSEX JOINT COMMITTEE - PART I - IN PUBLIC

27 March 2025

11:00 GMT Europe/London

Brentwood Community Hospital - Crescent Drive, Brentwood, Essex CM14 8DR - Conference room

AGENDA

- Agenda 1

MSECC Joint Committee Agenda - 27.03.25 Part I - In Public V2.pdf 2

1. Welcome, introductions and apologies (11:00) 3
2. Declaration of Interest (11:01) 4

Declaration of Interest March 2025 (1).pdf 5

3. Minutes of meeting 30th January 2025 (11:02) 6

Joint MSECC Part 1 Minutes 30.01.2025 DRAFT.pdf 7

4. Action log following 30th January 2025 (11:03) 14

MSECC Joint Commiee Action Log updated AHEAD of mtg on 27.03.2025.pdf 15

5. Matters Arising from Previous Minutes (11:04) 16
6. MSE Community Collaborative Update report (11:05) 17

Collaobrative Update Report March 25.pdf 18

7. Accountability Framework including exception reporting (11:15) 21

MSECC AF Assurance report - March 2025 (1).pdf 22

8. Future Joint Committee Governance (11:20) 26

Governance Paper March 2025.pdf 27

9. MSE Community Collaborative Finance and Efficiency Update (11:40) 49
10. Questions from the Public (11:50) 50
11. Any Other Business (11:55pm (5mins)) 51

AGENDA

Robert Parkinson

MID AND SOUTH ESSEX COMMUNITY COLLABORATIVE JOINT COMMITTEE - PART I IN PUBLIC
Thursday 27th March 2025, 11:00 - 12:00
Brentwood Community Hospital, Crescent Drive, Brentwood, Essex CM15 8DR - Conference Room (1st Floor)

REFERENCES

Only PDFs are attached

MSECC Joint Committee Agenda - 27.03.25 Part I - In Public V2.pdf

Mid and South Essex Community Collaborative

AGENDA

MID AND SOUTH ESSEX COMMUNITY COLLABORATIVE

JOINT COMMITTEE

Part I – In Public

Thursday 27th March 2025 – 11:00 – 12:00
Brentwood Community Hospital, Crescent Drive, Brentwood, Essex CM15 8DR
Conference Room (1st floor)

No.	ITEM	LEAD	REQUIREMENT	PAPERS	TIME
Formalities and Administration					
1.	**Apologies for Absence** Caroline Allum Caroline Dollery Mark Harvey Tania Sitch Eileen Taylor	Robert Parkinson, Chair	Information	Verbal	12:00
2.	**Declarations of Interest**	Robert Parkinson	Information	Attached	12:01
3.	**Minutes of meeting 30th January 2025**	Robert Parkinson	Approval	Attached	12:02
4.	**Action log following 30th January 2025**	Robert Parkinson	Information	Attached	12:03
5.	**Matters arising from previous minutes**	Robert Parkinson	Information	Verbal	12:04
Collaborative Update					
6.	**MSE Community Collaborative update report**	James Wilson	Information	Attached	12.05 (10mins)
Assurance					
7.	**Accountability Framework including exception reporting**	Alex Green and functional leads	Assurance	Attached	12:15 (5mins)
Governance					
8.	**Future Joint Committee Governance**	Philip Richards	Decision	Attached	12:20 (20mins)
Finance					
9.	**MSE Community Collaborative Finance and Efficiency Update**	Trevor Smith	Assurance	Verbal	12:40 (10mins)
Questions from the Public					
10.		Robert Parkinson	Verbal	Discussion	12:50 (5mins)
Any Other Business					
11.		Robert Parkinson	Verbal	Discussion	12:55 (5mins)
Meeting End					13:00
Future agenda items: May 2025 Electronic Patient Record					
Date of next meeting: **Thursday 29th May 2025, 10am-1pm – Wren House, Hedgerows Business Park, Colchester Road, Springfield, Chelmsford CM2 5PF**					

1. WELCOME, INTRODUCTIONS AND APOLOGIES

Standing item | Robert Parkinson | 11:00

Apologies are noted on the agenda.

2. DECLARATION OF INTEREST

Standing item | Robert Parkinson | 11:01

REFERENCES

Only PDFs are attached

Declaration of Interest March 2025 (1).pdf

REGISTER OF POTENTIAL CONFLICT OF INTERESTS FOR THE MID AND SOUTH ESSEX COMMUNITY COLLABORATIVE - 2024/2025							
NAME	**POSITION**	**ORGANISATION**	**FINANCIAL INTERESTS**	**NON-FINANCIAL PROFESSIONAL INTERESTS**	**NON-FINANCIAL PERSONAL INTERESTS**	**INDIRECT INTERESTS**	**DATE SIGNED**
Allum Caroline	Chief Medical Officer	North East London Foundation Trust (NELFT)	Employee of NELFT Consultant Radiologist - Royal Free London NHSFT				10.01.2024
Castro Luis Canto E	Lived Experience Leader	Essex Partnership University Trust (EPUT), North East London Foundation Trust (NELFT) and Provide Community Interest Company (CIC)	Unstoppable Living Ltd - Consultant As a Workplace Inclusion and Accessibility Consultant, we have been doing work with NHSE, NELFT and there are possibilities of other Trusts acquiring our services should they so choose				06.06.2024
Davey Anna Dr	General Practitioner	Mid and South Essex Integrated Care Board (MSEICB)	GP Partner - The Coggeshall Surgery GP Partner - Colne Valley Primary Care Network	Primary Care Partner, Member on the MSEICB Member of the GP Provider Collaborative for MSE	None	None	25.07.2024
Doherty Dan	Alliance Director, Mid Essex	Mid and South Essex Integrated Care Board (MSEICB)	Employee of MSEICB	Non Executive Board Member - Active Essex		Spouse is a Community Physiotherapist at North East London Foundation Trust (NELFT)	04.07.2024
Dollery Caroline Dr.	Primary Care Non-Executive Director	North East London Foundation Trust (NELFT)	GP Partner - Beacon Health Group Clinical Director - Aegros PCN	Trustee - Open Road Charity - Chair their Clinical Governance Committee and sit on Board Trustee - Kids Inspire - Safeguarding lead and sit on Board Trustee - Rural Communities of Essex, on Board and sit on Finance Committee			08.04.2024
Green Alex	Executive Chief Operating Officer	Essex Partnership University Trust (EPUT)	Employee of EPUT	None	None	None	04.07.2024
Harvey Mark							
Johnson Brid	Chief Operating Officer	North East London Foundation Trust (NELFT)				Partner is a Non-Executive Director at Mid and South Essex Integrated Care Board (MSEICB)	03.06.2024
Karele Milind Dr	Executive Medical Director	Essex Partnership University Trust (EPUT)	Employee of EPUT	None	None	None	24.07.2024
Lutchmiah John	Lived Experience Leader	Essex Partnership University Trust (EPUT), North East London Foundation Trust (NELFT) and Provide Community Interest Company (CIC)	Patient Board member - NELFT	None	None	None	25.07.2024
Makala Wellington	Executive Chief Nursing Officer/Executive Director AHP & Psychological Professions	North East London Foundation Trust (NELFT)	Adhoc Consultant work				12.01.2024
Morrison Siobhan	Group Chief People Officer	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC Director - React Homecare Limited Director - Provide Care Solutions Ltd Director - Provide Equipment Hub Limited				05.07.2024
Parkinson Robert	Group Chair	Provide Community Interest Company (Provide CIC)		Foundation Governor - St John's School, Horsham			04.07.2024
Persey Robert	Interim Executive Director for Adults and Health	Thurrock County Council					
Presmeg Nick							
Richards Philip	Chief Finance Officer	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC Director - Albion Outlook Ltd Director - Provide Wellbeing Ltd Director - Brantree Healthcare Ltd Director - Provide Digital Ltd Director - Provide Group Ltd Director - Provide Care Solutions Ltd Director - Provide Property Ltd Director - React Homecare Ltd Trustee - Ormiston Families Director - Provide Equipment Hub Limited				25.06.2024
Salmon Sheila	Chair	Essex Partnership University Trust (EPUT)	Chair - Essex Partnership University Trust	Emeritus Professor of Health Development - Anglia Ruskin University		My son was appointed through open external competition to an 8d role in People and Culture Directorate.	06.11.2024
Sitch Tania	Non-Executive Director	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC Director - React Director - Provide Care Solutions	Trustee - Thurrock Community and Voluntary Services (CVS)			30.05.2024
Stapleton Michelle	System Integrated Care Pathway Director	Mid and south essex Foundation Trust	NIL	NIL	NIL	NIL	20.11.2024
Taylor Eileen	Chair	North East London Foundation Trust (NELFT)	Chair - East London Foundation Trust (ELFT) Non-Executive Director & Senior Independent Director - MUFG Securities EMEA Plc Chair - North East London ICS Mental Health Learning Disability and Autism Committee				05.06.2024
Wightman Lucy	CEO Provide Health & Group Chief Nurse	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC	Honarary Professorship - University of Essex Member - Health Council at Reform (Health Think Tank) Fellow - Faculty of Public Health Member - UK Public Health Register (UKPHR) Member - Nursing and Midwifery Council (NMC) Member - Royal College of Nursing (RCN)			03.09.2024
Wilson James	Collaborative Lead Director	Hosted by Essex Partnership University Trust (EPUT) on behalf of our Mid and South Essex Community Collaborative	Employee of EPUT	Trustee - Hamelin Trust	Wife is a finance business partner at Essex County Council	Brother is a partner at PWC Consultancy	06.06.2024

3. MINUTES OF MEETING 30TH JANUARY 2025

Standing item | Robert Parkinson | 11:02

REFERENCES

Only PDFs are attached

Joint MSECC Part 1 Minutes 30.01.2025 DRAFT.pdf

Mid and South Essex Community Collaborative

DRAFT MINUTES

MSE COMMUNITY COLLABORATIVE BOARD

PART I – IN PUBLIC

30 January 2025 – 11am-1.00pm

Trust Head Office, EPUT, The Lodge, Lodge Approach, Wickford, Essex SS11 7XX - Training Room 1

Members present:		
Robert Parkinson (Chair)	RPa	Chair, Provide CIC
Luis Canto E Castro	LCa	Lived Experience Leader
Anna Davey	AD	Deputy Medical Director for Engagement, MSEICB
Dan Doherty	DD	Mid Essex Alliance Director, MSE ICS
Alex Green	AG	Executive Chief Operating Officer, EPUT
Milind Karele	MK	Executive Medical Director, EPUT
John Lutchmiah	JL	Lived Experience Leader
Moira McGrath	MM	Director Adult Social Care, Essex County Council
Wellington Makala – *virtual attendance*	WM	Executive Chief Nursing Officer, NELFT
Siobhan Morrison	SM	Group Chief People Officer, Provide CIC
Robert Persey	RPe	Interim Executive Director for Adults & Health, Thurrock Council
Tania Sitch	TS	Non-Executive Director, Provide
Michelle Stapleton	MS	System Integrated Care Pathway Director, MSEFT
Lucy Wightman	LW	CEO, Provide Health
James Wilson	JW	Transformation Director, MSECC
Invited Guests:		
Elesha Jones (agenda item 7)	EJ	Operational Lead for Community Adult Services, NELFT
Ondine Pannell (agenda item 7)	OP	Basildon Early Response Team Care Co-ordinator, PCN West Basildon
Marmade Auckburally, (agenda item 8)	MA	Interim Associated Director of Thurrock Community Services, Thurrock
Mousumi Basu (agenda item 8)	MB	Associate Director, Integration, EPUT
Caroline McCarron (agenda item 8)	CM	SEE Deputy Alliance Director
Observing:		
Dean Cox		Shadowing AG, Final year OT student
Annalisa Furnevel		Admin Lead, West Basildon PCN
Jo Debenham		Associate Director, Engagement & Workforce, MSECC

Candice Robinson		Communications Manager, MSECC
Minutes:		
Claire McPherson		Joint Committee administration support
Apologies:		
Caroline Allum		Chief Medical Officer, NELFT
Caroline Dollery		Non-Executive Director, NELFT
Judith Friedman		Executive Director of Allied Health Professionals, Psychological Professions & Social Work, NELFT
Mark Harvey		Executive Director of Adult Social Services, Southend City Council
Brid Johnson		Chief Operating Officer, NELFT
Nick Presmeg		Executive Director of Adult Social Services, Essex County Council (MM deputising)
Philip Richards		Chief Finance Officer, Provide CIC
Sheila Salmon		Chair, EPUT
Trevor Smith		Executive Finance Director, EPUT
Eileen Taylor		Chair, NELFT

Formalities and Administration	
1.	**Welcome and Introductions**
	RPa welcomed everyone to the meeting. The Committee gave a round of introductions for any new members of the Committee present.
2.	**Declarations of Interest**
	The Committee reviewed the Declarations of Interest log and no new declarations were made.
3.	**Minutes of the Meeting held on 28 November 2024**
	With amendment to job titles for Tania Sitch and Sultan Taylor notified prior to the meeting duly completed, the minutes of the meeting held on the 28 November 2024 were agreed as an accurate record.
4.	**Action Log from the Meeting held on 28 November 2024**
	The action from the meeting held on the 28 November 2024 was reviewed and the following updates provided: • **Action 95:** Work with each of the Executive Leads to compile and review risks is underway with an extended meeting in diaries for March Joint Committee meeting around risk appetite and tolerance. Action closed from action log. • **Action 116 and 117:** The Committee agreed that the updated progress provided closed the actions. All other actions had been completed.
5.	**Matters Arising from Previous Minutes**
	None.
Collaborative Update	
6.	**MSE Community Collaborative Report**
	JW presented a report providing an overview of progress, key strategic areas and highlights to set the context for proceeding items on the agenda. JW highlighted the following: <u>Winter and Flow</u> • We have seen a positive impact in how the Collaborative has supported the system during the last few months, with significantly improved length of stay for our community wards and improved utilisation of our virtual ward capacity,

	enabling good flow. Planning • Two workshops on our Focus for future. Subsequently to these we have supported at the Collaborative Executive the proposals for how we integrate both leadership and delivery models for Community beds, CYP, Wheelchairs and Adult Speech and Language services. We have also supported the design work to commence for the move to a single operational structure. • Work on planning prioritise is on the agenda and triangulates multiple areas of potential focus for 25/26. Delivery • Progress continues for delivery of 25/26 plan. 2 areas highlighted. CVD new guidance work, which is making best use of every contact and the work led by Ryan Cossington-Web on Hybrid close loop, which is at business case stage. People and engagement • Report highlights the many examples of positive engagement and partnership working that is continuing to build the trust and relationships from which our collaborative delivery is built. • Ellie Williams, Project Manager for the Collaborative was thanked for her contributions over the last few years. Ellie has now commenced her new role with MSEFT working on the Electronic Patient Record (EPR) system. Questions & Discussions • RPa asked how, as a Collaborative, do we have joint performance outcomes? JW advised we have a joint outcomes framework for the 3 community providers to bring reporting together, formed under the new single contract and within BCF and at ICP level we track joint outcomes across wider partners. • JL queried the principles of working together. JW responded that where it makes sense to do so, we do and this is the core principle of our collaborative, and set out in our vision of working better together. DD added, that it is apparent that to get consistency across community services in general, there is a need for more consistent commissioning, adding that the ICB have not made it easy for community providers to offer consistent community provision. • LW commented that there are shared principles that all 3 community providers signed up to. How that trickles down into decision making is tricky. It could be that we standardise to a lower level of provision. • AG commented the need to keep an eye on local devolution. There will be opportunities to do things hypo-locally, beds is a good example, moving towards outcome based commissioning. We need to keep flexible to adapt to an ever changing environment. • LW informed that NHSE have published their core offer for community providers, working up a set of measurements that we will have to abide by. **The Committee noted the update and ongoing progress being made.**
7.	**Service User Case Study – Transfer of Care Hubs (TOCH)**
	EJ and OP delivered a presentation (presentation slides to be circulated with the minutes) highlighting how Brentwood & Basildon TOCH are working in conjunction with Basildon Early Response Team (BERT): • EJ outlined the purpose of the Basildon & Brentwood (B&B) TOCH:- To meet once a day to discuss complex cases (adults 70+ and all residential/nursing home patients) referred to the TOCH teams by MSEFT with a decision to admit. • BERT steps in once the patient has been discharged from MSEFT; and a welfare call or discussion is carried out.

	• BERT meetings are 3 times per week, with up to 13 different teams taking part in supporting if required. • The Committee heard 2 case studies where BERT has had a positive impact on patient outcome. • Statistics were shared with the Committee which shows there is a noticeable reduction in patients that would have been admitted to MSEFT via TOCH if BERT had not been involved. <u>Questions & Discussions</u> • AG noted the opportunities with Mental Health and EJ mentioned that B&B do have a Mental Health TOCH and that is filtered via BERT also. • The Committee had a brief discussion on dementia patients and the need to avoid deterioration. • Scalability across B&B was discussed. Basildon PCN currently has 53k users. If each B&B PCN had an "Ondine/Care Co-ordinator", would this be replicable with current staff and is there capacity to operate this model across all PCNs in B&B? OP advised that Basildon have reutilised the resources that would have previously been used by individual MDTs for each surgery. • OP and EJ are working with the ICB to put plans in place to mimic this in other PCNs. • The Committee discussed the link with ECL and relationships with wider social care services. • The Committee were updated that JW, with Vicki Decroo, Deputy Director of Integrated Commissioning, ICB, is leading on an evaluation for all TOCHs. We have different models with different resources, all delivering positive outcomes – need to agree what we want as standard and what is bespoke to each TOCH. This will be reported back to the Joint Committee via the Collaborative Executive Team. EJ and OP were thanked by the Committee for their time. **The Committee noted the excellent progress made in the TOCH in Basildon and Brentwood and the assurance provided around future evolution of the model to support more people at home and speed up discharges and how we are using this learning across the Collaborative.**
Strategy & Transformation	
8.	**Strategic Priority Update: Creating an integrated delivery environment**
	Marmade Auckburally delivered a presentation (presentation slides to be circulated with the minutes) to the Committee on the work currently being undertaken in Thurrock. The Committee were briefed on: • The priorities and good news stories in Grays PCN. • How the 4PCNs across Thurrock are working together to provide personalised care for complex patients. • Integration at Place. Heather Joslin delivered a presentation (presentation slides to be circulated with the minutes) to the Committee on the work currently being undertaken in Mid Essex. The Committee were briefed on: • Progress so far in Mid Essex Integrated Neighbourhood Teams and the challenges being faced. • Update on Mid Essex TOCH. Caroline McCarron and Mousumi Basu delivered a presentation (presentation slides to

	be circulated with the minutes) to the Committee on the work currently being undertaken in South East Essex. The Committee were briefed on: • The key outcome for Integrated Neighbourhoods in SEE over the next two years is to deliver healthy neighbourhoods and the various models of delivery to achieve this. • SEE's multi-agency approach for patients with complex needs. • Targeted outreach; partners coming together to offer outreach services to targeted cohorts of people. <u>Questions & Discussions</u> • The Committee noted the positive impact of seeing partner (organisations/agencies) relationships have grown and the positive impact of getting people together. DD and AG left the meeting at 12:26 • RPe suggested that in the future the Committee may welcome a presentation from Local Government around devolution and reorganisation. • It was asked if there is an opportunity for the 3 localities (Thurrock, Mid Essex and South East Essex to integrate and CM agreed, recognising that all areas are saying the same thing, just using different language. A proposal is being worked on around bringing together to make it simple. • LW commented around the opportunities to align geographies and to optimise the relationships for acute and social care, are patients responding well to the fact that these are de-medicalised models, noting that service users often feel safest in hospital. • EJ commented that with BERT, as part of the OP's (care co-ordinator) role, every service user over the age of 75 receives a welfare call. Some are shocked by this but are grasping the fact to call OP prior to contacting their GP. **ACTION: Presentation from Local Government around devolution and reorganisation to come to a future Committee meeting.** The presenters all left the meeting at 12:34. **The Committee noted the positive impact of seeing how partner (organisations/agencies) relationships have grown and the positive impact of getting local teams to work together.**
9.	**Planning Priorities**
	The paper was taken as read. JW outlined that the purpose of the paper is to seek support from the joint committee on the approach to prioritisation and highlight any other areas to consider as part of the 25/26 priorities. • JW noted the complexity of finalising the priorities for 25/26 with many influences noted in the report having an impact. • A long list has been developed based on inputs as noted in the report that include commissioning intentions, national planning guidance, areas of work from 24/25 that are mid implementation and also areas of work that are supporting the maturity of our collaborative model, • Noted a priority matrix has been developed based on the original outcomes of the collaborative to be used as a blunt tool to help guide an internal prioritisation ahead of a final prioritisation with the ICB. JW noted the approach is including a wider range of clinical, operational and our patient leaders to help get a range of

views on priorities and the respective impact.

- It was noted that we can't do everything and the need to make difficult choices together that align to both our financial position and resources available to undertake the change.

Questions & Discussions

- MM made comment that the Better Care Fund (BCF) has just been circulated and how we align the BCF planning with the Collaborative funding is important.
- Discussed a concern with regards to the Local Government reform, from an Essex point of view, is that BCF resource allocation may not be the same and could end up with stranded costs.
- With regards the Planning Priorities, MK queried the process of identifying which services we focus on. JW advised that this is a complex process due to the many factors at play. The prioritisation matrix noted in the report has been through CCET and gives a tool to help guide the conversations. It is not an absolute science however and we ultimately need to agree with the ICB our focus for 25/26 It was noted that outputs will be bought back to the Joint Committee in March for review and approval.

ACTION: 25/26 Planning Priorities outcomes to be presented back to the Committee at the next meeting in March 2025 for review and approval.

The Committee supported the approach being undertaken to assess and develop a set of priorities for 25/26.

Assurance

10. **Accountability Framework**

As AG had left the meeting, JW provided verbal assurance on the work of the collaborative and a summary of key discussions from the Accountability Framework (AF) meeting in January, noting that due to meeting timings this month, a written report was not yet available. JW highlighted the following:

- Now in its 4th iteration, the AF brings together the data across 5 domains: quality and safety; operational performance; workforce and culture; finance; Strategy & Transformation.
- An update is provided against each domain using a common agreed set of key performance indicators (KPIs), to gain a collective understanding of current risk level and progress.

Escalations:

- Quality & Safety is rated as Amber due to progress. WM has been working on sub-quality governance and performance around quality. It is starting to mature but now need to see the next level of detail to give assurance it can move to green. The long waits in Paediatrics was highlighted.
- Operational Performance is rated as Red due to:
  - Significant waiting times in Paediatrics. There is significant work being undertaken to understand recovery trajectory within current resources available. The reality is that it won't be sustainable without moving to a different model. We will be looking for a business case to be developed around a longer sustainable model, managing diagnosis.
  - At the time of the AF meeting there had been waits in excess of 52 weeks in SE Wheelchairs and SW Spirometry provision. These patients have now all been seen and clock stopped. There are ongoing recovery plans being put in place to ensure a sustainable position.
  - There is positive performance around Stroke and Community beds, however these both remain rated as Red.
- Finance is rated as red, due to contract signature and recognising the resource challenge. The positive progress towards service line reporting was noted with

	an expectation that finance will move to amber next week. • Strategy & Transformation rated as Amber due to significant change resource required for the range of priorities as discussed in item 9. • Workforce & Culture rated as Green. Continuing to see reductions in bank and agency use and positive working on common priorities in this area. **ACTION: Formal notes from the AF meeting held on 15.01.25 to be circulated when available.** **The Committee noted the AF update and accepted the ratings position as highlighted with no further actions requested from the Joint Committee beyond those already in place.**
Finance	
11.	**MSE Community Collaborative Finance and Efficiency Update** With no finance colleagues present, the paper was taken as read with the expectation of a finance session at the March Joint Committee meeting. **ACTION: Finance session (including future governance) to be included at the March 25 Joint Committee meeting.** **The Committee agreed it required a full finance overview at the next Joint Committee.**
Questions from the Public	
12.	There were no members of the public present.
Any Other Business	
13.	JL raised a query around flow of information into patient groups. JW will pick this up outside of the meeting. **ACTION: JW to meet with JL regarding flow of information into patient groups.**
Date and Time of Next Meeting: Thursday 27 March 2025, venue to be confirmed	

Signed ……. **Date……**
Robert Parkinson, Chair

4. ACTION LOG FOLLOWING 30TH JANUARY 2025

Standing item | Robert Parkinson | 11:03

REFERENCES

Only PDFs are attached

MSECC Joint Commiee Action Log updated AHEAD of mtg on 27.03.2025.pdf

Mid and South Essex Community Collaborative Joint Committee
Open Actions

Action Number	Board Date	Agenda Item	Action	Owner	Due date for completion	Open/Closed	Comments
118	30.01.25	Strategic Priority Update: Creating an integrated delivery environment	Presentation from Local Government around devolution and reorganisation to come to a future Committee Meeting	Robert Persey	29.05.25	OPEN	
119	30.01.25	Planning Priorities	25/26 Planning Priorities outcomes to be presented back to the Committee at the next meeting in March 2025 for review and approval	James Wilson	27.03.25	CLOSED	On agenda.
120	30.01.25	Accountability Framework	Formal notes from the Accountability Framework meeting held on 15.01.25 to be circulated when available.	James Wilson	07.02.25	CLOSED	Complete.
121	30.01.25	Finance	Finance session (including future governance) to be included at the March 25 Joint Committee meeting.	Trevor Smith	27.03.25	CLOSED	On agenda.
122	30.01.25	AOB - Flow of information into patient groups	JW to meet with JL regarding flow of information into patient groups.	James Wilson	27.03.25	CLOSED	Complete.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Standing item | Robert Parkinson | 11:04

6. MSE COMMUNITY COLLABORATIVE UPDATE REPORT

Standing item | James Wilson | 11:05

REFERENCES

Only PDFs are attached

Collaobrative Update Report March 25.pdf

Mid and South Essex Community Collaborative (MSECC)

Joint Committee

Meeting	Mid and South Essex Community Collaborative Joint Committee
Subject	Collaborative Update report
Date of Meeting	27th March 2025
Agenda Item	6.
Author	James Wilson, Lead Director, MSECC
Approved by Responsible Lead	James Wilson, Lead Director, MSECC

For Decision	For Assurance	For Information
☐	☐	☒

Purpose

To give an overview of progress, key strategic areas for the board to be aware of and key highlights to set the context for the proceeding board items.

The Joint Committee is asked to:

The Joint Committee is asked to note the contents of the report.

Forums where content has been previously discussed

MSE Community Collaborative Executive Team ☒
MSE Community Collaborative Strategy & Transformation ☒
MSE Community Collaborative Core Leadership Team ☒
MSE Community Collaborative Joint Clinical Oversight Group ☒
MSE Community Collaborative Finance Workstream ☒
Other ☐ Please specify:

Link to MSECC Strategic Priorities

Strategic Priority/ Contractual priority	IMPROVE *(Work together to optimise and drive consistent delivery of community services, reducing inequalities)*	INTEGRATE *(With wider partners, facilitate community physical and mental health services integration with developing neighbourhood models at place)*	INNOVATE *(Take a lead role within the system to develop and deliver innovative models of care and use of technology)*
Creating an integrated delivery environment and culture	☒	☒	☒
Building healthier and resilient communities	☒	☒	☒
Supporting more people at home (directly impacting on capacity required in acute sector)	☒	☒	☒
Productivity and cost improvement	☒	☒	☒

Are there any risks in the report that need to be noted, escalated on the risk register or added to the Board Assurance Framework?

None

Glossary for acronyms in report (if any)

MSE Joint Committee: Overview February-March 2025

Within this last period significant change has been announced to the way the NHS will be overseen both Nationally, Regionally and significant budget reductions for ICBs locally. We also have building momentum around the consultation for Devolution and Local Government Reorganisation. This brings uncertainty but we are responding positively to this challenge as a Collaborative.

I am heartened by the way we have managed to closely work across our Collaborative and with our partners, using the medium term plan as our spine to shape and focus where we can add value moving into 2025/26. This is reflected in the priorities we have worked up and also the recognition that to deliver on those priorities is going to need us to evolve our operating model and be flexible to changes in the way we deliver together to be as efficient as possible. As committee members would expect these priorities also reflect the NHS Operating Plan and Priorities for 25/26 that relate to community provision.

Aside from planning, work is progressing at pace on the development of the future integrated Virtual Hospital model for MSE. A paper outlining the intent, scope and timeframe was approved by the ICB and is progressing via workstreams overseen by the Virtual Hospital Programme Board. Work has started to develop a financial recovery plan for our Virtual Wards to bring spend back in line with 25/26 budget allocations. This will dovetail with our future model development.

The initial Cardiovascular Disease (CVD) pilot was successful in testing the new community hypertension guidance and training and its impact on staff confidence managing blood pressure recordings as part of routine consultations. This means that we will continue to roll out this intervention with the aim of improving outcomes for people with or at risk of CVD.

Last month the MSE Children & Young People team held an event with ICB, service leads, Paediatricians, Family Forum and clinicians to set out the principles of a single Autism Spectrum Disorder (ASD)/Attention Deficit Hyperactivity Disorder (ADHD) pathway. Work is continuing with design and implementation.

I am pleased to note we now have confirmation from the ICB of continuation of the Mid Essex Ambulatory Wound Care clinic and are expecting shortly confirmation around the future funding for Long Covid and the CYP Bladder & Bowel provision.

Our latest Value and Impact report has been published and this is evidencing a benefit realisation for MSECC equivalent to a 650 bed hospital from the impact of our Frailty Virtual Wards, UCRT and Community Nursing teams. We are continuing to evolve this model and include other services over time.

Within the papers today we has progressed the governance model of the Collaborative and it is also important to note significant work has been happening on strengthening both our quality and financial and performance sub governance arrangements to reduce duplication across our organisations.

Patient participation, engagement and communications

We continue our engagement with the Family Forums who support families with children with special educational needs. Their feedback helps with making improvements on MyCareBridge; the new portal for Autism and ADHD services for children and young people in mid and South Essex.

We have been supporting the implementation of Purpose-T standardisation in Wound Care across MSE partners, including local hospices and the continued work on engaging with hospital staff and providing catheter essential items and information, to improve catheter care.

In Patient Participation we have had multiple public engagement events that have taken place across MSE. Engagement with stroke survivors and carers has been strengthened through the Stroke Involvement Group and support groups and our Virtual Ward clinicians are working with carers to gather feedback and shape the Virtual Hospital.

The culmination of our year's engagement is a refresh of the Patient Engagement Strategy that will be presented to the Quality Triangulation Group in April.

Our collective work across our People teams continues. A small but significant example was highlighted to me this month of the impact of our collaboration in supporting our workforce. We were able to avoid a redundancy situation by our HR partners working together to re-deploy an employee at risk of redundancy by finding suitable alternative employment in another partner. The Collaborative has not only reduced the likely costs associated with a redundancy situation but most importantly retained qualified nursing skills within the system and supported a positive outcome and experience for our employee. A more formal protocol is being developed.

Hello and Goodbye

We are very pleased to have successfully recruited to our fixed term Project Manager Position and hope to have recruitment processes complete and post holder in place for 1st April.

We said farewell to Hilary Armstrong our much valued Clinical Manager for adult Speech & Language therapy who was instrumental in the Collaborative speech and language programme.

We also say goodbye to Stephanie McNichol, our Fixed Term Patient Participation Lead. In the last year she has worked really hard with Lee Chester and others to bring the Patient Voice and Lived experience to the heart of what we do in the Community Collaborative.

7. ACCOUNTABILITY FRAMEWORK INCLUDING EXCEPTION REPORTING

Information Item | Alex Green | 11:15

REFERENCES

Only PDFs are attached

MSECC AF Assurance report - March 2025 (1).pdf

Assurance Report
To
Mid & South Essex Joint Committee

Subject	**Mid & South Essex Community Collaborative Assurance Framework**
Date of meeting	19 March 2025
Author	Graeme Jones, Director, Vaughan Jones Ltd
Approved by lead	James Wilson, Lead Collaborative Director, MSECC

For Decision Members are being asked to make a decision	For assurance Members are being provided with assurance	For Discussion Members are being asked to consider or discuss an item, or guidance/support is being sought	For Information Members are being asked to note for information only, with no discussion required
☐	☒	☐	☐

1. BACKGROUND / GOVERNANCE

The aim of the report is to provide the MSECC Joint Committee with assurance on the work of the collaborative and a summary of key discussions from the MSECC Assurance Framework meeting in February and March.

2. RISKS

There has been further progress in developing a single aggregated risk register for the Community Collaborative, which is now being led by the Director of Governance at EPUT. A seminar will be held to test the emergent risk register and discuss the Collaborative risk appetite. A risk register will be presented at the next and subsequent Accountability Framework meetings.

3. AREAS FOR ESCALATIONS TO THE MID AND SOUTH ESSEX JOINT COMMITTEE

The Accountability Framework meetings in February and March focused on the following key issues by domain.

<u>Quality and Safety</u>

There has been considerable progress in establishing the Quality and Safety governance of the Collaborative. There has also been progress in reviewing the Quality and Safety Key Performance Indicators and in developing a Clinical Governance Manual.

The process for Quality and Safety input and reviews of service changes, transformation and operational plans is now much clearer. Recent examples of input include providing clinical input into the review of the beds and pathways in the Collaborative and agreement to review the new Virtual Ward Operating Model through the Collaborative Quality Oversight meeting.

The Quality and Safety domain is rated amber while the governance matures. This is expected to become green when the KPI review, and the Clinical Governance manual are completed.

The lead director for Quality and Safety in the Collaborative is writing to the ICB to offer clarification and a stronger narrative on the reporting of quality and safety at a system level.

The March Accountability Framework meeting agreed that the Collaborative should undertake a review of the different approaches and funding routes for the collection of clinical waste from people's homes.

Operational Performance

The February and March Accountability Framework meetings spent quite a bit of time discussing the positive work to reduce length of stay in the community beds, however the risk to this being sustainable with an increasing volume of out of criteria patients and their impact on length of stay.

The meetings also discussed Virtual Wards and the level of acuity of patients in the MSE service.

There has been considerable focus on a set of actions to reduce wheelchair waiting times. The longest waits have been eradicated and there is a trajectory to move below 18 weeks by the autumn.

Similarly, there has been a strong focus on reducing Spirometry waits with changes to process and resourcing now delivering a reduction in the longest waits and the overall waiting list.

Significant performance issues in Children's Services remain with steadily increasing demand seen across all geographies. Work on single model and validation of waits continues. An Improvement and Transformation Plan for Children's Services will be presented to the April Accountability Framework meeting.

There is continued strong performance with the Urgent Care service indicators.

There is work to gather, record and report Continence waits which will be within the Accountability Framework performance report in April.

The Operational Performance domain is rated amber reflecting the small number of significant challenges within an overall context of delivery.

Workforce and Culture

The Workforce and Culture domain is rated green reflecting both the strong joint working through the Chief People Officer group and the success in delivering the key initiatives and indicators.

The reporting of workforce KPIs has improved over the last year and the Collaborative has taken a common position on KPI thresholds for Workforce and Culture.

The vacancy rate across the Collaborative continues to be strong and to improve. There are now temporary staffing scrutiny panels in all three geographies and the use of bank and agency staffing continues to decrease.

The Collaborative is progressing a shared common redeployment protocol to help to retain skilled staff.

The April Accountability Framework meeting will have a focus on the outlier areas for Agency and Bank use.

Finance

The Finance domain is rated red. This is partly driven by the issues in reaching signature on the main and subsidiary contracts. The March Accountability Framework meeting heard that agreement is now very close.

The red rating is also driven by a number of future financial risks including a forecast £1m to £1.5m overspend on Virtual Wards and the lack of ongoing ICB funding for the circa £1m central Collaboration costs. Both of these areas are the focus of considerable work. The Virtual Ward transformation programme seeks to deliver a single integrated model and to address the funding challenges. The ICB approved a paper in March to change the model.

The CFO group and finance leads are developing a single financial plan for the Collaborative that achieves financial balance in 2025/26.

Strategy, Transformation and External Relations

The Accountability Framework meetings reviewed progress with a number of key transformation programmes including the focus on the Virtual Ward model and finances; the CVD progamme and community hypertension guidance; a system approach on the communications and engagement for the FrEDA tool; and implementation of the Hybrid Closed Loop model for Type 1 Diabetes.

There has been a significant focus on ASD and ADHD services, the commitment of additional resources and addressing the longest waits.

Concerns were raised that there may not be ICB funding for the Asthma Allergy service beyond the end of March.

There were also concerns aired on the withdrawal of some GPs from Shared Care arrangements and an explanation of the mitigations in place.

This domain is rated amber driven by the need for a continued and greater focus on the transformation of Children's Services.

The next Accountability Framework meeting will spend some more time on external relations.

4. ASSURANCE

The Accountability Framework meetings are functioning well with good attendance from Director leads from the three Collaborative partner organisations, the Partnership Directors and professional leads.

The professional networks are also working well and governance in areas such as Quality and Safety is being embedded.

The development of a risk register has been protracted but is due to be completed in April.

5. RECOMMENDATIONS / NEXT STEPS

The Joint Committee is asked to note the areas of review and escalation by domain.

8. FUTURE JOINT COMMITTEE GOVERNANCE

Decision Item | Philip Richards | 11:20

REFERENCES

Only PDFs are attached

Governance Paper March 2025.pdf

Mid and South Essex Community Collaborative (MSECC)

Joint Committee

Meeting	Mid and South Essex Community Collaborative Joint Committee
Subject	Future Joint Committee Governance
Date of Meeting	27th March 2025
Agenda Item	8.
Author	Philip Richards
Approved by Responsible Lead	Strategic Direction Meeting

For Decision	For Assurance	For Information
☒	☐	☐

Purpose

The report is to update members of the Joint Committee about progress regarding the required changes to the Governance model. The report outlines a preferred direction of travel as agreed by the strategic direction meeting, and will be formally agreed at the first meeting of the Committee in Common.

The Joint Committee is asked to:

1. Note the contents of the report.
2. Approve the option as outlined in the paper.

Summary of Key Points/implications:

Formal decision making in the Collaborative is stifled until an appropriate legally allowable approach is agreed.

Forums where content has been previously discussed

MSE Community Collaborative Executive Team ☒
MSE Community Collaborative Strategy & Transformation ☐
MSE Community Collaborative Core Leadership Team ☐
MSE Community Collaborative Joint Clinical Oversight Group ☐
MSE Community Collaborative Finance Workstream ☐
Other ☒ Please specify: MSECC Governance Workstream, Strategic Direction Meeting

Link to MSECC Strategic Priorities

Strategic Priority/ Contractual priority	**IMPROVE** *(Work together to optimise and drive consistent delivery of community services, reducing inequalities)*	**INTEGRATE** *(With wider partners, facilitate community physical and mental health services integration with developing neighbourhood models at place)*	**INNOVATE** *(Take a lead role within the system to develop and deliver innovative models of care and use of technology)*
Creating an integrated delivery environment and culture	☒	☐	☐
Building healthier and resilient communities	☐	☐	☐

Supporting more people at home (directly impacting on capacity required in acute sector)	☐	☐	☐
Productivity and cost improvement	☐	☐	☐

Are there any risks in the report that need to be noted, escalated on the risk register or added to the Board Assurance Framework?

Yes, risk to the Governance arrangements for the Collaborative.

Glossary for acronyms in report (if any)

CIC – Community Interest Company
CiC – Committee in Common

Supporting documents/ appendices that can be provided on request

Governance Update

Joint Committee members will be aware of the challenge to the legality of the constitution of the Joint Committee, which cannot operate as we intended it to if one or more of its members is a non-NHS organisation. Provide as a CIC, does not pass the test to be a member of a Joint Committee, and so the two Foundation Trusts are not legally allowed to make decisions at the Joint Committee.

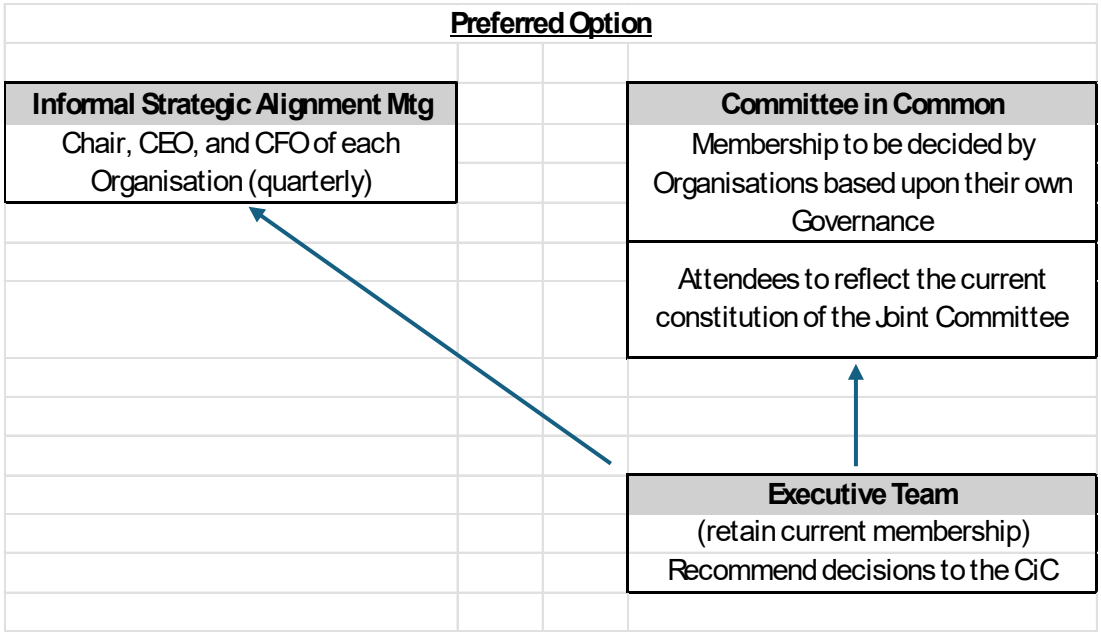
Discussions with lawyers arrived at two possible solutions:

- Continue to operate as a Joint Committee, but exclude Provide from any decisions made in this Committee, or
- Set up the decision-making body for the Collaborative as Committee in Common (CiC), which requires each sovereign organisation to form its own Committee to consider decisions to be made, with theses three Committees coming together as a CiC.

Previous discussions at the Joint Committee have agreed that the first option is sub-optimal, and whilst the second option feels like a slight backward step (with each sovereign organisation having one vote and no other partners being formally involved in the decision-making process), it was still agreed as the preferred option.

As a result of these discussions, the Governance workstream were asked to consider the overall options for the structure which replaces the Joint Committee, and once worked through, these options were shared with the Executive Team to get a view from each organisation about their favoured approach.

The consultation with sovereign organisations came up with the preferred option as shown below:



It is suggested that the group that replaces the Joint Committee is called the Community Collaborative Committee in Common (4C).

In this option, the three individual Committees will be constituted in accordance with the sovereign organisations own governance arrangements, and when these three Committees come together as a Committee in Common, the people in attendance will form the membership of the 4C. Each sovereign organisation will have one vote only, representing the view of its own Committee.

All other attendees of the current Joint Committee will retain their status as attendees, and will be a part of the discussions regarding the subject matter at each 4C meeting, but will not be involved in any formal vote.

This approach was agreed as the most appropriate direction of travel at a meeting of the Chairs, CEOs and CFOs of the three sovereign organisations (Strategic Direction Meeting) on Wednesday 19th March 2025. Whilst this cannot be formally recognised as a decision of 4C, the membership of the Strategic Direction Meeting is likely to shadow the constitution of the 4C, so should be assumed as a working model at this stage.

The key implications of the revised structure are:

- Each organisation will need to ensure that their own Committee is well represented at 4C meetings, and a quorum will require at least two members of each individual Committee, one of whom will be a NED;
- It would be best practice to ensure that the CEO of each sovereign organisation is present which differs from the current constitution of the Joint Committee;
- Each sovereign organisation should also have a NED in attendance, although this does not have to be the Chair of the sovereign organisation.

A working draft of the Terms of Reference for 4C is attached as an Appendix to this report for information and comment. The ToRs for 4C will need to be agreed when 4C first meets (probably in May 2025).

The Governance Workstream will also work on the scheme of delegation for the Community Collaborative so that we can be clear what decisions are reserved to 4C, and what decisions can be delegated to the MSECC ET.

The Mid and South Essex Community Collaborative – Committees in Common (4C)

TERMS OF REFERENCE

Introduction

1. The Essex Partnership NHS Trust ('**EPUT**'), North East London NHS Foundation Trust ('**NELFT**') and Provide Community Interest Company ('PROVIDE') who are partners of the Mid and South Essex Integrated Care System ('**ICS**'), have come together to form a Mid and South Essex Community Collaborative Committees in Common ('the **MSE Community Collaborative CIC**).

2. For the purpose of these terms of reference, EPUT, NELFT and Provide be known as the '**Partner Organisations**.' All definitions given in this terms of reference are set out in **Annex 5**.

3. The MSE Community Collaborative CIC, whose governance arrangements are described in these terms of reference, is the governance vehicle for joined up decision-making by the Partner Organisations, in relation to community **services in the Mid and South Essex ICS.**

4. The MSE Community Collaborative CIC has been established with a view to enabling the Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in Mid and South Essex.

Status

5. . Each of the Partner Organisations is permitted by its scheme of reservation and delegation or other governance documents to delegate decision-making to an internal committee.

6. The Partner Organisations have each individually agreed to establish a committee (**the Individual Committee(s)**) which shall work in common with the committees from the other Partner Organisations within the forum of the MSE Community Collaborative CIC, but which will each take their decisions independently on behalf of the respective Partner Organisation.

7. The Partner Organisations have each decided to adopt terms of reference in substantially the same form to the other Partner Organisations

Aims

8. The overall aim of the MSE Community Collaborative is to deliver *'A consistent and outstanding Community Health and Care service for residents across mid and south Essex'*

9. The Collaborative will focus delivery of services around three interconnected priorities, putting service users at the heart, to:

    - Improve: Work together to optimise and drive consistent delivery of community services, reducing inequalities
    - Integrate: With wider partners, facilitate community physical and mental health services integration with developing neighbourhood models at place
    - Innovate: Take a lead role within the system to develop and deliver innovative models of care and use of technology

Authority

10. The MSE Community Collaborative CIC shall operate as a forum for decisions to be taken jointly as between the Partner Organisations in relation to the functions set out in these terms of reference, and shall itself have no delegated authority on behalf of the Partner Organisations.

11. The Individual Committees meeting together to form the MSE Community Collaborative CIC are authorised by the Boards of the Partner Organisations to take all necessary actions to fulfil the remit described within these terms of reference.

12. For the avoidance of doubt, decisions taken by the Individual Committees will only bind the Partner Organisation from which they are constituted.

Role of the MSE Community Collaborative CIC

13. The MSE Community Collaborative CIC shall have the following function: to serve as a forum to enable joint decision making between the Partner Organisations in accordance with the Terms of Reference in relation to the CIC Functions set out at **Annex 1**.

14. The MSE Community Collaborative CIC has been established in order to provide a forum for the Individual Committees to:

    - provide the Partner Organisations with the ability to collaboratively direct and oversee the delivery of improved outcomes, quality, value and equity for people in Mid and South Essex;
    - ensure the development of further collaboration between the Partner Organisations, with joint accountability for the delivery of the collaborative's aim;
    - ensure alignment of the Partner Organisations to the Collaborative Principles;
    - promote and encourage commitment to the Collaborative Principles;

- formulate, agree and seek to ensure the implementation of strategies for achieving the Strategic Objectives and the delivery plan;
- discuss strategic issues and resolve challenges such that the Strategic Objectives can be achieved;
- respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Parties to the extent that they affect the Services;
- seek to agree policy as required;
- seek to agree performance outcomes/targets for the Integrated Community Healthcare offering such that it achieves the Strategic Objectives;
- seek to ensure and encourage the involvement of the Partner Organisations in the ICS;
- seek to ensure and encourage the involvement of other ICS partner organisations;
- seek to ensure that the views and expertise of residents with lived experience is at the heart of the collaborative's work;
- support the development of the ICS strategy and planning for Community services, and put in place arrangements to ensure its delivery with ICS partners;
- enable the exercise of the CIC Functions in a simple and efficient way (as outlined in **Annex 1**).
- identify and manage the risks associated with the development of an integrated Community Healthcare offering and integrating where necessary with each Partner Organisations own risk management arrangements;
- review internal matters and decisions proposed by the Partner Organisations which impact the Integrated Community Healthcare offering and services to the population of Mid and South Essex, where relevant;
- review the governance arrangements for the MSE Community Collaborative at least annually;
- be open, transparent and accountable in the actions and recommendations of the Individual Committees sitting together as the MSE Community Collaborative CIC;

- oversee and support the resolution of disputes between the Partner Organisations;

15. The CIC Functions have been delegated to the Individual Committees by the Partner Organisations. The Individual Committees sitting within the forum of the MSE Community Collaborative CIC may each take decisions in relation to the CIC Functions which shall be binding on the the relevant Partner Organisations. It is expected that the arrangements described in these terms of reference will evolve, including to bring further functions within scope over time.

16. [Decisions taken in relation to the CIC Functions may only be taken where they are agreed by all three of the Individual Committees, and in accordance with the arrangements set out in these terms of reference. Decisions taken by each of the Individual Committees shall be taken in accordance with their own internal governance procedures]

17. The CIC Functions shall be exercised with particular regard to the MSE Community Collaborative's priorities and objectives, described in the MSE Community collaborative strategic and delivery plan which the Individual Committees shall approve on behalf of the Partner Organisations. A summary of those priorities and objectives is contained at **Annex 2**.

18. The Individual Committees sitting together within the MSE Community Collaborative CIC will support the Partner Organisations to achieve the aims and the ambitions of:

    (a) The Integrated Care Strategy prepared by the MSE Integrated Care Partnership;

    (b) The joint local health and wellbeing strategies and associated needs assessments prepared by the three health and wellbeing boards;

    (c) The plans prepared by the four place-based partnerships, within the ICS area;

    (d) The developing ICB Financial Framework.

19. In supporting the Partner Organisations to discharge their statutory functions and deliver the strategic priorities of the ICS, the MSE Community Collaborative CIC will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

    (a) Improve outcomes in population health and healthcare;

    (b) Tackle inequalities in outcomes, experience and access;

    (c) Enhance productivity and value for money;

    (d) Help the NHS support broader social and economic development.

20. The MSE Community Collaborative CIC is also a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.

CIC Arrangements

21. Each of the Partner Organisations shall nominate a Chair in Common on a rotating basis to act as convenor of the MSE Community Collaborative CIC meetings for a period of 12 months at a time. The Chair in Common shall normally be the chair of one of the relevant Partner Organisations.

22. The Individual Committees sitting within the forum of the MSE Community Collaborative CIC will agree the nomination of a Deputy Chair in Common from amongst its members.

23. The term of office for the Deputy Chair in Common will align to their tenure of appointment or following a significant change in the scope and functions of the CIC following an annual review, whichever is sooner.

24. The Chair in Common (or in their absence, for all or part of a meeting for any reason, the Deputy Chair in Common) will be responsible for ensuring:

    (a) the Chair or relevant representative of each of the Indivudual Committees agrees the agenda,

    (b) matters discussed during the MSE Community Collaborative CIC meetings meet the objectives as set out in these terms of reference, and

    (c) the Chair or relevant representative of any Indivudual Committee escalating matters which require a decision by the Board of a Partner Organisation.

Membership

25. The MSE Community Collaborative CIC shall comprise three committees (**the Individual Committees**). The Individual Committees shall at first instance be constituted as follows:

    i. A committee from EPUT with the following members:

    - The Chair of EPUT
    - The Chief Executive of EPUT
    - Executive Director of Operations

    ii. A committee from NELFT with the following members:

    - The Chair of NELFT
    - The Chief Executive of NELFT
    - Executive Director of Operations

- NELFT Chief Operating Officer

iii. A committee from Provide with the following members:

- The Chair of Provide
- The Chief Executive (Health) of Provide
- The Chief Finance Officer of Provide

21. At the invitation of the MSE Community Collaborative CIC, the following individuals will be in attendance as and when required:

- Collaborative Lead Director
- Functional Executive leads for the Collaborative who do not form a part of the Committees above (Finance, Nursing and Quality, People, Medical Director, BI and Governance)
- ICB Executive Director of Community Services
- Lived Experience Leader(s)
- Director of Adult Social Services, Essex County Council
- Director of Adult Social Services, Southend-on-Sea Borough Council
- Director of Adult Social Services, Thurrock Council
- Representative of the MSE Foundation Trust
- Representative from ICS Primary Care

22. When determining the membership of the Individual Committees, active consideration will be made to diversity and equality.

23. Members of the Individual Committees may nominate a deputy to attend a meeting that they are unable to attend, in accordance with their own internal governance, standing orders and procedures.

Participants

24. The members of the Individual Committees may invite others to attend meetings, where this would assist it in the performance of the role and in the discharge of the CIC Functions. This may include other colleagues from the partner organisations within the ICS, professional advisors or others as appropriate.

Collaborative working and substructures

25. In performing its role and achieving the CIC Functions, the Individual Committees sitting within the forum of the MSE Community Collaborative CIC shall work with other provider collaboratives, CICs, committees, or sub-committees which have been established by the Partner Organisations or wider partners of the ICS (e.g. voluntary,

community and faith sector organisations). This may include, where appropriate, aligning meetings or establishing joint working groups.

26. The Individual Committees may together, sitting as the MSE Community Collaborative CIC, agree to delegate the exercise of the CIC Functions to sub-committees in Common. Any sub-committtees in Common must be established in accordance with these terms of reference, [and any decisions made by the sub-committtes in common must be made in accordance with the arrangements set out in these terms of reference.]

27. Where a function has been delegated to a sub-committee in Common it shall be recorded in **Annex 1.** All sub-committees in Common established by the MSE Community Collaborative CIC must operate under terms of reference approved by the MSE Community Collaborative CIC.

28. The Individual Committees sitting together within the forum of the MSE Community Collaborative CIC, and any sub-committees in Common, may establish transformation boards, working groups or task and finish groups. All groups must operate under terms of reference which have been approved by the Individual Committees sitting within the forum of the MSE Community Collaborative CIC, or by the sub-committee in Common which established said group(s).

Key duties relating to the exercise of the CIC Functions

29. When exercising any CIC Functions, the members of the Individual Committees sitting within the forum of the MSE Community Collaborative CIC will ensure that the Individual Committtee on which they are sitting acts in accordance with, and that any decisions made are informed by, the relevant policies and procedures which have been developed by the relevant Partner Organisation to support those functions and to inform the commissioning, provision and delivery of any relevant services.

30. When exercising a CIC function which has been delegated to a Partner Organisation, the Individual Committee(s) will have particular regard to the statutory obligations imposed on that Partner Organisation, and that Partner Organisation's policies and procedures. As particularly relevant to the CIC Functions, these include, but are not limited to, the statutory duties set out in the 2006 Act. Key duties are listed in **Annex 3**.

31. The Individual Committees and Partner Organisations will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010.

32. All sub-committees or groups established within the MSE Community Collaborative CIC's governance must also have due regard to the applicable statutory duties which apply to the Partner Organisations.

Resource and financial management

33. The Partner Organisations have made arrangements to support the MSE Community Collaborative CIC, and the exercise of the CIC Functions by the Individual Committees.

34. Further information about resource allocation and financial management is contained in the Collaborative Agreement and Partner Organisations' standing financial instructions and associated policies and procedures, which includes the developing ICB Financial Framework.

35. Financial decisions in relation to the work of the MSE Community Collaborative CIC and/or in relation to the CIC Functions will need to be made in line with the Standing Financial Instructions of the organisation at the source of funding; where this is multiple organisations this will need to be taken through all organisations' approval routes.

Collaborative Partnership Agreement

36. The Partner Organisations are intending to enter into a collaborative agreement to address a number of operational matters including:

    (a) Details of the operational resource to support the work to be undertaken within the MSE Community Collaborative CIC framework, and with regards to the CIC Functions;

    (b) Risk and gain share agreements between the Partner Organisations;

    (c) The process for commissioning / securing professional advice (including external advice);

    (d) Terms for withdrawal from the MSE Community Collaborative CIC;

    (e) Dispute resolution;

    (f) Information sharing;

    (g) Management of conflicts of interest;

    (h) Complaints handling.

37. The Collaborative Agreement will supplement these terms of reference. To the extent that there is any conflict between the terms of reference and the agreement, these terms of reference shall prevail.

Meetings

Scheduling meetings

38. The meetings of the Individual Committees sitting within the MSE Community Collaborative CIC meetings shall take place when the members of the Individual Committees are sitting together for the purpose of decision making in relation to the CIC Functions.

39. The MSE Community Collaborative CIC (4C) shall ordinarily meet on a bi-monthly basis and, as a minimum, shall meet on five occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair in Common.

40. The Boards of the Partner Organisations may ask the MSE Community Collaborative CIC to convene further meetings to discuss particular issues on which they want the MSE Community Collaborative CIC's collective advice.

Quoracy

41. In order for a meeting of the MSE Community Collaborative CIC to be quorate, it must be attended by each of the Individual Committees. Where each Individual Committee is quorate for the purposes of the meeting according to its own standing orders and each Individual Committee is composed of at least two members (one of whom is a Non-Executive Director), the meeting of the MSE Community Collaborative CIC will be quorate.

42. If any member of the Individual Committees is or has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum.

43. If the quorum has not been reached, then the meeting may proceed if those attending the meeting agree, but no decisions may be taken.

Voting

44. The MSE Community Collaborative CIC will reach conclusions by consensus between the Individual Committees. For the purpose of consensus, each Individual Committee will have one vote each.

45. The Individual Committees will take decisions in accordance with their own internal rules, standing orders and procedures.

Arrangements for meetings, Papers and notice

46. A minimum of five clear working days' notice and dispatch of meeting papers is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed.

47. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair in Common will give as much notice as possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair in Common.

Virtual attendance

48. The Chair in Common shall consult with the Individual Committees to determine whether or not the meeting of the MSE Community Collaborative CIC will take place virtually by means of telephone, video or other electronic means.

49. Where a meeting is not held virtually, the Chair in Common may [facilitate/permit] the attendance of a member of an Individual Committee virtually. Participation in a meeting in this manner shall be

deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Admission of the public

50. Meetings of the Individual Committees sitting within the forum of the MSE Community Collaborative CIC will usually be open to the public, unless the Individual Committees determine that it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for some other good reason.

51. The Chair in Common shall provide such directions as are agreed appropriate with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the business shall be conducted without interruption and disruption.

52. A person may be invited by the Chair in Common (in consultation with the Individual Committees) to contribute their views on a particular item or to ask questions in relation to agenda items. However, attendance shall not confer a right to speak at the meeting.

53. Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the MSE Community Collaborative CIC and others in attendance.

54. There shall be a section on the agenda for public questions to the MSE Community Collaborative CIC relating to matters on the agenda.

Recordings of meetings

55. Except with the permission of the Chair in Common (in consultation with the Individual Committtees) , no person admitted to a meeting of the MSE Community Collaborative CIC shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Minutes

56. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the MSE Community Collaborative CIC together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair in Common.

Work plan

57. The MSE Community Collaborative CIC will approve a work plan which sets out how the forthcoming meetings of the MSE Community Collaborative CIC will be used to ensure the CIC Functions are carried out effectively. This work plan will also take account of the work undertaken in other spaces connected to the work of the MSE Community Collaborative CIC, such as clinical networks, task and

finish groups and other sub-groups of the committee, and sub-committees. The MSE Community Collaborative CIC will review the work plan annually. In its first year of operation the work plan will also be reviewed after six months.

Governance support

58. Governance support to the MSE Community Collaborative CIC will be provided by the MSE Community Collaborative Support team.

Confidential information

59. Where confidential information is presented to the MSE Community Collaborative CIC, all those present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Conflicts of interest

60. Conflicts of interests will be managed in accordance with the relevant policies, procedures and joint protocols developed by the Partner Organisations' respective statutory duties and applicable national guidance.

Disputes

61. Where there is any uncertainty about whether a matter relating to a CIC Function is within the remit of the Individual Committees sitting within the forum of the MSE Community Collaborative CIC, including uncertainty about whether the matter relates to a matter for determination by a board or other governance structure of an Partner Organisation; then the matter will be referred to the relevant Partner Organisation's Board.

62. Where any other dispute arises between the Partner Organisations, which is connected to the operation of the MSE Community Collaborative CIC and its work, this shall be resolved in accordance with the dispute resolution procedure within the Collaborative agreement.

Behaviours and Conduct

63. Members of the Individual Committees [and attendees at MSE Community Collaborative CIC meetings?] will be expected to behave and conduct business in accordance with:

    (a) The policies, procedures and governance documents that apply to them, including any jointly developed procedures or codes developed by the ICS;

    (b) The NHS Constitution;

    (c) The Nolan Principles.

64. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

65. Members will seek to act in the best interests of the population of the ICS area, rather than representing the individual interests of the Partner Organisations.

Accountability, reporting, and shared learning

66. The Individual Committees sitting within the forum of the MSE Community Collaborative CIC are ultimately accountable to the Board of the relevant Partner Organisations.

67. A summary report following each meeting shall be shared for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval.

68. **Annex 4** shows the MSE Collaborative CIC's governance, including its usual reporting lines.

Sharing learning and raising concerns

69. Where the MSE Community Collaborative CIC considers that an issue, or its learning from or experience of a matter, to be of importance or value to the Mid and South Essex health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the Chairs of the Partner Organisations or Chief Executive of the ICB as appropriate.

Review

70. The MSE Community Collaborative CIC will review its effectiveness at least annually and provide an annual report to the Boards of the Partner Organisations on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference.

71. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Boards of the Partner Organisations for approval.

Annex 1 – CIC Functions

Part A: Community Services with the scope of the Community Collaborative CIC

Role of the MSE Community Collaborative CIC:
Community Services
The MSE Community Collaborative CIC will have delegated responsibility for delivering the following Community Services in Mid and South Essex: All community services (with the exception of community mental health services) contained in the lead provider contract between MSE ICB and EPUT

Part B: Functions delegated by each of the Boards of EPUT, Provide and NELFT to the Individual Committees sitting together within the forum of the MSE Community Collaborative CIC

	Role of the MSE Community Collaborative CIC:	Role of sub-committee (if any):
Planning		
The MSE Collaborative CIC will undertake the following specific activities in the domain of Planning:		
1	Making recommendations to the Partner Organisations' Boards in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as relates to Community Services.	
2	Developing and approving the Community Services Plan and assuring implementation and delivery of the plan, in so far as that requires the development and provision of Community Services and the relevant Partner Organisations' functions.	
3	Overseeing, and providing assurance to the Partner Organisations' Boards regarding, the implementation and delivery of the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as they require the development and provision of Community Services and the relevant Partner Organisations' functions.	

4	Providing information to the Partner Organisations' Boards for the purposes of each Trust's duty to prepare its annual report for provision to NHS England, in so far as NHS England has requested, or those reports require, information connected with the Community Services and the relevant Partner Organisations' functions.	
Transformation		
The MSE Community Collaborative CIC will undertake the following specific activities in the domain of Transformation:		
1	Overseeing any stakeholder involvement exercises relating exclusively to Community Services, consistent with each Partner Organisations' statutory duty in this context and the Partner Organisations' relevant policies and procedures. Such stakeholder engagement shall include political engagement, clinical and professional engagement, strategic partnership management and public and community engagement.	
2	Overseeing the development and delivery of patient and public involvement activities, including public consultation, as part of any service change process relating to Community Services.	
Leadership and engagement		
The MSE Community Collaborative CIC will undertake the following specific activities in the domain of Leadership and engagement:		
1	Responsibility on behalf of the Partner Organisations for engagement with other organisations within the ICS (including primary care, local authorities, etc) and service users on matters relating to the provision of, and the need for, Community Services with a view to ensuring that such needs are considered within wider system planning.	
Performance, quality and finance		
The MSE Community Collaborative CIC will undertake the following specific activities in the domain of Performance, quality and finance:		
1	Providing assurance to the Partner Organisations' Boards that continuous quality improvement in relation to Community Services is being delivered across the ICB's area, escalating specific issues to the Partner Organisations' Boards or relevant directors as appropriate.	
2	Responsibility for liaising, and providing assurance to, NHS England on programme delivery relating to Community Services and the Collaborative's work.	
3	Responsibility for and providing assurance to the Partner Organisations' Boards in relation Transforming Care requirements, in relation to Community Services.	
4	Assisting the Partner Organisations' Boards, to comply with statutory reporting requirements relating to Community Services, in particular as relate to quality and improvement of those services.	

5	Responsibility for and providing assurance to the Partner Organisations' Boards, in relation to the financial performance of activity within the Community Collaborative CIC's remit.	
Workforce Planning /Modellling		
The MSE Community Collaborative CIC will undertake the following specific activities in the domain of Planning in connection with workforce matters:		
1	Approving demographic, service use and workforce modelling and planning, where these relate to Community Services.	
Governance		
The MSE Community Collaborative CIC will undertake the following specific activities in the domain of Governance:		
1	Responsibility on behalf of the Partner Organisations for developing the governance framework of the collaborative, including: • making recommendations to the Partner Organisations' Boards on the functions which should be within the scope of the Collaborative; • establishing the sub-structures necessary to facilitate delivery of the CIC Functions; • putting in place the documentation necessary to ensure robust governance and assurance; • leading on horizon scanning for examples of best practice, in relation to Community collaboration.	
2	Approval of the Accountability Framework	

Annex 2- Collaborative objectives and priorities

The objectives and priorities are summarised in the MSE Collaborative strategic plan.

MSECC Strategic Plan Full FINAL.pdf

Annex 3 – Key statutory duties

Key statutory duties of EPUT and NELFT:

- Section 63 - Duty to exercise functions effectively, efficiently and economically
- Section 63A - Duty to have regard to the wider effect of decisions
- Section 63B – Duties in relation to climate change
- Section 223L – Joint financial objectives [where set by NHS England]
- Section 223M – Financial duties: use of resources
- Section 223N – Financial duties: additional controls on resource use
- [Section 223LA – Financial duties: expenditure limits][1]
- Section 242 – Public involvement and consultation

[1] Statutory provision not yet in force.

Annex 4 – Governance Diagram

CHART TO BE ADDED TO FINAL VERSION

Annex 5 - Definitions

TO BE UPDATED IN FINAL VERSION

9. MSE COMMUNITY COLLABORATIVE FINANCE AND EFFICIENCY UPDATE

Information Item | Trevor Smith | 11:40

10. QUESTIONS FROM THE PUBLIC

Discussion Item | Robert Parkinson | 11:50

11. ANY OTHER BUSINESS

Standing item | Robert Parkinson | 11:55pm (5mins)

Verbal