NHS
Essex
Integrated Care Board

Meeting of the Essex Integrated Care Board

Thursday, 23 April 2026 at 2.00 pm to 3.30 pm

Moot Hall, Town Hall, High Street, Colchester, CO1 1PJ

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	Approval of minutes of the previous Part I meeting, 1 April 2026	Approve	Attached	Prof. M Thorne	6
5.	2.13 pm	Matters arising (not on agenda)	Note	Verbal	Prof. M Thorne	-
6.	2.14 pm	Action Log (no outstanding actions)	Note	Verbal	Prof. M Thorne	-
		Items for Decision / Non-Standing Items				
7.	2.15 pm	Population Health Improvement Plan	Note	Attached	B Flowers	10
		Standing Items				
8.	2.25 pm	Chief Executive's report	Note	Attached	T Abell	44
9.	2.35 pm	Commissioning, Quality and Resource Summary Report	Note	Attached	J Kearton Dr G Thorpe S Goldberg	51
10.	2.55 pm	Neighbourhood Report (Primary Care / Alliances)	Note	Attached	B Flowers	73
11.	3.10 pm	General Governance:				
		11.1 Board Forward/Work Plan	Approve	Attached	T Abell	128
		11.2 Risk Framework Update	Note	Attached	T Abell	132
		11.3 Delegation to the Audit Committee for approval of the Mid and South Essex ICB Annual Report and Accounts 2025/26	Approve	Attached	Prof. M Thorne	138
12.	3.25 pm	Effectiveness of Meeting	Discuss	Verbal	Prof. M Thorne	-
13.	3.27 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-

No	Time	Title	Action	Papers	Lead / Presenter	Page No
14.	3.30 pm	Date and time of next Part I Essex Integrated Care Board meeting: Thursday, 16 July 2026, at 2.00pm, venue to be confirmed.	Note	Verbal	Prof. M Thorne	-

Essex Integrated Care Board
Register of Board Members' Interests - April 2026

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Tom	Abell	Chief Executive Officer	Nil				Direct				
Mark	Bailham	Non-Executive ICB Board 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	Non-Executive ICB Board 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.
Mark	Bailham	Non-Executive ICB Board Member	Cambridgeshire and Peterborough Foundation Trust	x			Direct	Non-Executive Director	October 2025	Ongoing	Will declare interest during relevant meetings
Jo	Churchill	Non-Executive ICB Board Member	Norfolk and Waveney Univeristy Hospitals Group	x			Direct	Non Executive Director	Dec 2025	Dec 2028	To declare this interest as necessary so that appropriate arrangements can be made if required.
Jo	Churchill	Non-Executive ICB Board Member	CCRH and CH				Direct	Ambassador	Aug 2025	Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropraite arrangements can be made to manage any conflict of interest.
Neha	Issar-Brown	Non-Executive ICB Board Member	Queen's Theatre Hornchurch (QTH)			x	Direct	Trustee - QTH often works with local volunteer sector including Healthwatch, social care sector for various community based initiatives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Neha	Issar-Brown	Non-Executive ICB Board Member	Independent Consultancy	x			Direct	Independent Consultancy contracts, including with other management consultancy firms (such as Deloitte, EY, etc.) on (predominantly international) research, innovation, early careers development, and R&D strategies. No contracts undertaken with any direct or indirect overlap with NHS/MSE/constituent Trusts/providers or consultancy firms (that I am aware are engaged with the system) to avoid conflict.	June 2023	Contract based and time limited	Info only. No direct action required.
Neha	Issar-Brown	Non-Executive ICB Board Member	British Pharmacological Society (BPS) BPS Assessments (BPSA)	x			Direct	British Pharmacological Society (BPS) - CEO & BPS Assessments (BPSA) - Managing Director The UK's primary learned society for pharmacologists, concerned with research into drugs and their mechanisms. Members work in academia, industry, regulatory agencies, and the health services, and many are medically qualified. BPSA is the learning and assessment arm of the BPS - it works to improve prescribing skills among medical and non-medical prescribers. BPSA works collaboratively in UK and globally to understand local prescribing needs and practice, to deliver tailored training.	December 2025	Ongoing	Info only. No direct action required at present.
Jennifer	Kearton	Executive Director of Finance and Commercial	Colchester Weightlifting Limited			x	Direct	Director	01/10/24	Ongoing	No conflict anticipated. To declare as appropriate.
Thomas	Lafferty	ICB Partner Member (Princess Alexandra Hospital Trust)	TBC								
Sarah	Muckle	ICB Partner Member (Essex County Council)	Essex County Council	x			Direct	Director of Wellbeing Public Health & Communities	24/04/25	Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Robert	Persey	ICB Partner Member (Thurrock Council)	Thurrock Council	x			Direct	Interim Executive Director of Adults and Health		Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Essex Partnership University NHS Foundation Trust	x			Direct	Chief Executive Officer	01-Jul-23	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Integrated Leadership Coaching Limited	x			Direct	10% share holder	August 2024	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Carradale Futures		x		Direct	Non Remunerated Non Executive Director	January 2024	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Dawn	Scrafield	ICB Partner Member (Mid and South Essex Foundation Trust)	Mid and South Essex NHS Foundation Trust	x			Direct	Interim Chief Executive Officer	01/11/2025	Ongoing	Interest will be declared if at any time issues relevant to the organisation are discussed so that approporiate arrangements can be implemented.
Dawn	Scrafield	ICB Partner Member (Mid and South Essex Foundation Trust)	Mid and South Essex Hospitals Charity		x		Direct	Chief Finance Officer of the Corporate Trustee	April 2020	Ongoing	Interest will be declared if at any time issues relevant to the organisation are discussed so that approporiate arrangements can be implemented.
Dawn	Scrafield	ICB Partner Member (Mid and South Essex Foundation Trust)	Healthcare Finance Management Association (HFMA)		x		Direct	Member of HFMA Trust Board	November 202	Ongoing	Interest will be declared if at any time issues relevant to the organisation are discussed so that approporiate arrangements can be implemented.

Agenda Item 2

Essex Integrated Care Board
Register of Board Members' Interests - April 2026

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Matthew	Sweeting	Executive Medical Director	Mid and South Essex Foundation Trust			x	Direct	Part Time Geriatrician - hold no executive or lead responsibilities and clinical activities limited to one Outpatient clinic a week and frailty hotline on call.	01/04/15	Ongoing	Any interest will be declared if there are commissioning discussions that will directly impact my professional work. I will liaise with CEO or Chair, as appropriate, for mitigations. These could include removal from said discussions, not voting on any proposals or nominating a deputy. For sign off of commissioning budgets, if a conflict arises, I will delegate to the CFO.
Mike	Thorne	ICB Chair	Nil								N/A
Giles	Thorpe	Executive Chief Nursing Officer	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.
Giles	Thorpe	Executive Chief Nursing Officer	University of Essex		x		Direct	Honorary Professorship	2023	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.

Agenda Item 2

Essex Integrated Care Board - Register of Interests of Regular Attendees at Board meetings - April 2026

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
Beverley	Flowers	Executive Director of Neighbourhood Health	Herts at Home Limited - a company established and fully owned by Hertfordshire County Council to provide care and support within the county.		x		Direct	Non remunerated Director role	Jan 2019	Ongoing	Will declare at meetings where relevant. Exclude self from decision making process in meetings if necessary.
Samantha	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 - On secondment	13/01/25	Ongoing	Whereby there is a conflict of interest on formal agenda items/discussions, will vacate the meeting to protect discussions/decisions.
Michael	Watson	Executive Director of Corporate Services	Nil								

NHS
Essex
Integrated Care Board

Minutes of the Part I Essex Integrated Care Board Meeting

Held on Wednesday 1 April 2026 at 10.10am – 10.30am

Via Microsoft Teams

Attendance

Members

- Professor Michael Thorne (MT), Chair, Essex Integrated Care Board (EICB).
- Tom Abell (TA), Chief Executive Officer, EICB.
- Jennifer Kearton (JK), Executive Director of Finance and Commercial, EICB.
- Mark Bailham (MB), Non-Executive Member, EICB.
- Jo Churchill (JC), Non-Executive Member, EICB.
- Dr. Neha Issar-Brown (NIB), Non-Executive Member, EICB.
- Sarah Muckle (SM), Partner Member, Essex County Council.
- Dawn Scrafield (DS), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Natalie Hammond (NH), Director of Nursing, EICB, (representing Dr Giles Thorpe, Executive Chief Nurse).

Other attendees

- Samantha Goldberg (SG), Interim Executive Director of Strategy, EICB.
- Michael Watson, (MW). Executive Director of Corporate Services, EICB.
- Beverley Flowers (BF), Executive Director of Neighbourhood Health, EICB.
- Jane King (JK), Assistant Governance Manager, EICB.
- James Sharp (JS), Communications Manager, Internal and Digital, EICB.
- Helen Chasney (HC), Governance Senior Officer, EICB (minutes).

Apologies

- Dr Matt Sweeting (MS), Executive Medical Director, EICB.
- Dr Giles Thorpe (GT), Executive Chief Nurse, EICB.
- Emily Hough (EH), Executive Director of Strategy, EICB.
- Robert Persey (RP), Partner Member, Thurrock Council.
- Mark Harvey (MHar), Partner Member, Southend City Council
- Nicola Adams (NA), Associate Director of Governance, EICB.

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

MT welcomed everyone to the Inaugural Essex Integrated Care Board (EICB) meeting and reminded members of the public that this was a 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 committee during discussions. A recording of the meeting would also be available via the ICB website to accommodate members of the public who were unable to attend the meeting.

MT thanked all colleagues for their significant efforts in establishing the new organisation and meeting NHS requirements for operating costs. Appreciation was expressed to colleagues who continued to support the organisation's progress, as well as those who had departed, many of whom had provided long and valued service to the NHS.

TA advised that the appointments panel had met prior to the meeting and confirmed the appointments to the Essex ICB Board, including Executive Directors, Non-Executive Members, and Partner Members.

Apologies were noted as listed above.

2. Declarations of Interest (presented by T Abell)

TA 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.

No other declarations were made.

Note: The Essex ICB Board register of interests would be made available on the ICB website in due course.

3. Essex ICB Governance Framework (presented by M Watson)

MW presented the Essex ICB governance framework, noting that all documents had previously been considered through the Essex Joint Committee or appropriate sub-committee. The documents formed the key pillars of the governance framework and required approval from the Essex ICB Board.

No further comments were made.

Resolved: The Essex ICB Board:

- **Noted and adopted the NHS ICB Constitution and Standing Orders approved by NHS England.**
- **Approved the Scheme of Reservation and Delegation, Functions and Decisions Map, and Standing Financial Instructions (sections 1.1, 1.2 and 3.1 of the Governance Handbook).**
- **Approved the assignment of lead roles (section 1.3 of the Governance Handbook).**
- **Established the sub-committees of the Board, namely the Audit, Risk and Compliance Committee; Remuneration Committee (including its sub-group, the**

Non-Executive Remuneration Panel); Executive Committee; Commissioning, Quality and Resource Committee; and Neighbourhood Health Committee and approved their terms of reference (section 2 of the Governance Handbook).

- **Approved the remaining elements of the Governance Handbook.**

4. Revised Delegation Agreements (presented by M Watson)

MW presented the revised delegation agreements between Essex ICB and NHS England, covering areas of specialised services and primary care, including general practice, pharmacy, optometry and dentistry. It was noted that these were a transfer of existing arrangements over to Essex ICB.

No further comments were made.

Resolved: The Essex ICB Board approved the Delegation Agreements for Specialised Services and Primary Care, including General Practice, Pharmacy, Optometry and Dental Services.

5. Adoption of Essex ICB policies (presented by T Abell and M Watson)

TA advised that the suite of policies detailed within Appendix A were required for adoption by the Essex ICB and that a number of those policies would form part of the ICB's Governance Handbook. These policies had been discussed and supported by the Essex Joint Committee or appropriate sub-committee and required formal ratification and adoption by the Essex ICB.

No further comments were made.

Resolved: The Essex ICB Board formally adopted the Essex ICB policies set out in Appendix A, noting that the following policies formed part of the ICB Governance Handbook:

- **Standards of Business Conduct Policy (including conflicts of interest and gifts and hospitality.**
- **Risk Management Policy.**
- **Policy for Developing Policies.**

6. Appointment of founder member of the Essex Integrated Care Partnership (presented by Prof. M. Thorne)

TA advised that, notwithstanding recent changes to ICB's, further legislative changes were anticipated, including consideration of the future role of Integrated Care Partnerships (ICPs). However, ICP's remained a statutory requirement unless legislation changed.

TA proposed the appointment of Michael Thorne, Chair of Essex ICB, as the Founder Member and Chair of the Integrated Care Partnership and sought approval of the associated terms of reference, noting that the role and function of the ICP would be reviewed over the coming year, particularly, in the context of local government reform.

MT confirmed that closer partnership working remained a clear direction of travel for the NHS and that the ICP, or a similar mechanism, would continue to support collaboration across local government and voluntary, community, faith and social enterprise sectors, ensuring best use of resources.

RP queried whether options existed within the statutory framework to maintain a manageable and effective ICP size. TA confirmed that this would be considered as part of the local government reform discussions, including the respective roles of the ICP and Health and Wellbeing Boards.

No further comments were made.

Resolved: The Essex ICB Board approved the appointment of Professor Michael Thorne, Chair of the Essex Integrated Care Board, as the founder member of the Essex Integrated Care Partnership (ICP) and approved the ICP terms of reference.

7. Population Health Improvement Plan (presented by B Flowers)

BF presented the Population Health Improvement Plan, noting that no substantive changes had been made since its consideration by the Essex Joint Committee, other than minor typographical corrections.

Following approval, the plan would be published on the ICB website. Over the coming months, the ICB would continue to implement the delivery plan, and review sections to reflect the recently published neighbourhood guidance, to provide greater clarity on planned outcomes and timelines.

In response to a query from MT, BF confirmed that the amendments related to a numerical error and a definition.

MT noted that delivery of the plan was challenging but welcomed the clarity and relevance of the document.

No further comments were made.

Resolved: The Essex ICB Board approved the draft Population Health Improvement Plan (PHIP).

8. Any Other Business

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

9. Date and Time of Next Part I Essex ICB Board meeting:

Thursday, 23 April 2026 at 2.00pm – 3.30pm, in the Moot Hall, Colchester Town Hall, High Street, Colchester, CO1 1PJ.

ICB Board Meeting of 23 April 2026

Agenda Number: 7

NHS Essex ICB Population Health Improvement Plan (PHIP)

Confidentiality / Circulation Restrictions

There are no restrictions on the circulation of this document.

Summary Report

1. Purpose of Report

1.1. To provide the Board with an overview of the Essex ICB's Population Health. Improvement Plan (PHIP).

2. Executive Lead

2.1. Beverley Flowers, Executive Director of Neighbourhood Health.

3. Report Author

3.1. Kate Butcher, Associate Director of Strategy.

4. Responsible Committees

4.1 The Essex Joint Executive Committee for initial approval in February, prior to submission to NHS England.

4.2 Review at the Essex Joint Committee on the 19 March 2026 for review and feedback.

4.3 Essex ICB Board on the 1 April 2026 for initial ratification.

4.4 Essex ICB on the 23 April 2026 for approval.

5. Link to the ICB's Strategic Objectives

5.1. This paper supports all ICB objectives as follows:

- Health inequalities narrowing year on year.
- A decisive shift towards neighbourhood care delivery and prevention.
- Timely access and excellent outcomes across services.
- Financially and clinically sustainable services across Essex which are safe and high quality.
- An organisation that is up to the job, good to work for and good to partner with.

6. Impact Assessments

A full Equality and Health Inequalities Impact Assessment will need to be developed post submission and feedback from NHS England.

7. Financial Implications

The PHIP has a section outlining the Essex ICB's position and approach to finances.

8. Details of patient or public engagement or consultation

As outlined in Section 2 and 4.3 of the PHIP, the strategy and commissioning intentions have been informed by insights from extensive public, staff and stakeholder engagement undertaken in 2024/25, primarily as part of the NHS Change: 10-Year Plan Insight Programme and other local engagement activity. There was strong alignment with the key themes from this engagement with over 500 residents and staff identifying themes that align with those highlighted in the ICB and Health and Wellbeing Board strategies. These included support for care closer. to home, accessible digital and in-person services, investment in prevention and action to reduce inequalities.

Drawing on all these insights, an initial set of priority outcome ambitions for the population of Essex was identified and tested with partners across the proposed Essex health and care system. This included engagement and input from a range of clinical leaders, Primary Care Networks, Alliance Committees (which include place-based leaders across health, local government and the voluntary, community, faith and social enterprise (VCFSE) sector), Health and Wellbeing Boards, neighbourhood groups, the ICB leadership team and the

Essex Joint Committee. Feedback from these discussions have been used to inform the draft ambitions outlined in the PHIP. However, the ICB recognises that more engagement on the priorities is required with partners, patients and the public. Further engagement and refinement of the strategy and the supporting implementation plan will take place during 2026/27.

9. Conflicts of Interest

None identified.

10. Recommendation/s

10.1. The Board is asked to receive the presentation for information and comment.

NHS Essex ICB Population Health Improvement Plan

1. Introduction

As part of the NHS Medium Term Planning framework, the proposed Essex ICB was required to develop a 5-year strategy and Population Health Improvement Plan.

The plan sets out the 5-year strategic ambition for improving health outcomes, reducing inequalities and delivering sustainable, high-quality services for Essex's two million residents. It aligns with the NHS 10-Year Health Plan and the Model ICB Blueprint, with a key focus on prevention, digital transformation and shifting care from hospitals into communities (often referred to as 'left shift').

The plan provides a clear framework that will enable the organisation to come together around shared priorities and that staff at all levels will be able to support and deliver. The plan will be used by the Essex ICB to set the organisations, directorates and individuals work plans over the coming years.

The draft plan was submitted to NHS England on the 12th of February 2026.

2. Main content of Report

The Population Health Improvement Plan (PHIP) is made up of 10 sections covering our approach to planning, the health of Essex and its health economy, a 5-year strategy, our delivery plan for the next 2 years, finance, workforce, the key enablers to delivery and our approach to governance and risks.

The draft plan sets out our aims to address the health and wellbeing needs of the population of Essex and recognises the need to improve outcomes for all our residents.

To address the challenges the Essex ICB has developed a set of strategic ambitions. the ICB is committed to systematically reducing health inequalities. In addition, the ICB has identified a set of six strategic ambitions aimed at supporting people to live well throughout their lives:

1. Start Well: Supporting babies, children, young people and families to build strong foundations for lifelong health and wellbeing through early help, prevention and joined up support from conception through to adulthood.
2. Live Well: Helping people to stay well and manage their health and any health conditions they have so that they can maintain independence and make informed choices to live longer, healthier lives.
3. Feel Well: Promoting and supporting good mental and emotional wellbeing for all, improving access to mental health services in the community and reducing reliance

on inpatient and inappropriate out of area beds through improved access to care and support that meets people's mental health needs when they need it most, including in an emergency.

4. Age Well: Supporting people to remain active, independent and as healthy as possible as they grow older through services that promote healthy ageing and reduce avoidable ill health and hospital admission, particularly for those who are living with frailty.
5. Die Well: Supporting people of all ages to live well until the end of their life, with clear care plans to support them to die in their preferred place through delivery of personalised, compassionate care plans.
6. Respond Well: Ensuring people receive the right care, at the right time, in the right place through coordinated services that people can access when they are needed urgently, or in an emergency to prevent further escalation.

To deliver on these ambitions, the ICB has established four major transformation programmes that underpin the Population Health Improvement Plan. These programmes have identified a range of projects, with a set of outcomes that can be monitored to track progress over the coming years:

1. Neighbourhood Health:
   Executive Lead: Beverley Flowers - Executive Director of Neighbourhood Health
   Directorate: Neighbourhood Health (Community, Primary Care and Neighbourhood Health Teams)

   This programme is focused on developing and commissioning effective Neighbourhood Health services across Essex. This includes improving access to and the quality of services across primary and community care, using new and innovative models of commissioning and contracting to support the transformation of care delivered closer to home in Neighbourhoods that are recognisable to the people of Essex. It will also support organisations to develop the capacity and capability to support new ways of working.

2. Sustainable Hospital Services:
   Executive Lead: Emily Hough - Executive Director of Strategy (Samantha Goldberg- Executive Director of Performance and Planning as interim cover)
   Directorate**:** Strategy (Acute Commissioning Teams)

   a. Planned Care: This programme is focused on improving access to and the quality of elective, diagnostic and cancer care services across Essex. That will include targeted efforts to reduce waiting lists, support early diagnosis of cancer and provision of more diagnostic services in the community. The programme will work closely with the Neighbourhood Health programme to

consider options to support the 'left shift' of elective care, particularly outpatients, out of hospital and into more community locations.

b. Unplanned Care and Flow: This programme is focused on developing integrated services that provide access to urgent and emergency care when people need it most. The programme will work in partnership with both the Neighbourhood Health programme and the Mental Health and Neurodiversity programmes to deliver integrated same day services across Essex, with access to urgent support when it is needed, reducing escalations and the need for emergency care.

3. Mental Health and Neurodiversity:
   Executive Lead: Emily Hough- Executive Director of Strategy ((Samantha Goldberg- Executive Director of Performance and Planning as interim cover) and Giles Thorpe – Chief Nursing Officer
   Directorate: Strategy (Adult Mental Health Commissioning Team) and Nursing (BCYP team)

   The ICB's Mental Health and Neurodiversity programme will bring together an all-age focus on mental health commissioning. The programme will deliver strategic commissioning of services to support people with mental health conditions and neurodiversity, supporting prevention and early intervention through effective community services to reduce the need for inpatient care, particularly out of area services. The programme will also continue to deliver improvements in inpatient care, including the quality of care and reduced length of stay. The programme will work in partnership all other ICB delivery programmes.

4. Complex Care:
   Executive Lead: Giles Thorpe - Executive Director of Nursing
   Directorate: Nursing (Children's and young people, Learning Disabilities, All Age Continuing Care)

   This programme brings together a range of services commissioned to support core patient groups, including:

   a. Babies, Children and Young People
   b. Learning Disabilities
   c. All Age Continuing Care

The Complex Care Programme is focused on commissioning services that will improve outcomes for each group of patients through a focus on more integrated and personalised care for individuals. Effective support for patients in these cohorts is often

dependent on access to services that fall outside the NHS, which will require close working with all other ICB delivery programmes and wider partners across Essex.

Within the delivery programmes, the highest priority work programmes have been identified. These are:

1. Developing Neighbourhood Health Service model for Essex, with a specific focus on frailty in 2026/27
2. Reviewing of community services across Essex
3. Reducing long waiting lists for elective care, including children's services and neurodiversity diagnoses
4. Improving cancer outcomes across Essex, with a plan to focus on earlier diagnosis
5. Developing an approach to Urgent Care across Essex – including mental health urgent and emergency care to support people in crisis
6. Procuring Talking Therapies and Psychological Therapies for people with SMI
7. Undertaking a quality review of perinatal services
8. Delivering an Estates strategy, including Community Hospitals, Neighbourhood Health Centres and Primary Care
9. Establishing the new organisation, including external relationships

Delivery of the Essex PHIP will be supported by a range of enablers within the ICB including workforce development, digital and data transformation, estates modernisation, medicines optimisation, research and innovation, and a strengthened approach to quality and public involvement. The ICB is also establishing a new approach to governance, risk management and annual reporting that will oversee delivery and maintain accountability. This is described in section 10 of the plan.

This Population Health Improvement Plan provides a realistic, but ambitious roadmap for transforming health outcomes in Essex over the next five years. It draws on the existing work across the NHS in Essex with a focus on addressing health inequalities and delivery of both national and local priorities.

3. Next Steps

Given the pace of change and planning required for ICBs, the PHIP will remain a draft during 2026/27, allowing the ICB time to undertake more engagement with patients, the public and partners across Essex to inform both delivery and the development of future iterations of the plan to ensure that Essex has an NHS that is fit for the future. A plan for further engagement is currently being developed.

The strategy and delivery plans will be refreshed annually, as per NHS England's Medium Term Planning guidance.

4. Recommendation(s)

The Board is asked to receive the presentation for information and comment.

5. Appendices

Appendix 1 – Population Health Improvement Plan

NHS Essex

Population Health Improvement Plan for Essex (PHIP) 2026/27

‘Making health services better in Essex’

Purpose of the PHIP for Essex

- Sets out the Essex ICB's 5 year **strategic ambitions**, 1 to 2 year (2026-2028) **commissioning intentions**, and **delivery plans**
- Sets out the 'what, why and how' we will commission NHS services for our 2 million Essex residents to ensure we:
  - Improve health outcomes
  - Reduce inequalities
  - Deliver sustainable high-quality services for Essex's population
- Sets out how investment will shift over time, including a planned movement of activity and resources from acute settings into neighbourhood and preventative services
- Built from existing strategies across Essex, including Health and Wellbeing Board strategies
- Aligns with the NHS 10-Year Plan shifts:
  - Hospital → Community
  - Analogue → Digital
  - Treatment → Prevention

How engagement informed the PHIP

- The ICB has a legal duty to involve patients, carers and the public in service planning and decisions
- Extensive engagement took place across 2024/25 through the Neighbourhood Health Centres Change: 10-Year Plan insight Programme:
  - 500+ residents and staff involved via focus groups, workshops and online sessions
  - Inclusive representation: Black, South Asian, Jewish, Gypsy Roma Traveller, South African communities, mental health and maternity groups, Healthwatch, local campaign groups
- Key themes:
  - Strong support for **care closer to home**
  - Need for **accessible digital & in-person services**
  - Desire for greater investment in **prevention**
  - Clear expectation for actions for **reduce inequalities**
- The commissioning intentions set out in the PHIP have been refined following engagement across the ICB, with local providers, local authorities and place-based partners
- These insights have formed the foundation of the PHIP, but further engagement is required as delivery develops
- The PHIP will remain a draft in 2026/27 to allow continued co-design and engagement with communities and partners

Health and Care in Essex

3 Acute Hospital providers
East Suffolk and North East Essex NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
The Princess Alexandra Hospital NHS Trust

4 Community providers
East Suffolk and North East Essex NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
North East London NHS Foundation Trust | Provide Health

Over 880 Primary Care providers
204 General Practices, working across 41 Primary Care Networks
195 Dental Practices | 295 Community Pharmacies | 192 Optometry Practices

2 Mental Health providers
Essex Partnership University NHS Foundation Trust (Adults)
North East London NHS Foundation Trust (Children)

8 Hospices
Farleigh | St Luke's Hospice | St Helena Hospice | Saint Francis
Havens Hospice | St Clare's Hospice | East Anglia Children's Hospice | Haven House

1 Ambulance Trust
East of England Ambulance Service NHS Trust

26 Acute and Community Health Facilities
5 Acute Hospital site | 10 Community Hospitals | 6 Community Diagnostic Centres
5 Urgent Treatment Centres

Partners
3 upper tier Local Authorities*
12 District Councils*
3 Healthwatch Organisations*
11 VCSE Infrastructure Organisations
**Current configurations 2026/27, subject to change through LGR*

Population Health in Essex – Key Insights

Population & Demographics

- Ageing population: 20% aged 65+
- Fastest growth in 65–8
- 9 age group (+20% by 2034)
- Increasing ethnic diversity, especially in Thurrock and Harlow

Deprivation & Inequalities

- 220,000 residents in Essex live in the most deprived 20% of areas nationally;
    - Highest deprivation in Southend, Clacton, Harwich, Basildon, Harlow & Tilbury
    - Higher smoking, inactivity, obesity and alcohol harm in deprived areas
    - Low physical activity in children and young people and higher maternal smoking in deprived areas
    - Persistent inequalities in school readiness linked to deprivation
- Life expectancy gaps of up to 12.4 years between most and least deprived areas
- Large inclusion health populations: carers, disabled residents, GRT communities, homeless households, veterans, vulnerable migrants

Health Needs & Risks

- Rising long-term conditions: Hypertension, Obesity, Depression, Diabetes, Asthma
- Adults with Serious Mental Illness (SMI): 15–20 years shorter life expectancy
- Adults with Learning Disabilities (LD): 20 years shorter life expectancy

Children & Young People

- 50,000+ children with Special Educational Needs or Disabilities (SEND) and demand rising

Public Health

- Immunisation coverage below WHO 95% threshold
- Four-in-one (Diptheria, Tetanus, Whooping Cough & Polio) booster uptake at age 5 is <90% across Essex
- Measles, Mumps & Rubella (MMR) uptake by age 5 is <90% across Essex

Wider Determinants

- Loneliness linked to higher hospital use and early mortality
- Rising economic inactivity due to poor health, caring responsibilities and skills mismatch
- Highest inactivity in Tendring, Maldon, Thurrock

Biggest drivers of early mortality in Essex

Health Behaviours

More adults are considered **obese** in Essex (65.3%), than the England average (63.9%), despite high levels of physical activity

An increasing number of children are being classified as **overweight**, with much higher prevalence at 10/11 years

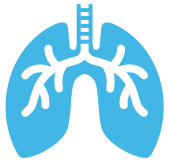
Rates of **smoking and drug misuse** in Essex have levelled off and track below England, but there are big inequalities

Across Essex, apart from in Southend, **alcohol related mortality** is lower than England

Health Conditions

Cardiovascular Disease

Cancer



Respiratory diseases

NHS Performance in Essex - The health of our health system

Area	Key Headlines
Elective Care	• 47% of patients across Essex (Nov 2025) treated within the national standard of 18 weeks - national target is 65% • Specialties with the longest waits: Oral Surgery, Ear Nose and Throat, Trauma and Orthopaedics and Paediatrics
Diagnostics	• 23% of patients have waited more than six weeks for a diagnostic test - national target is less than 20% • Over 5,600 patients (Nov 2025) have been waiting more than 13 weeks for a diagnostic test • Longest waiting lists: Echocardiography and non-obstetric ultrasound
Cancer	• 66% of people received a definitive diagnosis of suspected cancer within 28 days of referral, national target is 80% • 86% of people have started treatment within 31 days of decision to treat, national target is 95% • 55% of people have started treatment within 62 days of a referral for suspected cancer, national target is 85%
Quality	• Major pressures in acute trusts: maternity safety, UEC flow, elective waits, cancer • Mid and South Essex NHS Foundation Trust (MSEFT), The Princess Alexandra Hospital NHS Trust (PAH), and East Suffolk and North Essex NHS Foundation Trust (ESNEFT) all hold “Requires Improvement” Care Quality Commission (CQC) ratings • Mid and South Essex NHS Foundation Trust: lowest National Oversight Framework (NOF) segment (5); Princess Alexandra Hospital NHS Trust: NOF rating of 4; East Suffolk and North Essex NHS Foundation Trust: NOF rating 4 • Community providers rated Good/Outstanding by the CQC • Primary Care is generally rated well by the CQC across Essex.

NHS Performance in Essex - The health of our health system

Area	Key Headlines
Community Services	• Most community services are seeing over 92% of patients within 18 weeks of referral, in line with national standards • Exceptions are; Community Paediatrics (38%), Children's Physiotherapy (81%), Biomechanics (89%) and Parkinson's (89%) • Over 2,000 children have been waiting more than a year (52 weeks) for a community appointment
Mental Health	• 69% of people are experiencing reliable recovery following support from Talking Therapy - national target 48% • Wider challenges with access to community Mental Health services and effective discharge is creating pressure across the mental health system in Essex.
Primary Care	• In 2025/26 the number of GP appointments provided in Essex has increased and is expected to exceed 11 million • GP experience broadly in line with national averages • In 2024/25 around 116,000 urgent Dental Appointments were delivered, with continued growth in available appointments • 42% of adults in Essex and 61% of children in Essex have seen an NHS dentist in the last 12 months, above the national standard • In 2024/25, there were around 172,000 Pharmacy First Consultations
Finance	• Predecessor ICBs have all been in a financially sustainable position since their creation in 2021, delivering a breakeven or surplus position annually • New Essex ICB allocation: £5.275bn • Essex providers delivered deficit positions in 2025/26 and all received deficit cash support • Essex ICB benchmarks poorly with comparatively high spend across All Age Continuing Care Services

Outcome ambitions for the population

Reducing Health Inequalities

We will…

- Understand what health inequalities exist in experience, access and outcomes across Essex.
- Plan and deliver ways to address specific inequalities experienced by individuals and communities.

So that people in Essex have…

- Improved life expectancy and healthy life expectancy in deprived communities
- Narrower gaps in access, waiting times and outcomes for protected and priority groups
- Better performance against Core20PLUS5 indicators
- Strengthened patient experience and engagement among those who face the greatest health barriers

Start Well

We will…

- Support babies, children, young people and families to build strong foundations for lifelong health and wellbeing through early help, prevention and joined up support from conception through to adulthood.

So that people in Essex have…

- Improved outcomes and experience
- Safer maternity and neonatal care;
- Better early childhood development
- Reduced inappropriate prescribing;
- Strengthened mental health support in schools
- Better access to high-quality, inclusive services for those with SEND and neurodiversity

Live Well

We will…

- Help people to stay well and manage their health and health conditions so that they can maintain independence and make informed choices to live longer, healthier lives.

So that people in Essex have…

- Increased healthy life expectancy
- Higher uptake of prevention programmes
- Better management of long-term conditions
- Reduced lifestyle-related risks timely access to primary
- Community and elective services strengthened personalised and community-based support for people with complex needs, learning disabilities and autism

Feel Well

We will…

- Offer good mental and emotional wellbeing for all, improve access to mental health services in the community and reduce reliance on inpatient and inappropriate out of area beds
- Improve access to care that meets people's mental health needs when they need it most, including in an emergency

So that people in Essex have…

- Improved access to timely and effective psychological therapies
- Reduced premature mortality and suicide
- Increased uptake of physical health checks
- Expanded community-based and school-based mental health support
- Greater access to employment for people with severe mental illness
- Reduced inappropriate out-of-area placements
- Fewer inpatient admissions for people with learning disabilities or autism

Age Well

We will…

- Support people to remain active, independent and as healthy as possible as they grow older
- Ensure services promote healthy ageing, reduce avoidable ill health and hospital admission, particularly for those who are living with frailty

So that people in Essex have…

- Better identification of frailty and dementia
- Reduced avoidable hospital admissions and readmissions
- Fewer falls
- Strengthened community-based nursing support
- Improved outcomes for people living in care homes

Die Well

We will…

- Support people of all ages to live well until the end of their life, with clear care plans to support them to die in their preferred place through delivery of personalised, compassionate care plans

So that people in Essex have…

- Better identification of people approaching the end of life
- Reduced avoidable hospital admissions
- Increased advance care planning
- Increase in people supported to die in their preferred place

Respond Well

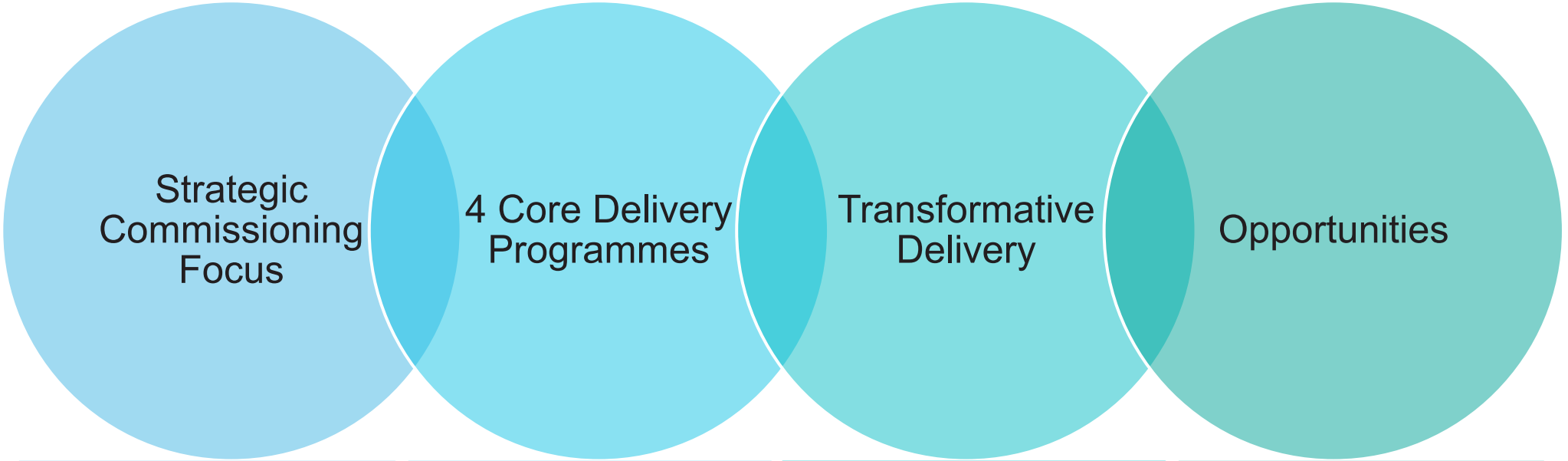
We will…

- Ensure people receive the right care, at the right time, in the right place through coordinated services that people can access when they are needed urgently, or in an emergency to prevent further escalation

So that people in Essex have…

- Faster access to A&E, ambulance and same-day primary care services
- Reduced avoidable non-elective hospital use and delayed discharges
- Increased community and virtual ward capacity
- More effective integrated urgent care pathways
- Improved stroke care through faster diagnostics and timely specialist treatment

Essex ICBs approach to Transformation



- Shift from system wide delivery to targeted strategic commissioning across all services
- Clear focus on what we commission, how we invest, and population outcomes

- The four programmes will drive transformation;
- 5-year vision
- 1 to 2 year delivery plans
- Work with partners to understand population needs, service gaps and improvement opportunities
- Outcome metrics at project, programme and strategic level

- Respond to the three national shifts
- Use population health management data to inform decisions, model impact, value and outcomes
- Manage the transition to the Model ICB Blueprint
- Demonstrate how learning and best practice will be scaled

- Review and align commissioning across Essex
- Spread best practice and innovation
- Introduce a consistent review framework for clinical, quality, financial and commercial assurance

Delivery Programmes

Neighbourhood Health

- Developing and commissioning effective Neighbourhood Health services
- Improving access to and the quality of services across primary and community care
- Using new and innovative models of commissioning and contracting to support the transformation of care delivered closer to home

Sustainable Hospital Services

Planned Care:

- Improving access to and quality of elective, diagnostics and cancer care services
- Targeted efforts to reduce waiting lists, support early diagnosis of cancer and provision of more diagnostic services in the community
- Deliver 'left shift' of elective care, particularly outpatients, out of hospital and into more community locations

Unplanned Care:

- Developing integrated services that provides access to urgent and emergency care when people need it most
- Delivery of integrated same day services with access to urgent support when it needed

Mental Health & Neurodiversity

- Will bring together an all-age focus on mental health commissioning
- Delivery of strategic commissioning of services to support people with mental health conditions and neurodiversity
- Supporting prevention and early intervention through effective community services to reduce the need for inpatient services, particularly those that are out of area.
- Continue to support improvements in inpatient services, including the quality of care and reduced length of stay

Complex Care

- Brings together a range of services commissioned to support core patient groups: Babies, Children and Young People, Learning Disabilities and Autism (all age), All Age Continuing Care
- Focused on commissioning services that will improve outcomes for each group of patients through a focus on more integrated and personalised care for individuals

Priority work programmes for 2026/27

Multi-disciplinary projects for 2026/27:

1. Developing the Neighbourhood Health Service model for Essex, with a specific focus on frailty in 2026/27
2. Undertaking a system wide strategic commissioning review of community services across Essex
3. Reducing long waiting lists for elective care, including children's services and neurodiversity diagnoses
4. Improving cancer outcomes across Essex, with a plan to focus on earlier diagnosis
5. Developing an approach to Urgent Care across Essex – including MH UEC to support people in crisis
6. Procuring Talking Therapies and Psychological Therapies for people with SMI
7. Undertaking a quality review of perinatal services
8. Delivering an Estates strategy, including Community Hospitals, Neighbourhood Health Centres and Primary Care
9. Establishing the new organisation, including external relationships

Outcome Ambitions aligned to Delivery Programmes

Delivery Programmes →

↓ Outcome ambitions

	Neighbourhood Health	Sustainable Hospital Services		Mental Health and Neurodiversity	Complex Care (inc CYP, LDA & CHC)
		Planned Care	Unplanned Care		
Reducing Health inequalities	✓	✓	✓	✓	✓
Start Well	✓	✓		✓	✓
Live Well	✓	✓		✓	✓
Feel Well	✓		✓	✓	✓
Age Well	✓	✓	✓	✓	✓
Die Well	✓		✓	✓	✓
Respond Well	✓		✓	✓	✓

Neighbourhood Health Work Programmes

Neighbourhood Health

A. Implement agreed neighbourhood footprints across all places in Essex

B. Agree and develop further plans for Integrated Neighbourhood Teams (INTs)

C. Improve relationships and performance across Primary and Secondary care interface, implementing the recommendations from the Red Tape Challenge (RTC) locally

D. Develop neighbourhood health system archetypes across Essex

E. Undertake a Better Care Fund review and implementation

F. Incorporate any further national requirements once the Neighbourhood Health Guidance is published

Primary Care

A. Strengthen access and capacity in general practice: Improving access, tackling unwarranted variation across General Practice and improving patient experience

B. Develop and commission an Essex wide approach to Enhanced Primary Care Services (Local Enhanced Services and Direct Enhanced Services), drawing on best practice from access Essex to help move towards neighbourhood delivery models

C. Improve access to dental services

D. Improve access to pharmacy services

E. Improve access to optometry services

Community Health Services

A. Undertake a system wide strategic review of all Community services

B. Address variation in capacity, provision and long waiting times of core community health service provision

C. Monitor progress of Mid and South Essex NHS Foundation Trust (MSEFT) on the implementation of the agreed recommendations for community hospitals

D. Review and recommission community equipment services within Essex

E. Expect providers to continue to develop Virtual Ward models across Essex, to maximise capacity and outcomes

Prevention and Long Term Condition Management

A. Improve secondary prevention measures for weight management and obesity

B. Improve secondary prevention measures for tobacco dependency

C. Improve secondary prevention measures for cardiovascular disease

D. Improve Diabetic Care

E. Improve outcomes for those with chronic kidney disease (CKD)

F. Improve care and treatment for those with respiratory conditions

Sustainable Hospital Services – Planned Care work programmes

Elective Care

A. Working with providers to deliver elective recovery plans, as agreed through the 2026/27 planning and contracting round

B. Working with system partners to improve hospital referral pathways through supporting patients Right to Choose, optimised use of Advice and Guidance, the development of Single Points of Access referrals

C. Implementing newly commissioned pathways for dermatology and MSK to support improved access to care and out of hospital provision

D. Reviewing priority elective care pathways where there is opportunity for improvements and left shift of care into the community

E. Supporting the commissioning of specialised services as part of wider patient pathways

Cancer Services

A. Develop and implement an Essex-wide approach to supporting earlier diagnosis of cancers

B. Work with the East of England Cancer Alliance and providers across Essex to support implementation of agreed cancer recovery plans in line with national requirements and as agreed in contracts for 2026/27

C. Work with the East of England Cancer Alliance to support testing new innovations in cancer services

D. Support the East of England Specialist Commissioning review of cancer services

Diagnostic Services

A. Commissioning of diagnostic provision across Essex in line with national standards

B. Continued commitment to commissioning more diagnostic services in the community, including continued roll out of Community Diagnostic Services across Essex

Other service developments &reconfigurations

A. Hold MSEFT to account for delivery of the outcomes from the2018 'Your Care in the Best Place' decision-making business case (DMBC)

B. Review of fragile services

Sustainable Hospital Services – Unplanned Care Work Programmes

Unplanned Care Services

A. Work with providers to support implementation of urgent and emergency care recovery plans and winter plans

B. Develop and implement an Essex-wide approach to Urgent Treatment Centres (UTCs)

C. Agree and implement an approach to commissioning Integrated Urgent Care (111, Out of Hours and Unscheduled Care Co-ordination Hub) across Essex, or at greater scale with partners

D. Work with providers to implement improvements in access to emergency Stroke Services and review options to improve stroke rehabilitation for the population of Essex

Improved Flow

A. Commission an Essex wide Integrated Care Transfer Hub (ICTH)

B. Commission services to support effective Discharge to Assess service for Pathway 2 across the whole of Essex

C. Work with partners to increase capacity for urgent, rehabilitation and reablement services at a multi-neighbourhood level

D. Develop and commission an Essex-wide approach to an Unscheduled Care Co-ordination Hub (UCCH)

E. Procure an Essex-wide Non-Emergency Patient Transport Service (NEPTS)

Mental Health (MH) & Neurodiversity Work Programmes

MH for Children and Young People

A. Increasing access to Mental Health Support Teams in schools

B. Continue to test and improve the impact of the THRIVE framework for system change

C. Work with specialist commissioners and the East of England Provider Collaborative to support the commissioning of the ‘day service’ for eating disorders

D. Providers of children’s inpatient mental health beds to continue with the ‘72-hour bed’ model, with outcome and experience measures to be designed and published

E. Work with local authority partners, and healthcare providers to further review the transitions process to improve support for those young people reaching

MH Inpatient Services

A. Hold EPUT to account for delivering the benefits outlined in their Time to Care business case to improve inpatient care and reduce length of stay

B. Work with system partners to improve flow across adult inpatient wards to reduce delayed discharge

C. Continue to explore alternative options for commissioning out of area placements for Essex

Adult Community MHServices

A. Embed the Personalised Care Framework principles across all services

B. Review all community mental health services, reducing variation and improving quality for all

C. Procure an Essex-wide service to provide Talking Therapies services and Psychological Therapies for Severe Mental Health Problems

D. Work with providers to strengthen Intensive and Assertive Outreach(I&AO) services

E. Continue commissioning wider community mental health services improving the physical and mental health for residents

F. Ensure mental health is included in the developing neighbourhood health model - clear commissioning of mental health in primary care

G. Expand EPUT provision of non-emergency patient transport

Neurodiversity Services

A. Improve outcomes for neurodivergent children, young people and adults by commissioning timely, accessible, and person-centred assessment and support pathways for autism and ADHD

Urgent and Emergency MH Services

A. Redesign how mental health patients access urgent care when in crisis

B. Support the Essex-wide roll out of the regional crisis text support service

Complex Care – Babies, Children, Young People (BCYP) and Perinatal Work Programmes

Perinatal Services

A. Review of Perinatal Services
B. Assurance of provider plans to deliver national requirements and recommendations for maternity and neonatal services
C. Maternity and Neonatal Improvement Support Team (MNIST) for acute providers
D. Maternity and Neonatal Voices Partnership (MNVPs)

CYP Physical health Services

A. Support providers to delivery on the Elective Reform Plan to recover elective care performance for children waiting for treatments in line with national targets/recovery plans
B. Improve support for children and young people to 'wait well' whilst waiting for diagnosis or treatment
C. Review how care for children and young people is provided across Essex, focussing on those conditions with greatest impact on outcome, mortality and morbidity in Essex.
D. Work with providers to increase coverage of diabetes, epilepsy and asthma care bundles for children in Essex

CYP Special Educational Needs and Disabilities (SEND)

A. Implement the SEND Quality Assurance framework across Essex, with local authority partners
B. Review SEND strategic plans against operational delivery
C. Fully Implement the joint data dashboard for SEND across Essex
D. Continue implementing and delivering the Southend-on-Sea, Essex and Thurrock (SET) Therapies Transformation Programme
E. Successful implementation of Paediatric Early Warning Score (PEWS) and reasonable adjustments for young people with SEND

Complex Care Work Programmes

Support for people with Learning Disabilities

A. Implement and embed new governance structures to ensure hosted Learning Disabilities and Health Equalities commissioning functions deliver against the expectations set out within the Transforming Care guidance

B. General Practice providers to improve the uptake of Annual Health Checks and Health Action Plans for children and adults with Learning Disabilities and Autism across Essex

All Age Continuing Care & Section 117

A. Develop and deliver implementation plan for the recommendation from the Good Practice Document for AACC

B. Develop a plan to reduce unwanted variation in delivery and cost of AACC services across Essex in partnership with upper tier local authorities and service providers

C. Review and implement new approach to AACC operating model

D. Undertake a review of Section 117 pathways

Serious Violence & Victims of Abuse

A. Strengthen role as an active and accountable partner within the Southend-on-Sea, Essex and Thurrock Violence and Vulnerability Partnerships (VVP)

B. Use the Serious Violence Strategic Needs Assessment (SNA) as the core evidence base to drive a coordinated, prevention first response to serious violence and abuse, including domestic abuse and violence against women and girls

C. Work with system partners to embed a multiagency, trauma informed, and detailed approach across commissioning, care pathways and workforce practice, ensuring that health services consistently contribute to early identification, effective safeguarding, and timely access to psychosocial support

Enablers for Delivery

Public involvement	• Incorporate meaningful public involvement as a key requirement to effective strategic commissioning • Ensure population health improvement activity is shaped by lived experience and local insight
Medicines Management	• Improve outcomes and experience, reduce medicines-related harm and unwarranted variation and release capacity and value • Embed a targeted, data-led and proactive approach, focusing effort where it will most reduce inequality and avoidable demand
Quality	• Develop a fully integrated, collaborative quality system, where every provider reports against a single quality framework • Patient safety and experience data are routinely used to improve care across pathways
Research and Innovation	• Increase the volume and quality of research and innovation projects supported and scaled across Essex • See the faster adoption of NICE and other evidence-based interventions
Estates	• Develop and deliver a coordinated, efficient, and future-focused estate strategy that supports the delivery of Neighbourhood Health Services and sustainable hospital services, in partnership with local providers and other public sector partners, with best use of all public sector assets in the development of services
Digital and Data	• Deliver the national ambition to transition from analogue to digital, maximising the use of data and digital solutions across the NHS in Essex • Achieving this will mean working in partnership with providers to support their delivery of a range of key programmes that will see improved digital solutions for both local people and the health system
Environmental sustainability	• Address the impacts of climate change and reducing carbon emissions in both how the ICB runs itself and in the services that it commissions • Maintain and implement an ICB 'Green Plan', focusing on actions that can be taken to reduce emissions i.e. sustainable buildings, effective waste management, staff active travel and volunteering

Finance

Financial Framework

- Essex ICB revenue allocation:
  - £5.275bn (2026/27)
  - £5.421bn (2027/28)
  - £5.581bn (2028/29)
- Plan to live within allocation over 3 years
- Requires 2–3% annual efficiencies while supporting prevention, digital and left-shift ambitions
- Commitment to Mental Health Investment Standard and rebalancing spend towards neighbourhood, digital and prevention (target: 2.5% shift per year)

Contracting & Procurement

- Move to data-driven payment models
- Adoption of Neighbourhood Model Contracts to enable left shift and new ways of working
- Streamlining large contract portfolio to improve clarity, consistency and collaboration
- Funding to follow the patient, maximising value for money
- Contract levers used to support service development and, where needed, decommissioning of persistently poor-quality services

Estates & Capital

- Capital allocation: £9.8m (2026/27)rising to £10.3m (2029/30)
- Multi-year capital planning to accelerate delivery
- Prioritisation based on geographical and building need
- Support for providers to utilise£191m national capital (Urgent 7Emergency Care, diagnostics, estate safety, constitutional standards)
- Continued joint working with local authorities through One Public Estate

Workforce

Workforce at the Heart of System Change

- Staff capability, capacity and wellbeing
- Workforce will enable prevention, digital transformation and left shift to community care

Building a Skilled, Flexible & Inclusive Workforce

- Strengthening clinical leadership and embedding multidisciplinary teams
- Growing the future workforce through:
    - Health & Care Academy, schools & Further Education engagement
    - Partnerships with Department of Work and Pensions, Kings Trust, Enable East, local council engagement
    - System careers platform: *Our People Your Future*

Expanding Roles to Deliver the Three Shifts

- Growth of Additional Roles Reimbursement Scheme roles, Community Diagnostic Centres, Enhanced Therapeutic Observations and Care teams
- Embedding clinical pharmacists & pharmacy technicians in multi-disciplinary team meetings
- More flexible deployment of staff across pathways

Driving Productivity & Improvement

- Stewardship programme to equip leaders with data, evidence and redesign skills
- System-wide Quality Improvement culture to empower staff
- Stronger system medical leadership to drive change

Education, Training & Retention

- Partnerships with Anglia Ruskin University, University of Essex, Further Education colleges
- Expansion of clinical placements, My Learning Platform, HCA Academy
- Support for wellbeing, flexible working, apprenticeships, advanced practice
- Implementation of the NHS Equality, Diversity & Inclusion strategy

Workforce Reform & Collaboration

- Reducing reliance on temporary staffing; improving rostering and pipelines
- Integrated workforce planning across PCNs, community pharmacy, care homes and secondary care
- Shared digital infrastructure and consistent clinical pathways

Governance, Delivery and Risk

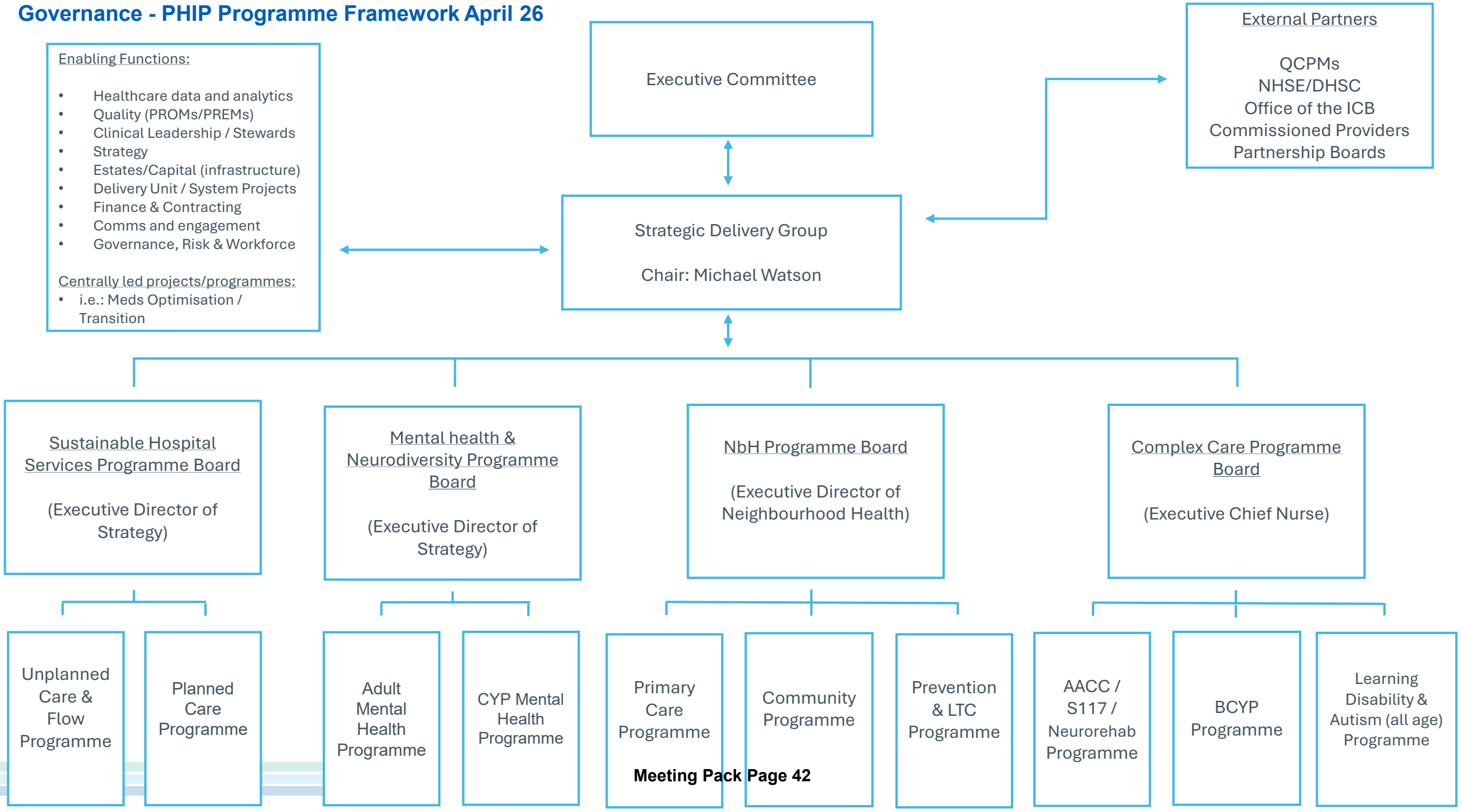
Governance & Delivery

- Clear, robust governance to oversee business-as-usual and transformation
- The ICB will retain system-level oversight of programmes and service improvements delivered by providers, collaboratives and commissioned services that impact the population of Essex and contribute to delivery of strategic ambitions
- All enabling functions will be embedded within programme governance and delivery processes
- Executive Officers will be accountable for the delivery of activities within their respective portfolios, in accordance with the ICB Accountability Framework
- ICB Delivery Unit will coordinate activities aligned to the PHIP, supporting the delivery of agreed programmes of work via four programme boards
- Escalations will happen via the ICB Executive and relevant Quality, Contracting and Performance Meetings

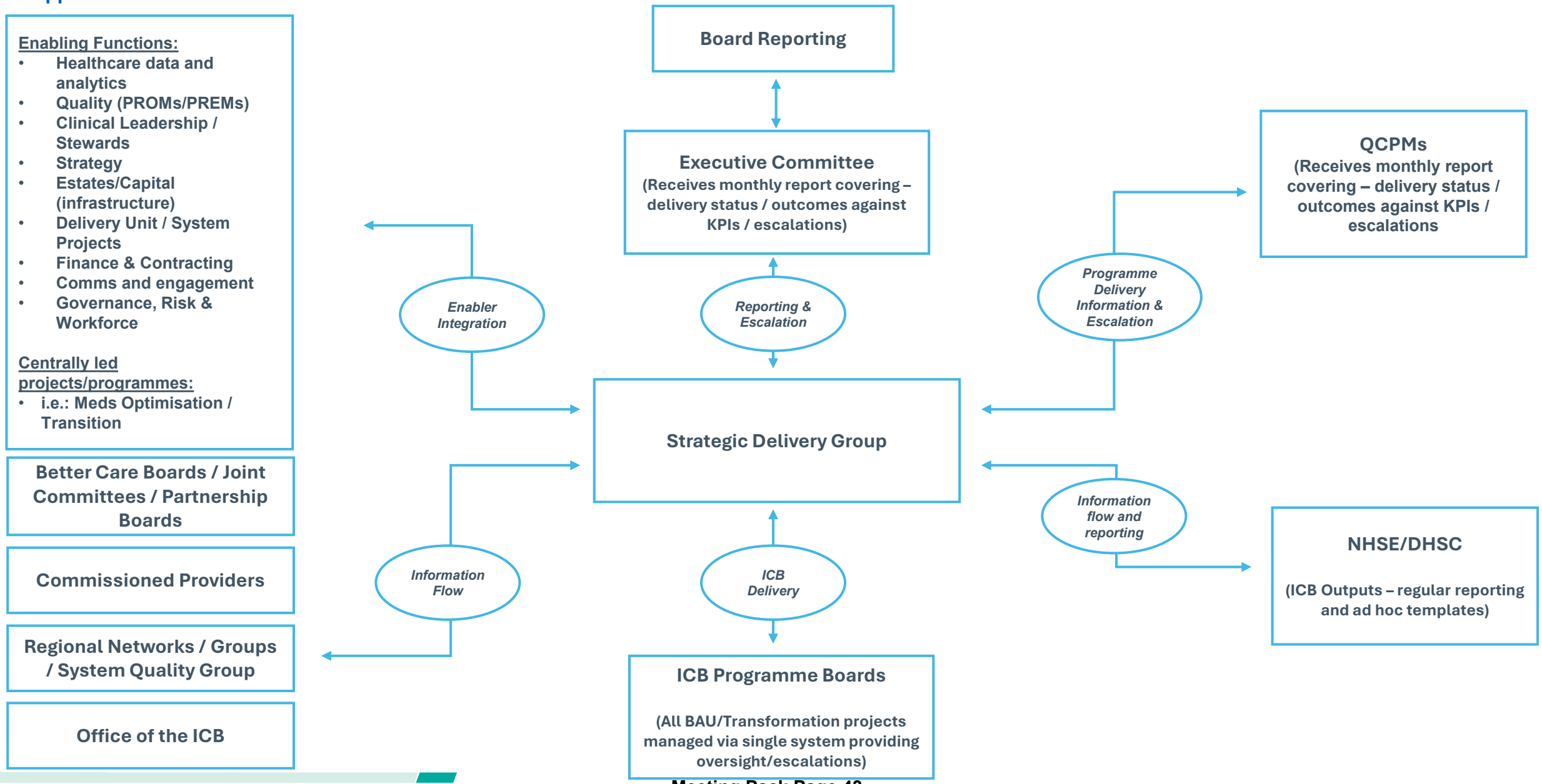
Risk Management

- Board responsible for strategic risk oversight via the Board Assurance Framework (BAF)
- This framework aims to provide assurance that the risk management approach being applied is appropriate, aligned across the Essex footprint and reflects system-wide learning.
- The Essex ICBs Executive Team undertakes monthly review of the BAF and all red rated risks
- Sub-committees receive relevant BAF extracts and directorate risk registers
- During 2026/27: review of risk approach, including revised risk appetite and updated BAF

Governance - PHIP Programme Framework April 26



Governance- PHIP Strategic Delivery Programme Governance & Support functions



NHS
Essex
Integrated Care Board

Part I Essex Integrated Care Board Meeting, 23 April 2026

Agenda Number: 8

Chief Executive's Report

Summary Report

1. Purpose of Report

To provide the Board with an update from the Chief Executive.

2. Executive Lead

Tom Abell, Chief Executive.

3. Report Author

Tom Abell, Chief Executive.

4. Responsible Committees

Not applicable.

5. Impact Assessments

Not applicable.

6. Financial Implications

Not applicable.

7. Details of patient or public engagement or consultation

Not applicable.

8. Conflicts of Interest

None identified.

9. Recommendation/s

The Board is asked to receive the report for information and note the updates provided.

Chief Executive's Report

1. Introduction

This report provides the Board with an update from the Chief Executive on the work of the ICB since the last update. The report also provides a summary of activity of the Executive Committee.

2. Main content of Report

2.0 ICB transition

Board members will be aware that the creation of NHS Essex Integrated Care Board was completed as planned on 1 April 2026, succeeding the three ICBs which previously commissioned services across Essex.

Following approval by the ICB Board on 1 April 2026, work is now well underway to establish the approved governance and all other requirements to ensure that NHS Essex can operate effectively and meet its statutory duties.

We are also at the final stages of the organisational change process, with all members of staff having an initial outcome. We continue to support some individuals who have not been successful in securing a role so far, where there are potential suitable alternative employment opportunities.

To support staff members with the move to NHS Essex, and the new role of ICBs, we are holding a number of briefing sessions for staff and have launched our programme of co-design work with staff to design the future intended culture and ways of working for the new organisation.

2.1 2026/27 planning update

The Board approved the Population Health Improvement Plan for NHS Essex on 1 April 2026, which sets out the proposed work of the ICB over the coming years, and the ways in which we will assess whether we are making sufficient progress on this change programme.

We resubmitted our numerical plan to NHS England at the end of March to update this in line with revised metrics from Mid and South Essex NHS Foundation Trust (MSEFT). These updates did not change the overall financial position of the ICB, or overall funding allocation between services, but did improve overall waiting list size for Essex by c.50,000 over the course of 2025/26 alongside improvements in other access standards. These revised numbers will be reflected within the future commissioning and performance reports which the Board and Committees will receive.

2.2 Local Government Reform

On the 25 March 2026, the Secretary of State for Housing, Communities and Local Government made a statement setting out the 'minded to' decision of Government in respect of Local Government Reform. This decision set out that, from 1 April 2028, the existing county, unitary, city, district and borough councils will be replaced by five new unitary councils, these being:

- **Mid Essex Council** covering Brentwood Borough Council, Chelmsford City Council and Maldon District Council.

- **North East Essex Council** covering Braintree District Council, Colchester City Council and Tendring District Council.

- **South East Essex Council** covering Castle Point District Council, Rochford District Council and Southend-on-Sea City Council.

- **South West Essex Council** covering Basildon Borough Council and Thurrock Council.

- **West Essex Council** covering Epping Forest District Council, Harlow District Council and Uttlesford District Council.

We had been preparing in Essex for this decision to take the opportunity of these changes, alongside our own to drive collaboration with local authorities to improve outcomes for the residents of Essex. The first step that has already been taken is to align our Associate Directors of Neighbourhood Health and their teams to these new areas, these being South West, Mid and South East, North East and West.

Our initial priorities in this initial period are:

- Collaborating on data analytics, to look at what shared capability can be built across Essex and to secure a common view on the challenges of Essex to inform our joint work to tackle these.

- Collaborating on estates to release value and efficiencies, including the wider public sector in Essex such as Police and Fire Services. This work will also focus on improving NHS engagement in the section 106 and local development processes.

- Considering what opportunities there are to establish joint ICB / Local Authority joint posts to integrate commissioning activity and breaking down silos.

- Working with local authorities to identify areas where there would be benefit for commissioning at scale across Essex for certain services, or for certain communities with specific needs.

- Shaping our convenor model (the mechanism by which we aim to engage differently with the Community, Voluntary and Faith sector) on these new footprints to enable joint working and commissioning between the ICB and local authorities.

- Working to align our neighbourhoods and local government Neighbourhood Delivery Committees.

- Continuing to work closely with all existing safeguarding boards and supporting the emerging structures as a result of these changes. A specific focus being how we can deliver a safe and sustainable system which protects residents of Essex.

2.3 Neighbourhoods and Neighbourhood Health Guidance

Last month, the Department of Health and Social Care (DHSC) alongside NHS England published the Neighbourhood Health Framework.

This framework marks a clear shift from neighbourhood working being encouraged in principle to it being expected as a core delivery model for the NHS and its partners. National policy now frames neighbourhood health as a practical vehicle for the wider reform agenda: moving care closer to home, strengthening primary and community services, increasing prevention and proactive care, moving more outpatient activity into neighbourhood settings, and reducing avoidable pressure on hospitals and care homes. The framework also makes clear that this is a joint endeavour with local government and wider partners, rather than an NHS-only programme.

For ICBs, this is important because it places neighbourhood health squarely within the role of the strategic commissioner. The accompanying letter makes clear that 2026/27 is intended to be a foundational year in which systems put in place the practical architecture for neighbourhood health, while the framework signals that ICBs should reflect this explicitly in refreshed five-year strategic commissioning plans. Alongside service redesign, NHS England and DHSC are signalling a commissioning reform agenda built around population-based commissioning, new payment approaches for neighbourhood services, financial flows that support a shift of resources into neighbourhoods, and the beginning of outcome-based contracting within three years.

The immediate national expectation in 2026/27 is that ICBs and local government, working through Health and Wellbeing Boards, agree neighbourhood footprints around natural communities, develop plans for integrated neighbourhood teams focused on high-priority cohorts, confirm intentions for pooled funding through the Better Care Fund, identify organisational ownership for delivery, and put in place suitable data-sharing arrangements for patient identification and evaluation. From 2027/28, systems will be expected to develop a formal local neighbourhood health plan that sets out how national reform objectives will be delivered locally, how neighbourhood health will improve outcomes and reduce inequalities, how plans are informed by the Joint Strategic Needs Assessment (JSNA) and wider assessments, what the final geographies are, who is responsible for delivery, and how neighbourhood health aligns with related local initiatives.

Implications for NHS Essex

For NHS Essex, the framework is helpful in that it broadly validates the direction of travel we are already pursuing: a stronger neighbourhood model, a clearer strategic commissioning role for the ICB, and a greater emphasis on prevention, proactive care and shifting resource over time from hospital-based models to care delivered closer to home. It also strengthens the case for the ICB to move beyond being a sponsor of neighbourhood collaboration and instead become the body that defines the commissioning architecture, outcomes, incentives, and governance needed to make neighbourhood health work consistently across Essex.

The main implication is that NHS Essex will need to translate what is currently a broad strategic ambition into a more explicit operating model. In practice, that means agreeing clear neighbourhood geographies with partners, being precise about which cohorts and services are in scope first, clarifying the relationship between

neighbourhood, place and Essex-wide commissioning, and ensuring that delivery arrangements are robust enough to operate consistently across a large and complex system. The framework gives local flexibility, but it does not let systems off the hook: we will be expected to show that we have made real choices about footprint, provider expectations, ownership, data, and funding.

There are also specific implications for the ICB's commissioning function. The national direction points toward a more active use of population-based commissioning, new payment mechanisms and, over time, outcome-based contracts. For NHS Essex, this means that neighbourhood health cannot sit only as a service development programme; it needs to be built into commissioning intentions, contracting strategy, financial planning, and the development of measurable outcomes. Put bluntly, if neighbourhood health is not reflected in contracts, incentives, resource flows, and accountability arrangements, it will remain an aspiration rather than a delivery model.

The framework also has important partnership implications. Delivery is explicitly expected to happen jointly with local government through Health and Wellbeing Boards, with links to wider initiatives such as housing, family hubs, mental health hubs, and employment support. For NHS Essex, that means success will depend not only on NHS alignment but on how effectively we can build a shared programme with local authorities and other partners, particularly in the context of wider public sector reform and changing local government arrangements. In that sense, neighbourhood health is not just a care model issue; it is also a test of the ICB's ability to lead through partnership, influence, and strategic commissioning rather than through direct operational control.

Finally, there is a delivery risk as well as an opportunity. The policy direction is sensible, but it is ambitious, and there is a danger that neighbourhood health becomes a catch-all label unless it is anchored in a small number of visible priorities and practical early actions. For NHS Essex, the immediate challenge will be to turn this national direction into a credible local programme with a clear first-phase focus, realistic milestones, and line of sight between neighbourhood development and tangible improvements in access, proactive care, patient experience and reduced avoidable hospital use. Done well, this gives the ICB a strong framework for the next phase of reform; done badly, it risks adding another layer of rhetoric to an already crowded landscape.

We have also made some progress in delivering against the initial expectations of the framework, firstly we have completed the engagement and design work on the new neighbourhoods of Essex which were approved at the three Health and Wellbeing Boards last month, these are detailed in Appendix A of this report for information and we have now commenced work on how transition to these new neighbourhoods will work, over what time period and what this may mean for commissioned services and partner organisations.

Secondly, we have also some good, at-scale opportunities which are beginning to be delivered on outpatient reform, most notably with the launch of the new dermatology and musculo-skeletal services in the mid and south Essex footprint in recent months, early data indicates significant impact on outpatient referrals and patient support. Work has now commenced on additional speciality areas alongside understanding how existing good practice in some parts of Essex can be scaled more broadly across the county. We have however agreed the principle that the new multi-neighbourhood

contracting approaches set out within the framework will operate on the new unitary council footprints.

Thirdly we have a lot of development work to do, firstly to define what services and commissioning activities will sit at neighbourhood, multi-neighbourhood, and Essex-wide level, alongside work to pilot new commissioning approaches on these footprints during 2026/27.

2.3 Resident doctor industrial action

At the time of writing, Resident Doctors across England were undertaking industrial action. Across Essex we have worked closely with all NHS organisations to ensure that plans were in place to ensure services continue safely and disruption to patients is kept to a minimum.

I would like to take this opportunity to thank frontline teams across Essex who have worked so hard to support patients during these periods of action.

3. Essex Executive Committee Decisions

As the ICB has now formed, the Essex ICB Executive Committee has been established to transact operational business of the ICB.

With the formation of Essex ICB, a full workplan is being developed for the new committee to ensure effective oversight and scrutiny of the activities of the ICB and its' commissioning activity.

My future reports will provide a regular update on the decisions undertaken by the Executive Committee.

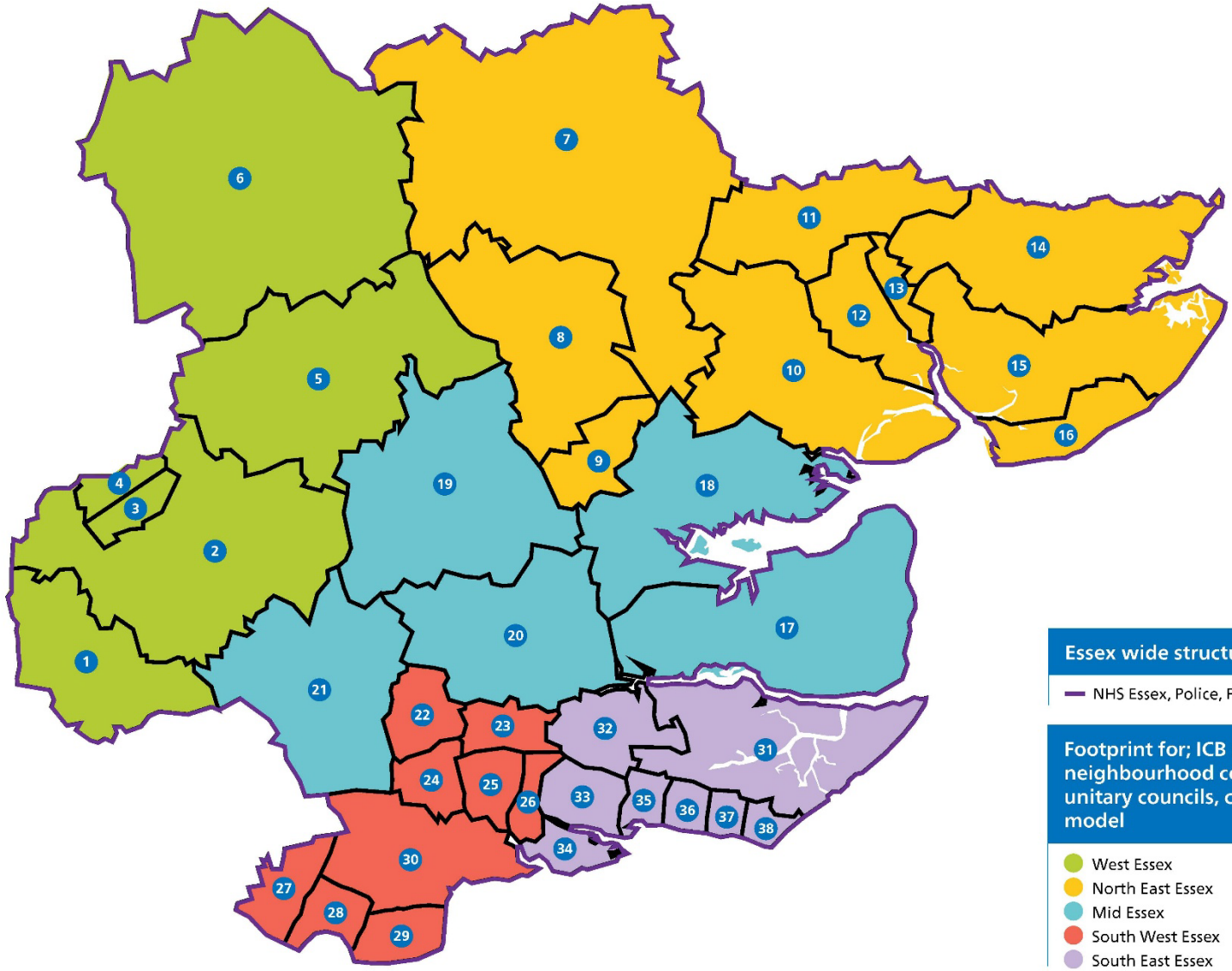
4. Recommendation(s)

The Board is asked to receive the report for information and to note the updates within.

5. Appendices

Appendix A – Health and Wellbeing Board Approved Neighbourhood

Appendix A – Essex Health Neighbourhoods



Essex wide structures

NHS Essex, Police, Fire

Footprint for; ICB multi neighbourhood contracts, unitary councils, convener model

- West Essex
- North East Essex
- Mid Essex
- South West Essex
- South East Essex

Footprint for; ICB single neighbourhood contracts, most local planning footprint to work with local government

1. Loughton and Buckhurst Hill
2. Epping North
3. Harlow South
4. Harlow North
5. South Uttlesford
6. North Uttlesford
7. Colne Valley
8. Braintree
9. Witham
10. Colchester South
11. Colchester North
12. Colchester City
13. Greenstead and East Colchester
14. Harwich and Tendring North
15. Tendring Rural
16. Clacton Central
17. Dengie
18. Maldon
19. Chelmsford City
20. Chelmsford South
21. Brentwood
22. Billericay
23. Wickford
24. Laindon
25. Basildon
26. Pitsea
27. ASOP
28. Grays
29. Tilbury and Chadwell
30. Stanford-le-Hope
31. Rochford
32. Rayleigh and District
33. Benfleet
34. Canvey
35. Southend West
36. Southend Central West
37. Southend Central East
38. Southend East

NOTE – Some lines on the map reflect areas which still require refining in terms of graphic design

NHS
Essex
Integrated Care Board

Part I Essex Integrated Care Board Meeting, 23 April 2026

Agenda Number: 9

Commissioning, Quality and Resource Summary Report

Summary Report

1. Purpose of Report

The report provides a summary position of the Revenue and Capital resource in Essex ICB for the 2026/27 financial year and the application of that resource across spend areas.

There is no change to the budget envelopes since the plan was approved by the Board. The Commissioning, Quality and Resource Committee has reviewed more detailed budget information ahead of Executive Director sign-off.

The report also presents a proposal for future reporting across Commissioning, Quality and Resource areas. This provides an opportunity for the Board to shape the reporting received.

2. Executive Lead

Jennifer Kearton, Executive Director of Finance and Commercial

Giles Thorpe, Executive Chief Nurse

Sam Goldberg, Executive Director of Commissioning - Acute & Adult Mental Health Services

3. Report Author

Jennifer Kearton, Executive Director of Finance and Commercial

4. Responsible Committees

The Commissioning, Quality and Resource Committee will review the detailed reporting at its meeting on 21 April 2026.

5. Impact Assessments

Not applicable.

6. Financial Implications

There are no direct financial implications arising from this paper.

7. Details of patient or public engagement or consultation

Not applicable.

8. Conflicts of Interest

None identified.

9. Recommendations

The Board is asked to note the report and provide feedback on the proposal for future reporting.

Commissioning, Quality and Resource Committee.

Executive Director Report to the Board

April 23rd, 2026

Sam Goldberg – Executive Director of Commissioning
Dr Giles Thorpe – Executive Director of Nursing
Jen Kearton – Executive Director of Finance and Commercial

1. Introduction

The following report provides a summary position of the Revenue and Capital resource in Essex ICB for the 2026/27 financial year and the application of that resource across spend areas.

The report also presents a proposal for future reporting across Commissioning, Quality and Resource areas. This provides an opportunity for the Board to shape the reporting received. Detailed reporting will be reviewed at the Commissioning, Quality and Resource Committee prior to the board (CQRC). The CQRC is supported, by Estates, Procurement, Contracting and System Quality Groups.

Escalations from the Chair of the CQRC will be received by the Board alongside the minutes of each meeting.

Escalations from the CQRC Chair	**Mark Bailham** ***Non Executive Director***
The first CQRC meeting is scheduled for the 21st April 26, as a result any escalations will be made verbally at the board meeting on the 23rd April 26.	

1a. Recommendation

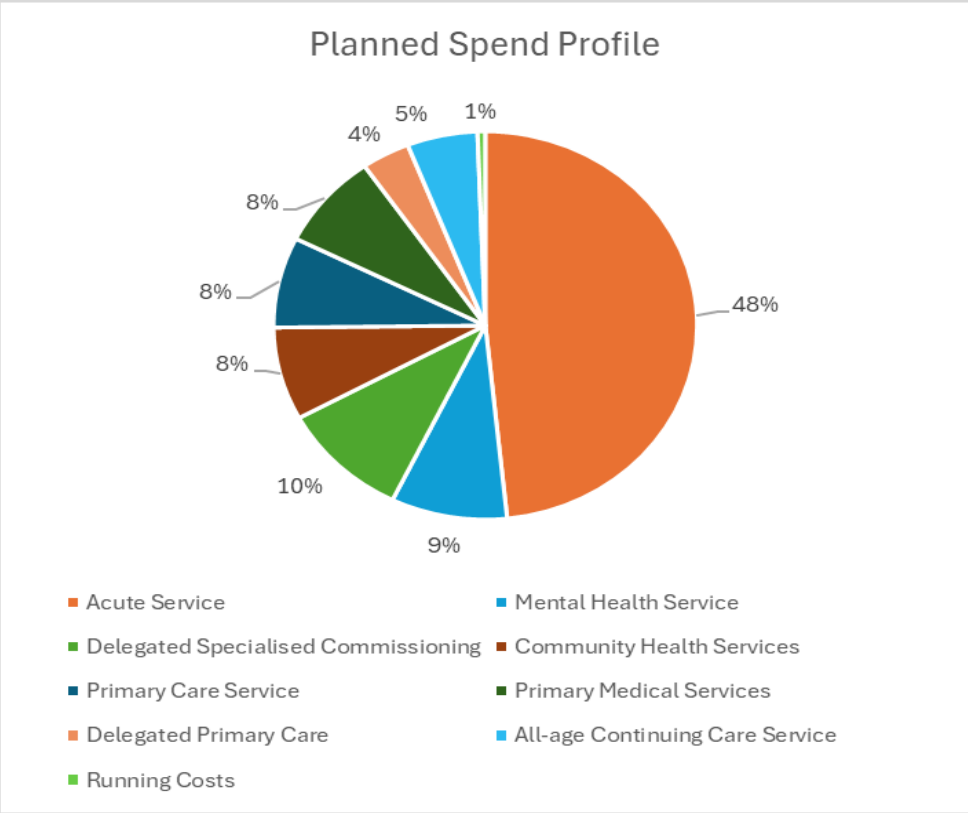
To note the report and provide feedback on the proposal for future reporting.

2. ICB Operating Plan – Revenue Resource Allocation and Application

2.1 Essex ICB budgets have been built from the consolidated forecast outturn of Mid and South Essex ICB and the Essex apportionment of Suffolk and Northeast Essex and Hertfordshire and West Essex ICBs. The forecast outturn was adjusted for non recurrent income and expenditure, cost pressures, inflation and investments to provide a budget envelope for 2026/27.

2.2 The Essex Joint Committee agreed the Plan for submission during March, which included the high-level budget envelopes for spend areas. This plan presents more detailed budget lines, which will be worked through with Executive Director Leads for approval and will form the basis of the quarterly reporting to the Commissioning, Quality and Resource Committee and the Board.

Chart 1



Mental Health Investment Standard expenditure meets or exceeds allocation	Yes
Primary Medical Services expenditure meets or exceeds allocation	Yes
Delegated primary care expenditure meets or exceeds allocation	Yes
Dental ringfence expenditure meets or exceeds allocation	Yes
Delegated Specialised Commissioning expenditure meets or exceeds allocation	Yes
Operational Capital - system is compliant	Yes

Table 2

Table 1

Resource Allcoation	2026/27 Plan Position £m
Recurrent allocation	
ICB Programme Allocations	4,064
Primary Care Medical Services	413
Delegated Primary Care (POD) and Other POD	190
Delegated Specialist Commissioning	472
Delegated Mental Health Resource	53
Running Cost Allowance	31
Recurrent Baseline	**5,224**
Further Non Recurrent Allocations	
NR Elective Recovery	10
Service Development Fund (SDF)	11
Charge exempt overseas visitor and UK cross border ad	(2)
Depreciation/amortisation - additional ringfenced func	26
Central technology licence arrangement adjustment	(2)
SR21 CDC funding	23
Other POD allocations	4
ICB Cost of Commissioning Adjustment	(25)
Management of obesity drugs	2
Specialised - Top ups and NR elective funding	10
Secondary dental elective funding transfer to POD	(4)
Total Non Recurrent Adjustments	**54**
Business Rules - Revenue Bonus	**4**
Total Recurrent and Non Recurrent Allocations	**5282**

Application	
Acute Service	2,554
Mental Health Service	469
Delegated Specialised Commissioning	521
Community Health Services	409
Primary Care Service	399
Primary Medical Services	421
Delegated Primary Care	194
All-age Continuing Care Service	285
Running Costs	31

Total ICB Planned Expenditure	**5282**
Net Position	**0**

2a. ICB Operating Plan – Capital Resource and Allocation

Capital Allocation	2026/27 Plan Position £m
Funding Source:	
Operational (BAU) Capital	3.6
ICB Strategic Capital	6.0
Utilisation & Modernisation Fund (UMF)	1.8
TOTAL	**11.4**
Application:	
GPIT Relacement Programme	1.8
Laindon Health Centre	3.0
Shoebury Health Centre	3.0
Prioritised UMF Schemes	1.8
TOTAL	**9.6**
UNCOMMITTED	**1.8**
Uncommitted Range by Funding Source	
Opertional (BAU) Capital	0-1.8
ICB Strategic Capital	0-1.8
Utilisation & Modernisation Fund (UMF)	0

Key Points to note:

Projects

The Essex ICB capital allocation is held by NHSE as three separate allocations.

- £3.60m Operational (BAU) Capital
- £6.00m ICB Strategic Capital
- £1.75m Utilisation & Modernisation Fund

£1.80m is currently uncommitted. Work is underway to clarify understanding of commitments associated with inherited projects, and subsequent alignment of funding.

Governance processes require NHSE sign off in line with delegation arrangements.

Void & Bookable, Open Space, and Sessional Space

ICB is liable for costs associated with void and unleased space within NHSPS and CHP (LIFT) buildings.

Other

ICB engaged on five large scale planning applications (1,000+ homes)
Asset Business Cases required for Fryatt and Colchester 27/28.

CQR Performance Updates – Proposed Reporting.

The following slides are a proposal for future reporting. Due to the timing of publication, at points this document contains dummy data to provide the board with a visual to support the discussions. We welcome feedback to shape this report as we move through the financial year.

3. Executive Summary

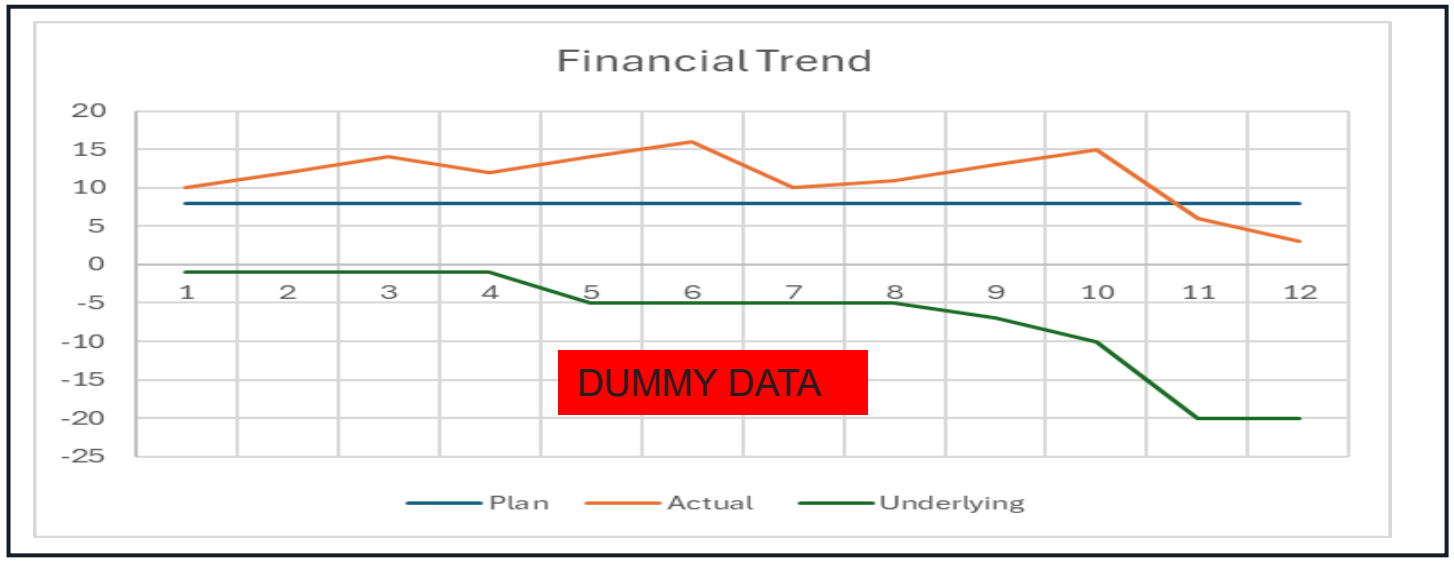
Commissioning

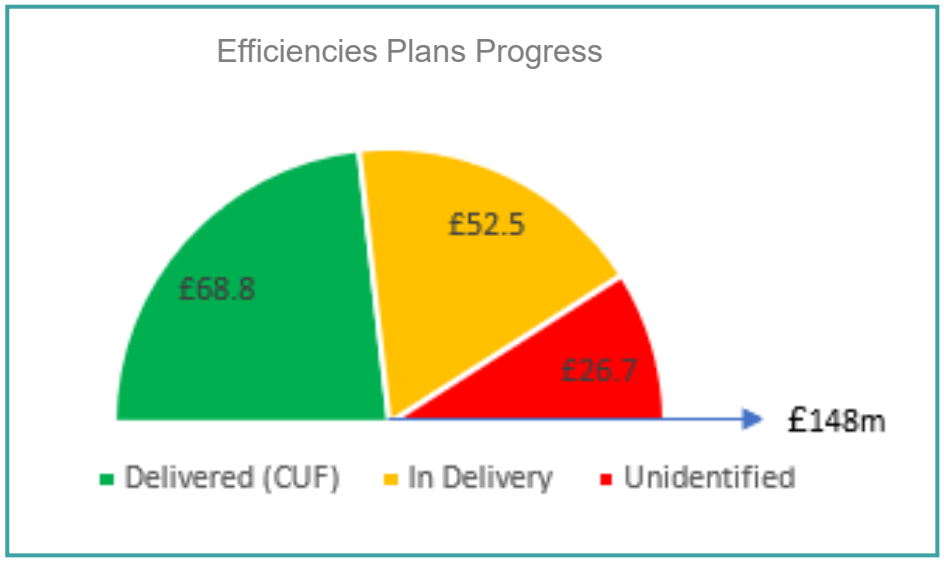
- *To provide an overview of the quarterly position. Picking up progress, risk and escalation as required….*

Quality

Resources

4. Key Financials – *Draft for comment*





Directorate	Executive Lead	Trend	On Plan
Acute Services	Sam Goldberg		
Mental Health Services	Sam Goldberg & Giles Thorpe		
Specialist Commissioning	Matthew Sweeting		
Community Health	Beverley Flowers		
Primary Care Services	Beverley Flowers		
Continuing Health Care	Giles Thorpe		
Running Costs	Jen Kearton & Michael Watson		

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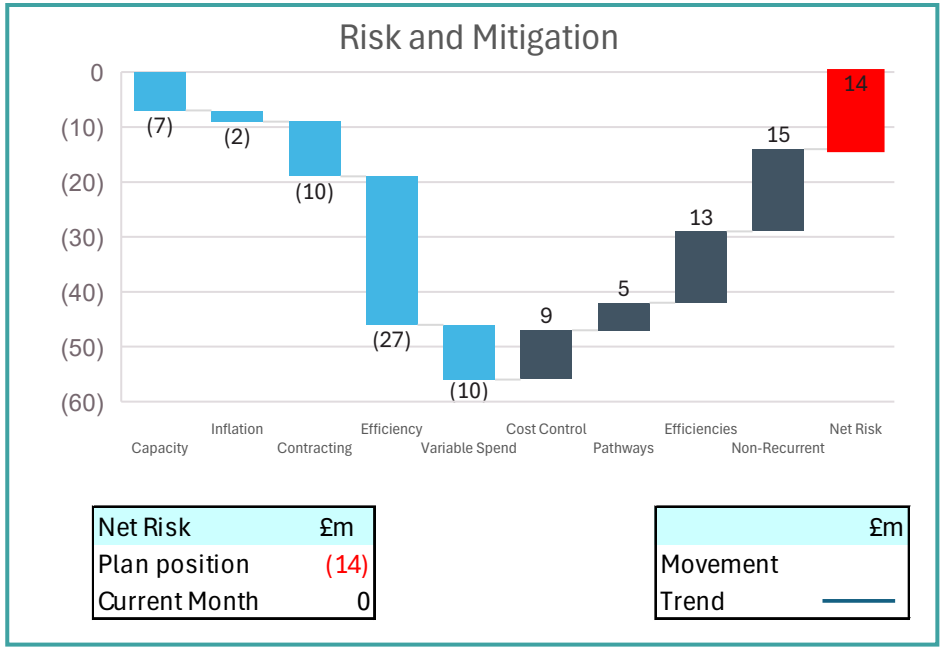
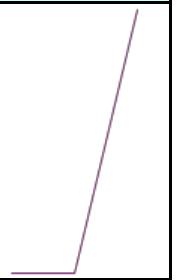
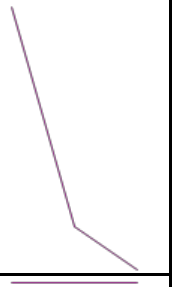


5. Focus on spend areas

Spend Area	Annual Plan £m	CURRENT PERIOD PERFORMANCE – Current Quarter Plan £m	Actual £m	Variance £m	CURRENT PERIOD RAG	TREND	PROJECTED PERFROAMANCE – RUN RATE	RUN RATE TO PLAN VARIANCE	CURRENT PERIOD RAG	RISK – FORECAST EFFICIENCY DELIVERY	RUN RATE TO PLAN VARIANCE	Key Movements, Mitigations and Actions
Acute Services *(Commissioning of short term, and urgent medical care from hospitals provided by the NHS and Independent sector, commissioning of Ambulance services)*	2,554				G				G			
Mental Health Services *(Commissioning of a range of care to deliver assessment, treatment and support for people in various settings, In hospital and community services from NHS, Independent sector and Voluntary Services)*	469				G				G			
Specialist Commissioning *(Commissioning of services to support individuals with rare and complex needs)*	521				G				G			

DUMMY DATA

6. Focus on spend areas continued

Spend Area	Annual Plan £m	CURRENT PERIOD PERFORMANCE: Current Quarter Plan £m	Actual £m	Variance £m	CURRENT PERIOD RAG	TREND	PROJECTED PERFROAMANCE: RUN RATE	RUN RATE TO PLAN VARIANCE	CURRENT PERIOD RAG	RISK: FORECAST EFFICIENCY DELIVERY	RUN RATE TO PLAN VARIANCE	Key Movements, Mitigations and Actions
Community Health Services *(Commissioning of a range of services to provide care for individuals from birth to end of life. Supporting independence and recovery and long term management of care conditions. Delivered across various settings, NHS, independent and Voluntary services)*	409				G				G			
All Primary Care Services *(Commissioning of services which are the first point of contact for the population of Essex. General Practice, Community Pharmacy, Dentistry and Optometry Services across communities provided by via the NHS and Independent provider)*	1,014				G				G			
All-age Continuing Care Service *Delivery of a complete approach to providing care for those who have long-term health needs and require health related support, at times combined with social care, to maintain quality of life. Working with multiple providers in various settings.*	285				G				G			
Running Costs *(The cost of running the integrated care board. Staffing, Estates, legal and statutory).*	31				G				G			

7. Technical annexes.

Cash Flow
Better Payment Practice code

8. Capital and Estates

Capital Spend Area	Budget	Plan	Actual	Variance	Key Points to note	
Operational Capital						
Strategic Capital						
Utilisation and Modernisation Fund						

S106 Progress Update

Neighbourhood Health Estates Progress

9. Contracted Activity

Outpatients – All

SPC Chart

Community

SPC Chart

Continuing Health Care

SPC Chart

UEC

SPC Chart

Mental Health

SPC Chart

Primary Care

SPC Chart

Elective

SPC Chart

Mental Health

SPC Chart

Primary Care

SPC Chart

10. Essex ICB Metrics – Operating Plan

DUMMY DATA

ACUTE		MENTAL HEALTH		COMMUNITY		PRIMARY CARE	
DMO1 Diagnostics	🔴	Talking Therapies	🟢	UCR: Urgent Community Response Referral Rate	🔴	General Practice Appointments	🟢
Cancer Waiting times	🔴	Out of Area Placements	🟢	UCR: Two Hour Response Times	🟢	Pharmacy First Consultations	🟢
RTT	🔴	CYP Waiting times	🟢	Waiting list size	🟡	Urgent Dental Appointments	🟢
		Bed days – Reduced Length of Stay	🟢	Waiting times: 18 + weeks	🟡	% Seen by an NHS dentist	🟢
		Perinatal Access	🟡	Virtual Wards: Utilisation	🔴	Dental Units of Activity	🟢
		Individual Placement Support	🟢				
		Mental Health Teams in Schools	🟢				

Last Quarter	🔴
This Quarter	🔴

Last Quarter	🟢
This Quarter	🔴

Last Quarter	🟡
This Quarter	🔴

Last Quarter	🟢
This Quarter	🔴

11. National Oversight Metrics

DUMMY DATA

Summary Metric	TREND	Current Period
Outpatient First attendances		
Outpatient Follow up		
Outpatient Procedures		
Percentage w aiting for a first appointment		
Elective day case		
Refferal to Treatment Completed		
New Referral to Treatment		
Total Referral to Treat w aiting list		
% on w aiting list, w ithin 18 w eeks		
Patients receiving a response w ithin 28-days follow ing an urgent referral		
Total number of patients receiving a communication for cancer follow ing urgent referral		
Patients receiving a first treatment for cancer w ithin 62 days		
Total number of patients receiving a first treatment for cancer		
Patients receiving first definitive or subsequent treatment for cancer w ithin 31 days		
Total number of patients receiving a first or subsequent treatment for cancer		
The number of diagnostic tests or procedures carried out in the period		
Number of patients w aiting 6 w eeks or over for a diagnostic test or procedure follow ing a referral		

12. National Oversight Metrics

DUMMY DATA

Summary Metric	TREND	Current Period
Total number of patients w aiting for a diagnostic test or procedure follow ing a referral		
Percentage of patients w aiting for a diagnostic test or procedure for 6 w eeks or over		
Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period		
Access to Mental Health Support Teams Mental Teams in schools and colleges		
Number of Children and Young People w ith mental health w aits over 104 w eeks		
Sum of total bed days across all Adult Acute and PICU mental health beds		
Total number of discharges from Adult Acute and PICU mental health beds		
Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds		
Sum of total bed days across all Older Adult Acute mental health beds		
Total number of discharges from Older Adult Acute MH beds		
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds		
Number of w omen accessing Specialist Community Perinatal Mental Health Services - rolling 12 month		
Number of Children And Young People (0-17) accessing (1+ contact) mental health services (rolling 12-month)		
Number of patients accessing Individual Placement Support services - rolling 12-month		
Appointments in General Practice		
Count of Pharmacy First Consultations		
Number of clinically urgent appointments seen on the same day		
Number of clinically urgent appointments		
Percentage of clinically urgent appointments seen on the same day		
Urgent dental appointments		

13. Provider Quality Update

- **Mid and South Essex NHS Foundation Trust**
  - MSEFT is receiving support as part of the national intensive support programme.
  - Quality Review Summits continue, led by NHSE regional team, with an overarching improvement plan being developed by the Trust for wide stakeholder information and engagement..
  - MSEFT women and children's division have initiated an incident management process following a recent Trust audit of ultrasound scans that are subcontracted to a secondary provider at Basildon and Southend sites.
  - Focussed Quality Assurance Visits relating to Sepsis management have been undertaken at the Broomfield site.
- **Essex Partnership University Hospitals NHS Foundation Trust**
  - Ongoing improvements at Ardleigh Ward in North East Essex are being led by the Trust, with involvement of the ICB, NHS England and the CQC post their visit to the ward in 2026
- **The Princess Alexandra Hospital NHS Trust**
  - Ongoing incident management relating to the provision of Paediatric Audiology services is in place following identification of a national incident of Auditory Brainstem Response Testing. Close link with NHS England regional team in place to provide assurance on service transformation and delivery of national standards of care.
  - Estates issues in maternity continue to be resolved, to ensure no disruption to service provision whilst remedial solutions are found.
- **Community Dermatology**
  - The new provider (CHEC) is currently working through 74 patients that have delayed in the transfer from the previous provider.
  - To date no harm has been identified and CHEC continue to use PSIRF principles to review

14. Provider Regulatory Position

Domain	Number	Comments
Providers with an overall inadequate CQC rating	1	Basildon Hospital rated as inadequate (overall Trust rating – RI)
Active CQC warning notices across Essex	10	EEAST (Section 29a) Basildon CYP (S29a) Broomfield CYP (S29a) Basildon UEC (S31) Broomfield Maternity (S31) Colchester Elderly Medicine (S29a) Colchester UEC (S29a) Ipswich Road, EPUT MH (S29a) Lister Medical Centre – Governance Hollies Practice – Medicines & Governand
Providers with a Requires Improvement Rating	20	GP Practices x 13 HTG (Hospital Transportation Group Eastwood Encoscopy Essex Partnership University NHS Foundation Trust (MH/LD services) Mid and South Essex NHS Foundation Trust (overall) The Princess Alexandra Hospital NHS Trust Colchester Hospital site (as part of East Suffolk and North Essex NHS Foundation Trust) East of England Ambulance Service NHS Trust

15. Future Assurance Mechanisms

Meeting to be held with Population Health Data analyst to align current data sets to a single dashboard.

Assurance on provider quarterly report data and KPI metrics through QCPM routes.

Position on all ICB NOF metrics (once confirmed) included in reporting process and review of all provider NOF metrics as part of contractual process.

Liaison with national team to receive final Model System Quality metrics to form part of ongoing contractual conversation with providers.

16. Complex Care Performance – future reporting

All Age Continuing Care

- high level performance reporting in existence for adult CHC – to be summarised and benchmarked
- children's performance to be reported from local data sets
- Financial outturn against core AACC, Personal Health Budgets and position on Court of Protection/Deprivation of Liberty Safeguards

Individual Placement Team (Section 117 placements)

- reporting on levels of activity, referral patterns and esclations
- Financial outturn and high level reporting on high cost packages of care

Neurorehabilitation Service

- Type of referral, level of care requirements and pathology
- Financial outturn on packages of care, including high-cost requirements

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Thank you

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Integrated Care Board

Part I Essex Integrated Care Board Meeting, 23 April 2026

Agenda Number: 10

Neighbourhood Report (Primary Care / Alliances)

Summary Report

1. Purpose of Report

To provide the Board with information regarding the new Neighbourhood Directorate, the deliverables and objectives. This will provide the context of the work that will be undertaken which will inform future reporting.

2. Executive Lead

Beverley Flowers, Executive Director of Neighbourhood Health.

3. Report Authors

Karen Wesson, Associate Director of Neighbourhood Health.

Lynn Stimson, Associate Director of Neighbourhood Health.

Jenni Speller, Associate Director of Neighbourhood Health.

Amy Jackson, Associate Director of Community and Neighbourhood Development.

William Guy, Director of Commissioning for Primary Care and Neighbourhoods.

4. Responsible Committees

Not applicable.

5. Impact Assessments

Not applicable.

6. Financial Implications

Not applicable.

7. Details of patient or public engagement or consultation

Not applicable.

8. Conflicts of Interest

None identified.

9. Recommendation/s

The members of the Board are asked to receive this report for information.

Neighbourhood Report (Primary Care / Alliances)

1. Introduction

The Neighbourhood Directorate has been established as part of NHS Essex, this report will outline the responsibilities of the directorate and its component parts, objectives and work programme as detailed within the Population Health Improvement Plan.

Future Board reports will provide updates on the progress of the work completed by the Directorate and performance against the deliverables and relevant performance measures from the Operational Plan 2026/27.

2. Directorate Overview

The Neighbourhood Health Directorate is structured around four interconnected pillars:

- **Neighbourhood Health** – Leading local integration and establishing the delivery mechanisms for the Essex Neighbourhood Health Service, ensuring capability, relationships, and readiness at a local level.
- **Primary Care Commissioning** – Delivering statutory commissioning for general practice, ensuring services are high-quality, equitable, and sustainable.
- **Community Commissioning** – Commissioning out-of-hospital services across Essex and working with Primary Care Commissioning to identify services suitable for delegation to neighbourhood teams.
- **Primary Care Operations** – Overseeing resilience, access improvement, vaccination and immunisation programmes, and operational coordination across providers.

Its establishment reflects the principles set out in the Model ICB Blueprint in creating a lean, outcome-focused operating model that empowers place-based leadership and fosters collaboration at every level. It also supports delivery of the ambitions within the 10 Year Plan for health, with a clear emphasis on prevention, integrated neighbourhood models of care, and a fundamental shift towards community-based services.

Through the development of the Essex Neighbourhood Health Service, community services will be commissioned and configured to reduce avoidable admissions, improve patient flow, and enable timely hospital discharge. This will be achieved through increasingly integrated models of care that bring together NHS providers, local authorities, Primary Care Networks (PCNs), and the voluntary and community sector. Central to this approach is the development of new models of care that are prevention-focused, digitally enabled, and equitable across Essex ensuring that services are responsive to the needs of local populations.

As outlined within the Population Health Improvement Plan for Essex, the Neighbourhood Directorate will be working with all partners including but not limited to:

- 207 GP Practices
- 41 Primary Care Networks
- 308 Community Pharmacies

- 203 Dental practices (with an NHS contract)
- 180 Optical practices
- 10 Community Hospitals
- 6 Community Diagnostic Centres
- 698 Care Homes (nursing and residential - gov.uk)

Delivering a sustainable Neighbourhood Health Service requires two complementary and interdependent functions:

1. **Commissioning the Service**:
   Led through the commissioning function, this work defines the outcomes, funding frameworks, and standards that underpin neighbourhood-based service provision. This includes:

   - Defining population health outcomes and developing commissioning arrangements (in partnership with the Finance and Commercial Directorate).
   - Setting expectations for integrated models of care and metrics for impact.
   - Ensuring alignment with local and national policy and strategic priorities.
   - Assuring delivery against agreed outcomes.

2. **Creating and Developing the Service**
   Led through Neighbourhood Health teams, this work focuses on building the local capability, partnerships, and infrastructure required to deliver services in practice. This includes:

   - Developing partnerships between PCNs, community providers, local authorities, and the voluntary sector.
   - Establishing governance, relationships, and community engagement mechanisms.
   - Supporting system design, operational readiness, and delivery implementation.

Together, these functions ensure that commissioning is grounded in the realities of delivery, while local delivery remains aligned to shared system outcomes.

Neighbourhood Directorate Objectives:

The Board approved the Directorate objectives on the 1 April 2026, these are:

1. Commission neighbourhood-based models of care.
2. Improve access to primary and community services.
3. Strengthen population health management in neighbourhoods.
4. Improve Care for Frailty and End of Life.

Achievements to date: April 2026

Recruitment:

The Directorate has completed nearly all the recruitment to the team, with ongoing recruitment to the remaining establishment.

Neighbourhoods:

The Neighbourhood localities have been aligned and shared with Health and Wellbeing Boards in March 2026. This information can be seen within Appendix One.

Neighbourhood Health Committee:

The Neighbourhood Health Committee, a formal sub-committee of NHS Essex will be established with the first meeting being planned for May 2026. Work on developing the Terms of Reference for the meeting is in progress.

Better Care Fund (BCF) 2026/27:

As outlined in the 10 Year Health Plan, the Government is introducing initial changes to the BCF to help local areas go further in joining up the delivery of health and social care services and support the development of relevant areas of neighbourhood health, while devolving more responsibilities.

For 2026–27, the first year of reform, local areas are asked to start to align their pooled funding plans with the wider development of relevant areas of neighbourhood health plans. There are no changes to the current system of minimum funding contributions for this year.

Local Authorities and NHS Integrated Care Boards are asked to agree 2026/27 plans at Health and Wellbeing Board level for how best to use available funding to provide joined-up services for people with more complex health, social care, and housing needs for national submission on the 19 May 2026, this is on track to meet the deadline.

Work has commenced across Essex to review the current schemes and planning work; it is recognised that the locality specific schemes in each area will impact different acute and community providers and therefore scalability may not be possible across Essex but needs to be further explored.

There is recognition that Local Authority re-organisation and devolution, and changes to Integrated Care Board boundaries and responsibilities might affect funding flows and the work undertaken in the BCF space. Pre-planning has therefore commenced with Local Authority colleagues within the parameters of information currently available.

National Neighbourhood Health Improvement Programme (NNHIP): North East and West Essex:

The NNHIP has instigated some national reporting arrangements for neighbourhood health across 43 sites for the national cohort (intermediate/high Hospital Frailty Risk Score) (HFRS) cohort aged 18+ and local NNHIP cohorts. Reporting will continue in line with the national expectations for the NNHIP sites in West Essex and North East Essex, with an intention to look to extend this reporting into other parts of Essex over time. This reporting includes:

- Monitoring of health activity metrics across acute, community and general practice – national data extracted nationally, local data submitted monthly by ICBs.
- Patient reported outcomes measures (PROMS), patient reported experience measures (PREMs) and carers experience via digital survey sent directly to national cohort by national team and sent locally to local cohort.
- Collaborative behaviours assessment (local partners invited to respond to national survey).

- Progress against the neighbourhood health maturity matrix.

In West Essex Healthwatch have been commissioned to undertake some engagement and analysis that builds on the earlier frailty and ageing well work. This will explore the lived experience of people with multiple long-term conditions, and their carers so this can be incorporated into neighbourhood health approach, building on the current proactive care model. Work will commence in April 2026, with the report due in September 2026.

North East Essex are undertaking an evaluation exercise from the two test and learn sites to develop a recommendations paper outlining opportunities for scaling and learning across wider geographies. This is due the end of April 2026.

Neighbourhood Directorate Quarter One Plan:

Neighbourhood Health:

With the forming of the new directorate, the intention for quarter one 2026/27 will be to transition the legacy alliance governance to the new Essex neighbourhood governance. The new or revised governance per neighbourhood will be in place by the end of Quarter Two.

Primary Care:

The Primary Care Team are prioritising key business as usual functions for the new Essex ICB to ensure our primary care providers can remain fully functional during this period of transition to the new ICB.

Alongside this work, the Primary Care Team are taking forward actions to ensure that new contractual requirements are fully implemented across Essex. This includes national changes to both the GP contract and dental contract.

National changes to the GP contract include:

- The 2026/27 GP contract includes a 3.6 per cent cash uplift (£485 million nationally) to the core GP contract.
- Funds from the PCN-level Capacity and Access Payment have been repurposed to a practice-level reimbursement scheme, aimed at increasing GP capacity, worth £292 million.
- Practices must provide a same-day response for all urgent patient requests and may not ask patients to contact practices later. Practices will not be able to ask patients to call back or make contact on a different day but instead be given advice on how their enquiry will be managed on the same day. Online consultations must remain on during core hours and not capped.
- New requirements have been introduced for patient choice and practice-level communication with community pharmacy.
- PCN responsibilities regarding vaccinations, cancer screening, continuity of care, and neighbourhood geography have been more clearly defined.
- The Additional Roles Reimbursement Scheme is expanding to include greater flexibility for roles, and to remove restrictions around employing GPs on the scheme.

- Quality and Outcomes Framework (QOF) changes to heart failure, referrals to weigh management and obesity services and achievement of 8 NICE recommended care processes for diabetes.
- The advice and guidance (A&G) enhanced services is being retired with the funding moved into core contract. Instead, there is a requirement for practices to prioritise A&G, local referral pathways and Single Points of Access that are in place.
- Several other contractual terms and conditions are being amended including the requirement for practices to engage with ICBs where unwarranted variation has been identified and/or the practice is at risk of contractual breach. Practices relationships with community pharmacy will be enhanced through patient choice of pharmacy for dispensing or clinical referrals e.g. Pharmacy First and provision of an email address for sharing of patient information with pharmacies if GP Connect is unavailable.

National changes to dental contracts include:

- Dental Providers with mandatory services contracts of 100 Unit Dental Activities (UDAs) or more will be required to deliver 8.2% of their contract value as unscheduled care activity in 26/27.
- Suitably trained dental nurses will be able to apply fluoride varnish for children up to 16.
- Fissure sealants will become Band 2 eligible at either 3 or 5 UDAs dependent on number of affected teeth.
- Dentists, therapists and hygienists will be able to claim £213 on completion of an appraisal.
- An optional Quality Improvement Programme will be introduced focussing on appropriateness of recall intervals.
- From June 2026, further changes will include, the introduction of complex care pathways, changes to denture care reimbursement and eligibility criteria for discretionary payments.

The latest primary care consultation data (February 2026) continues to demonstrate growth in overall consultation numbers across Essex.

February Consultation (NHS Digital)	February 2025 (thousand consultations)	February 2026 (thousand consultations)
Mid and South Essex	550k	603k
West Essex	146k	151k
North East Essex	175k	192k

Speed of access into primary care shows improvement. NB. Current published data reports all patient consultation not those identified as clinically urgent.

Feb Consultations (NHS Digital)	Same Day	Within 1 day of contact	Within 2 – 7 days of contact	Within 8 – 14 days of contact	Over 14 days of contact
Mid and South Essex	45.3%	7.8%	18.6%	12.6%	15.8%
West Essex	48.3%	6.0%	15.9%	14.6%	15.2%
North East Essex	38.5%	7.3%	19.8%	15.6%	18.8%

Action Plan for Primary Care

The Primary Care Team are compiling a response to the NHS England requirements for the Action Plan for Primary Care. This includes:

General Medical Services

- Supporting practices to comply with urgent care requirements.
- Workforce planning and growth.
- Tackling unwarranted variation.
- Use of digital tools.
- Development of Neighbourhoods and Estates.

Pharmacy

- Utilisation of Pharmacy First and other community pharmacy provision.
- Development of relationships between community pharmacy and general practice.
- Development of independent prescribing services.
- Use of contraception services.
- Use of discharge medicines services.
- Use of community pharmacy to support vaccinations.
- Use of NHS App.

Dental

- Urgent and unscheduled care access.
- Maximising and optimising use of dental resources.
- Implementing contract reforms.
- Improving access.
- Support for Special Educational Needs and Disabilities (SEND) pupils in a residential and day special educational settings.

Optometry

- Support for SEND Pupils in a residential and day special educational settings.

Neighbourhood Development:

WorkWell is a national programme designed to support people with health conditions or disabilities to stay in, return to, or enter work through more joined-up health, employment and wider support. Essex successfully submitted its WorkWell plan and funding has now been confirmed for the full three-year programme. Work is underway with the Department for Work and Pensions and system partners to refine the approach ahead of the publication of the national delivery template in June. This work will ensure alignment with existing and related employment, health and wellbeing programmes across Essex, building on the system-wide programme alignment approach previously taken, to ensure complementary delivery and avoid duplication. A full delivery plan will then be developed in line with the national template, with mobilisation expected to commence from November.

Community Services Review is a strategic assessment of community-based health services across Essex, aligned to the NHS Long Term Plan, Medium-Term Plan and the Neighbourhood Framework. It will review performance, quality, sustainability and contractual arrangements, with a focus on prevention, neighbourhood health models, improved access and stronger integration across health and care.

The review will have a focus on reducing unwarranted variation, aligning services to population health needs, strengthening prevention and neighbourhood care, improving productivity and value for money, and informing future commissioning models. The key quarter one activities in support of this work are outlined below:

- **April 2026:** Development of an Executive Committee paper (28 April 2026) seeking approval to secure short-term community services contracts in MSE and West under Provider Selection Regime processes, aligned to the review objectives and including a high-level scope of the review.
- **May 2026:** Executive Committee approval of the review scope and programme plan/timeline.
- **May 2026:** Initial provider engagement.
- **June 2026:** Commencement of the strategic review, including baseline analysis.

Dashboard and Reporting:

The intention will be that future reports for the directorate will include reporting against the Board approved measures which align to the directorate objectives, listed below. In addition, delivery against 2026/27 Operational Plan metrics applicable to the Neighbourhood Directorate will be reported.

Work is underway with wider teams within the organisation to commence the development of the dashboard to enable future reporting and oversight of delivery against expectation.

- Improved access to primary care.
- Improved experience of accessing GP services.

- Reduced waits for community services.
- Increased levels of activity delivered in neighbourhood settings.
- Improved hypertension control rates.
- Increased uptake of screening and vaccinations.
- Increased delivery of diabetes care processes.
- Improved uptake of health checks for priority groups.
- Increased number of people on the frailty register.
- Reduction in avoidable emergency admissions for over 65s.
- Increased preferred place of death achieved.
- Increased number of people on the end-of-life register.

3. Findings/Conclusion

There is an increasing focus on development of Neighbourhoods nationally and locally, the directorate will be using quarter one to establish the new teams, review and build on the work undertaken to date by the previous organisations.

The Neighbourhood Development Team will be initiating the Community Services review during May 2026.

The Directorate, with other organisational teams will be working on the development of the dashboard for future reporting.

In May 2026 the inaugural Neighbourhood Health Committee meeting will be held.

4. Recommendation(s)

The members of the Board are asked to receive this report for information.

5. Appendices

Appendix One: Health and Well Being Board Presentation showing Neighbourhoods.

NHS Essex

Update to Health and Wellbeing Board

March 2026

Contents

1. ICB organisational change update
2. Emergent ICB strategy, aspirations and culture building on the 6C's **for comment**
3. Update on the Population Health Improvement Plan for Essex **for comment**
4. Neighbourhood maps **for approval**
5. Update on Convener model **for noting**

Organisational change update

Organisational change update

- Remain on track for formation of Essex Integrated Care Board on **1st April 2026** with inaugural Board scheduled for the same day.

- Appointment process to new structure underway, with completion of the first phase of appointments by **13th March 2026**.

    - We will be working with each individual member of staff within the existing ICBs to agree transition plans for their current work responsibilities.

Emergent ICB strategy, aspirations and culture

Strategy and aspirations (working version)

NHS Essex – making health services better in Essex

This means we will:

- Establish a consistent service offer
- Reduce long waits for care
- Implement evidence based practice
- Improve public perception of NHS services
- Make the best use of public money
- Act in cases of poor performance

**these are supported by the 6C's work previously discussed and included within the appendix to this pack.*

Our target culture (working version)

Trusted, excellent, honest

Stewardship of public trust
We act as guardians of the public pound and the public's health:

- We take decisions for long term population benefit.
- We uphold quality, safety and equity – always.
- We use resources wisely, transparently and fairly.

Professional excellence
We do the basics brilliantly, every time:

- We commission for high quality access and outcomes.
- We use data, evidence and expertise to guide decisions.
- We take pride in getting the detail right.

Courageous candour
Every voice matters. Every perspective is respected:

- We are open, honest and clear, even when it is difficult.
- We invite challenge and listen properly.
- We raise issues early and solve them together.

One system, shared success
We win and lose together as Essex. We make decisions based on what is best for our population. We support neighbourhood teams to succeed.

Population Health Improvement Plan

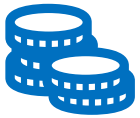
Purpose

Each ICB is required to produce a Population Health Improvement Plan (PHIP), a five year plan which sets out the strategic ambition for improving health outcomes, reducing inequalities and commissioning sustainable high-quality services for residents.

The PHIP aligns with the 10 Year Plan for Health and the Model ICB Blueprint, with a focus on prevention, digital transformation and shifting care from hospitals into communities (referred to as ‘left shift).

The current version for Essex is a ‘working’ document with an ambition to undertake further engagement over the coming months to refine.

PHIP objectives



Commissioning services for the population of Essex **within the available resources**

Developing as a strategic commissioner of the health services in Essex, with data-driven and evidence-based decisions

Leading effective **quality assurance and contract management** for commissioned services, taking action as required

Supporting staff in developing the skills and capabilities to do their job well

Being a good organisation to work with and for

Delivering on key priorities within the **PHIP** for 26/27

PHIP structure - built around 7 themes and 5 work programmes

Work Programmes →

Themes ↓

	Neighbourhood Health	Sustainable Hospital Services		Mental Health and Neurodiversity	Complex Care (inc CYP, LDA & CHC)
		Planned Care	Unplanned Care		
Reducing Health inequalities	✓	✓	✓	✓	✓
Start Well	✓	✓			✓
Live Well	✓	✓		✓	✓
Feel Well	✓		✓	✓	✓
Age Well	✓	✓	✓	✓	✓
Die Well	✓		✓		✓
Respond Well	✓		✓	✓	✓

PHIP – headline outcome measures

Health inequalities narrowing year on year

- Reduction in premature mortality from CVD, cancer and respiratory disease in our most deprived communities.
- Improvement in Core20PLUS5 indicators.
- Improved school readiness and early years outcomes in our most disadvantaged areas.

A decisive shift towards neighbourhood care delivery and prevention

- 2.5%+ shift of acute expenditure into neighbourhood care over the life of the plan, including a significant shift of outpatients.
- Reducing crisis events through improvement in frailty and end of life identification, care planning.
- Higher uptake of screening and vaccinations.
- Improved long term condition management, initially focusing on Cardiometabolic optimisation.

Timely access and excellent outcomes across services

- Delivery of national standards for elective, diagnostic and cancer pathways by the end of the planning period.
- Reduction in long waits for mental health, community, children's and neurodiversity services.
- Increased patient experience and access scores across NHS services.

Financially and clinically sustainable services across Essex

- In balance over the life of the plan.
- Reduction in high-cost institutional care.
- Specialising and rationalising services where required.
- Commissioning for productivity and value for money.
- Modernised estates.

Summary of programmes and outcomes

1. Neighbourhood Health

Build a consistent, Essex-wide neighbourhood model delivering proactive, joined-up care closer to home.

Key outcomes:

Improved access to primary and community services.

More multi-disciplinary neighbourhood teams supporting frailty and long-term conditions.

Increased community-based activity and reduced reliance on hospital care.

Reduced variation in service provision across Essex.

2a. Sustainable Hospital Services – Planned Care

Restore timely access and improve quality for elective, diagnostic and cancer services

Key outcomes:

Delivery of 18-week RTT standard.

Improve cancer diagnosis and treatment performance.

Expansion of community diagnostics and outpatient transformation.

2b. Sustainable Hospital Services – Unplanned Care

Improve urgent and emergency care access and system flow.

Key outcomes:

Reduced A&E waits and ambulance handover delays.

Improved same-day urgent care pathways.

Better integration with neighbourhood and mental health services.

Summary of programmes and outcomes

3. Mental Health and Neurodiversity

Deliver an integrated all-age mental health system focused on prevention and community care.

Key outcomes:

Improved access to community mental health services.

Reduced out-of-area placements and inpatient lengths of stay.

Earlier intervention for children, young people and neurodiversity.

Improved quality and experience of inpatient care.

4. Complex Care

Deliver personalised, coordinated care for high-need populations, including babies, children and young people, people living with a learning disability and some people in receipt of all-age continuing care.

Key outcomes:

More people supported in the community rather than institutional settings.

Improved outcomes and experience for SEND and vulnerable cohorts.

Better integration with health, local government and VCFSE partners.

Improved value and sustainability in AACC and complex care pathways.

The big commissioning / transformation items for 2026/27

Multi-disciplinary projects for 2026/27:

1. Developing Neighbourhood Health Service model for Essex, with a specific focus on frailty in 2026/27
2. Reviewing of community services across Essex
3. Reducing long waiting lists for elective care, including children's services and neurodiversity diagnoses
4. Improving cancer outcomes across Essex, with a plan to focus on earlier diagnosis
5. Developing an approach to Urgent Care across Essex – including MH UEC to support people in crisis
6. Procuring Talking Therapies and Psychological Therapies for people with SMI
7. Undertaking a quality review of perinatal services
8. Delivering an Estates strategy, including Community Hospitals, NbH Centres and Primary Care
9. Establishing the new organisation, including external relationships

Neighbourhoods

Recap

- We have worked to identify health neighbourhoods across Essex, with a focus on establishing natural communities within Essex to provide the core geographical building blocks for the future commissioning of NHS services.

- We have engaged with a range of partners on the development of these proposals, including:

    - Officers in District, City, Borough, County and Unitary authorities.
    - Elected members in HOSC's
    - Elected members in Health and wellbeing boards
    - The CEO's forum
    - Alliance areas
    - VCFSE groups
    - NHS colleagues
    - Police, fire and crime commissioner

Today

- We are asking for approval to proceed with these, with the understanding that:
    - Transition to these new neighbourhoods will not be immediate and will happen over time.
    - That the ICB will work with partners and providers over what these mean for them and any implications for the future.
    - We will continue to engage with professionals and the public on these, particularly once the outcome of Local Government Reform is known.

Summary of proposed neighbourhoods 1

Basildon

1 – Billericay
The town of Billericay with the rural areas such as Bursted which are more demographically aligned to Billericay than central Basildon.

2 – Wickford
The traditional town and immediately connected areas.

3 – Pitsea
The Town of Pitsea, while quite under 50,000, it was felt that Pitsea was a clear town and the level of need justified its separate neighbourhood.

4 – Basildon
This is broadly the “new town” and immediately connected areas.

5 – Laindon This is the town of Laindon and connected Langdon Hills area.

*Maps and further details are available at Appendix 2

Braintree

1 – North Braintree
This is the rural northern section of the district, stretching from Kelvedon to Hedingham.

2 – Braintree central
The main town of Braintree and rural areas reaching down to Chelmsford boundary.

3 – Witham
The main town of Witham.

Brentwood

1 – Borough
The whole of Brentwood borough is the neighbourhood given the difficulty with finding a logical split, and given the capacity at Brentwood Community Hospital being something of an anchor.

Castle Point

1 - Mainland
The main towns of Benfleet, Thundersley, and Hadleigh.

2 – Canvey
The island of Canvey.

Chelmsford

1 – City
The city centre and Broomfield is over 100,000 people, however, the local council made a credible case that there was no logical way to divide the city.

2 – Rural
The rural areas to the South and East of the city.

Colchester

1 – Colchester North
Great Tey to the boundary of Tendring and Ardleigh.

2 – Colchester City
We did debate uniting the city centre but it was felt to be unnecessary given the clear identity of Greenstead.

3 – Colchester South –
From the tip of the North, across to Tiptree on the west and across to Mersey and the border of Tendring.

Neighbouhood 4
Greenstead and Colchester East – this area is built around a strong identity with very vibrant community groups.

Summary of proposed neighbourhoods 2

Epping Forest

1 – Loughton and Buckhurst Hill
The “central line” communities already used for neighbourhood planning.

2 – Epping North
The northern areas of the district above Loughton, already well established. The current working is supported by the local council.

Harlow

1 – Harlow North
A clear North South Divide, as per the current areas used by the local partnership.

2 – Harlow South
As above. The current working is supported by the local council.

Maldon

1 – Dengie
The Dengie has a clear identity, and also requires focus given the size of the area

2 – District
The main town of Maldon and areas north of the Dengie.

Rochford

1 – Rayleigh and District
The towns of Rayleigh and Hockley. There was a debate about Hulbridge joining this area and swapping with Hockley. There isn’t a very strong clear argument either way so we will keep this under careful review.

2 – Rural
The rural communities from Foulness to Hullbridge, including the town of Rochford. There was a debate regarding Great Wakering joining Shoebury, but breaking city and district boundaries at this time adds too much complexity to the positioning across the county.

Tendring

1 – North
The northern section of the district, from the easterly boundary of Colchester through to Harwich.

2 – Mid –
Brightlingsea to Walton.

3 – South
Reflecting on feedback from TDC, we are ensuring the currently unparished areas from Point Clear to Holland has its own neighbourhood to give focus to those communities and to the need in central and coastal Clacton.

Uttlesford

1 – South Uttlesford
A clear North South Divide, as per the current areas used by the local partnership.

2 - North Uttlesford
As above. The current working is supported by the local council.

Summary of proposed neighbourhoods 3

Southend

1 – SS9
The Western area of the city, centred around Leigh.

2 – Southend West Central
From Southend Airport down to Westcliffe.

3 – Victoria
The urban area is very dense from the highstreet to areas with apartment and tower blocks. There are arguments which would allow certain clusters of roads to join other areas, but it would overly grow other areas while taking a focus from the deprivation in this area.

4 – Southend East
From Southchurch to Shoeburyness.

Thurrock

1 – Stanford, Corringham, and the East Thurrock villages
Stanford and Corringham is a logical area, however, the rural villages simply don't have the needed size to stand alone, making this conglomeration required.

2 – Tilbury and Chadwell
Areas currently working together and with such in common in terms of demography.

3 – Grays and Chafford
Bringing these towns together makes a lot of sense given they are too small separate and is dense and urban enough to make sense.

4 – Purfleet, Ockendon, and Aveley
The western towns of the borough bordering London. This cluster is simply geographically the only option.

Convener model – moving into design phase

This is a working draft, informally being shared prior to a final version going to consultation with the sector

What is the convener model?

- Essex NHS sees the voluntary, community, charitable, faith and enterprise sector as vital and as equal partners in wellbeing.

- The end goal is a VCSFE led body, working with NHS and local government, with devolved budgets, nurturing the third sector to issue community grants aligned to high level “problem statements” on wellbeing.

- A convener will be a roughly a 10-member board on the footprint of the new unitary councils.

- It will be supported by the ICB but not owned or controlled by the ICB.

- The benefit of this approach will be the insight from the VCSE sector to ensure money spent is wise, enhances the hidden strength in local groups, and brings diverse talent together to enable the neighbourhood health agenda outside of the larger NHS contracts.

Why we need to do this

Trust

Some of the ways in which the NHS works has undermined confidence from the public and VCFSE. Some of the issues with our historic action include;

A- annual funding which robs groups of long-term planning
B- overly prescriptive tenders which stiffle innovation
C- An overly centralised process which is often slow and forces groups to compete and not collaborate
D- Constant restructures which prevent the sector and the public from maintaining working relationships.

Stability

With 3 ICB's and alliance structures changing and with the whole of local government being restructured, the environment for the VCFSE sector is very uncertain with funds, known people to work with and so much more. The VCFSE is mission critical to the NHS mission for better healthcare for the public – therefore we need to build stability and clarity.

Summary – emerging thinking on VCFSE and what we intend to consult on

The emerging thinking of the convener model has come from dozens of meetings with almost 100 VSC groups across Essex, 3 large events in Tendring, Harlow and Thurrock with ECF, and with a pilot group on vaccines.

There is clearly more to do and the thoughts contained here are very fluid – hence this “informal consultation” phase.

The following slides outline the draft thinking for the body.

- Informal consultation – Feb 2026 to summer 2026
- Formal consultation with in q3 this year,
- Going out to tender for groups to bid to be the convener host / chair in q1 2027
- With a go live date of July 2027.

The end goal is a VCSFE led body, working with NHS and local government, with devolved budgets, nurturing the third sector to issue community grants aligned to high level “problem statements” on wellbeing.

Emerging thinking on convener principals and design / what could be in a convener tender - pt 1

1 - Exercising Community grants, opposed to tenders, for rapid turnaround. The general aim being up to a 3 year commitment, opposed to short termism.

2 - The convener should endeavour to hold conversations in public regarding great work and best practise undertaken by the VCSFE – these should be frequent and always working to widen the size of the audience

3 - The convener model must have a clear feedback function to help groups strengthen bids, opposed to a simple rejection

4 - The ICB neighbourhood team will offer some lite-touch "problem statements" per annum i.e. a focus on frailty for those outside of care homes, while staying away from centralised KPIS's. KPI's will be designed by the convener and ratified by the ICB. These will be informed by the neighbourhood plans/Pop health improvement plan

5 - No one is expecting VCSFE groups to restructure to meet us.

6 - Voting membership on each convener must be a majority from the VCSFE sector

7 - The activity is non resistive but should be very mindful of the issues of acting in the space with contract implications i.e. vaccines. Advice should be sort first.

Emerging thinking on convener principals and design / what could be in a convener tender - pt 2

8 - The convener model must work to link groups together i.e. a small group may have the ability to support a community accessing services, but lack the capacity to deliver the service alone.

9 - The ICB will seek to use the convener as the primary way of delivering grants, BCF spend and the such as a devolved budget. We would seek to grow the pot by seeking pooled budget opportunities.

10 - The ICB will seek to engage a single body to hold the money, and handle transactions as a “convener bank” – this will help ensure admin burdens and costs are not replicated. The “bank” will also be able to provide value for money advice based on the best practise they see from the other conveners. There will be an admin fee capped at circa 3%

11 - The convener will be tendered for by the ICB ahead of May 2027 on the footprint of the new unitary councils to ensure as much synchronicity as possible with community’s and social care. This will be following a full 60 day consultation period in sept 2026.

12 - In terms of hearing appeals or complaints, the convener will be empowered to issue grants without the ICB interfering. The ICB would only hear appeals on the basis of a conflict of interest, and only after they have been heard by the banking function as the first port of call. The ICB will not offer comment on the membership unless at least 30% of the membership make representations. In terms of individual bis, another convener could hear an appeal to give some independence to the process, but only on the grounds of conflict, not on the principle of the bid.

Emerging thinking on convener principals and design / what could be in a convener tender - pt 3

13 - The convener models will be constituted on the footprint of the new unitary councils as we seek co-terminosity with social care, public health, and community functions to support and mutually benefit from our partnership with local government.

14 - The convener must demonstrate regular engagement with the ICB neighbourhood structure in the community to best reflect local insight and leverage local assets / relationships. The convenor is responsible for ensuring adequate engagement at a Neighbourhood and Place/Locality level

15 – The plan is to focus on equity not equality with funding – so focusing on deprivation opposed to a capitated budget

16 – The chairs of each convener will come together as a board for Greater Essex conveners to gives consistency of oversight, share best practise, and sign off the KPI's to align to the neighbourhood plans. This board will also consider the evaluation matrix to help inform future ROI. This board will also give the sector a strong voice within the ICB to stand up for the sector and offer insight.

17 – The conveners must evidence engagement with relative structures such as heath and wellbeing boards.

17 – A bid to be a convener chair / host can come from a single entity or a group with a clear outline of how they will collaborate as one, however, all bids must demonstrate experience of leading the VCFSE sector, working with the NHS and local government.

Emerging thinking on governance – VCSFE members

Seat and appointment	Voting?	Rationale
Chair – appointed by the entity that wins the convener tender. ICB criteria for tender success will be predicated on proving it could lead all VCSFT colleagues in the health space	Yes	The chair will be from the VSC sector – combined with the 3 VSC reps, this is over 50% of the voting membership coming from the VCSFE sector with the chair also holding the casting vote. This means that this body will truly be VSC led. The chair will need to evidence an inclusive process of appointments to the body, as well as act as the secretariate. The chair will be able to table propositions to co-opt members, but would require a 75% super majority. The chair will be remunerated in line with an ICB NEM.
VSC rep – large i.e. turnover of over £500k and or more than 10 full time paid staff – appointed by the chair	Yes	Having a mix of small VCS reps ensures that the lived experience of different Communtiy groups is a clear and strong voice around the table. It will be the duty of the entity who wins the convener contract to act as host and chair to identify this person via their own process.
VSC rep – medium i.e. turnover of between £500k and £250k and or fewer than 5 full time paid staff – appointed by the chair	Yes	Having a mix of small VCS reps ensures that the lived experience of different Communtiy groups is a clear and strong voice around the table. It will be the duty of the entity who wins the convener contract to act as host and chair to identify this person via their own process.
VSC rep – small i.e. turnover of under £250k and or fewer than 3 full time paid staff – appointed by the chair	Yes	Having a mix of small VCS reps ensures that the lived experience of different Community groups is a clear and strong voice around the table. It will be the duty of the entity who wins the convener contract to act as host and chair to identify this person via their own process.

Emerging thinking on governance – Non-VCSFE members

Seat and appointment	Voting?	Rationale
ICB rep – appointed by the ICB	Yes	The ICB will have 1 rep to help ensure the convener is connected to the wider NHS Essex. The rep will come from the neighbourhoods team to ensure that the convener works in sync with the core offer and neighbouhood contract, and doesn't represent duplication.
Local government – public health – appointed by the council CEO	Yes	The local government public health team will having a rep to help ensure data led work is a core part of the convener. During the transition to LGR, we will need to be flexible to respect the current upper tire councils and the emerging unitary council. This will be done by asking the 3 DPH to service the convener for the intervening period to May 2028, with non voting reps from the shadow councils.
Elected member – appointed by the council cabinet	Yes	Inviting an elected member is vital democratic input. During the transition to LGR, we will need to be flexible to respect the current upper tire councils and the emerging unitary council. This will be done by asking the leaders forum to agree a voting rep for each convener with a non voting rep being drawn from the emerging shadow councils.
Voice of the resident (patient / service user). Appointed by the ICB	No	The ICB is committed to supporting an independent body to hold us to account. Allowing observer status is a good way to ensure wider insight of the patient and public voice is heard.
ICB subject expert – appointed by the ICB as per subject need	No	Sometimes there are matters of national or regional compliance i.e. vaccine contracts. The ICB will ensure that emerging agenda items have had advisor with observation status.
"Bank" rep – appointed by the banking function	No	The finance function which will hold the finance and issue grants will sit on the convener to offer VFM advice, as well as lead on audit / compliance, and issues such as declarations of interest.

County wide governance – convener star chamber

Purpose –

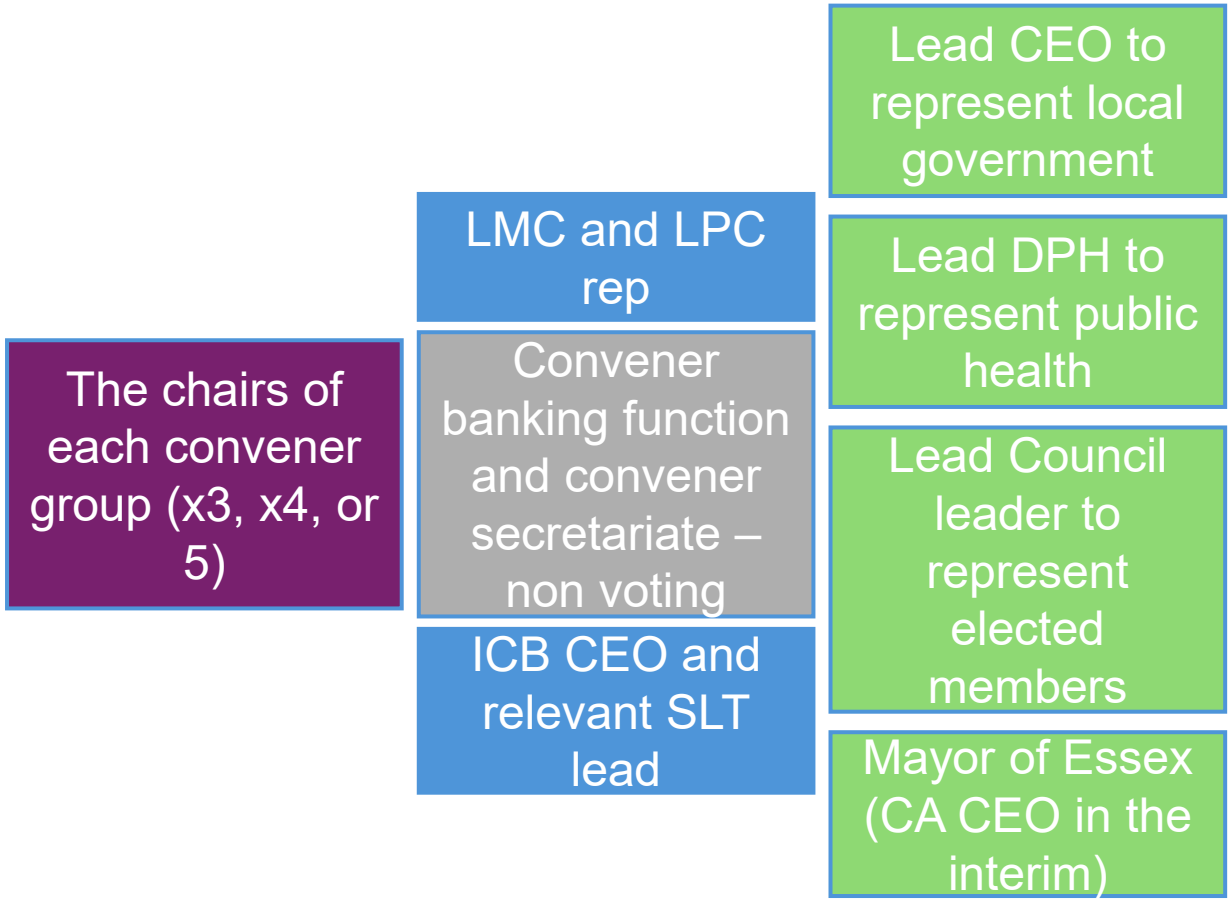
To act as a county-wide convener for issues which can only be sensibly commissioned at county wide level

To act as the “led by learning” body to share best practise with each convener and act as a mentor body

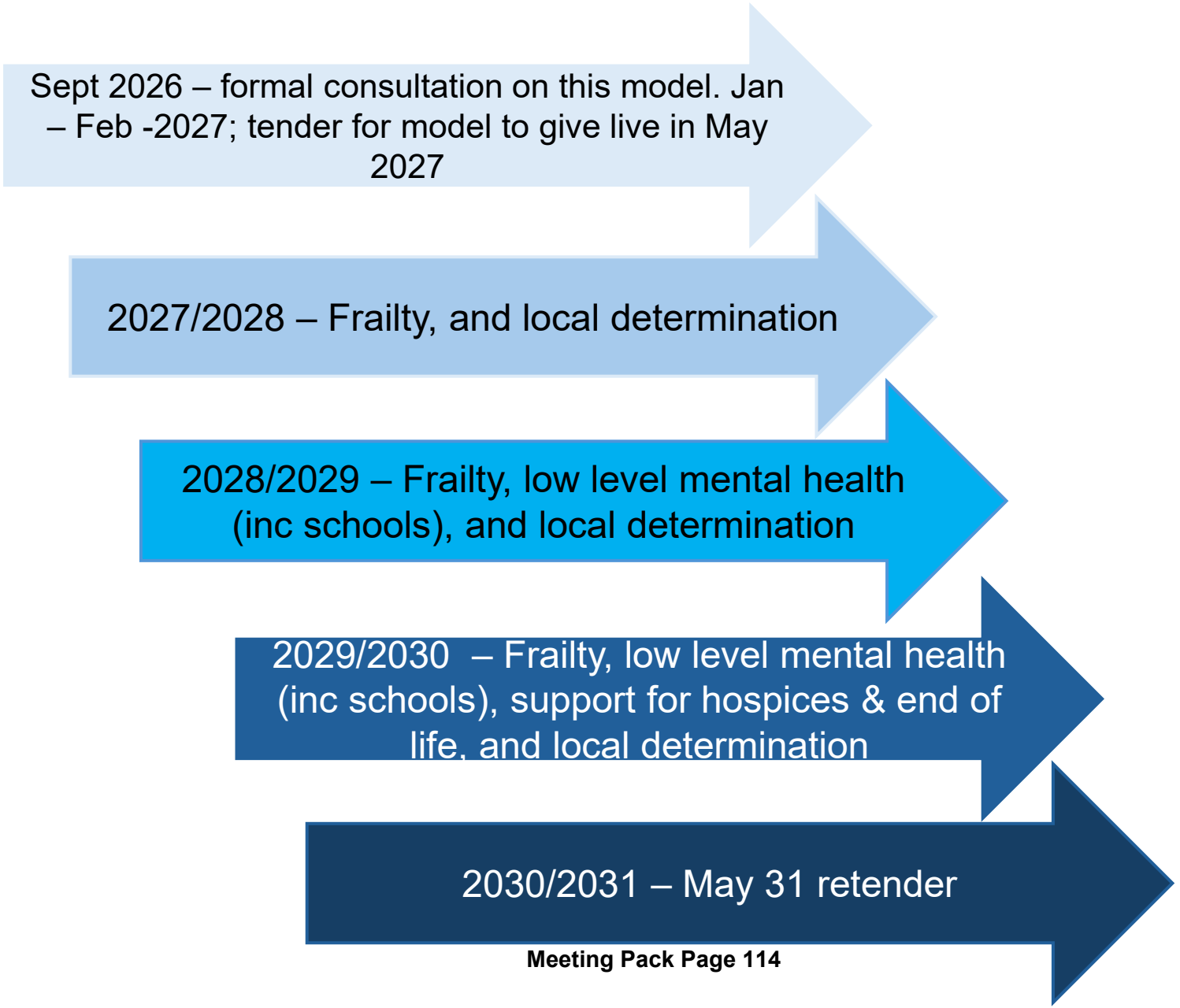
To act as the body that interfaces with region and supports national policy coordination

To hear any appeal or support in the resolution of conflict

To provide the secretarial support for each convener and commission the banking function for each convener



Initial thinking on timing and targets



Some questions for you

Does the governance give us the “right people” around the table?

Does this allow us to also preserve what already works?

Is there anything extra we need to do to aid transition to this new approach?

How will we know if the convener model is working and how could we make changes as we go along?

How can we keep the public and wider sector involved?

Appendix 1 – 6Cs update

6 C’s

Collaboration - Making sure we seize the opportunity of local government reform to build the most simple and coterminous wellbeing service as possible. This means linking our work on health neighbourhoods with council neighbourhoods’ delivery committees through everything from communication to governance.

This is also an exciting time for healthcare as new technologies give us scope to revolutionise delivery which we must seize together.

Finally, this means working with communtiies to ensure services and structures match their expectations wherever possible and brings services closer to them in a holistic manner.

Convening **-** Building a closer and stronger link between the NHS and the community, charity, voluntary, faith and private sectors. This should soon mean consulting the sector on a plan to build a CVS led convener body to hold devolved funds to nurture collaboration and innovation through community led grants.

Core - Getting the core offer right. This means getting the offer right in terms of what every resident in Essex should expect to see. This is about equity, not just equality i.e. what are the services we all need to access, and where do we need to flex these up in areas of greater need.

We know this also means making sure children services are a large part of core decision making than in the past.

6 C's

Commissioning - We need to make the shift to strategic commissioner meaning we deliver less ourselves but rather support others in standing up with their own freedom and devolved power to address the main elements of the 10-year plan and system shift.

We will also maximise the role the ICB will have in utilising data and residents views to take a longer term view of the healthcare needs of Essex in the future - and to use its commissioning powers to ensure those needs are met. Commissioning needs to be aa conversation.

Challenge - This also means robustly offering support and challenge to under performance. Working with partners to ensure that NHS services meet the required standards of accessibility, quality and person focus. We can't have quality at the core unless we call out the issues.

This means for groups in special measures we need to help reduce demand on them to help them recover, while helping to lead conversations regarding what is the most viable future and formation for acute care across the county.

Care - The ICB has a massive role to work with the police, civil society, private sector and beyond to be a cog in a wider machine to drive positive change. Working with all our councils and wider Essex community, we have embedded the key themes of the caring communities commission;

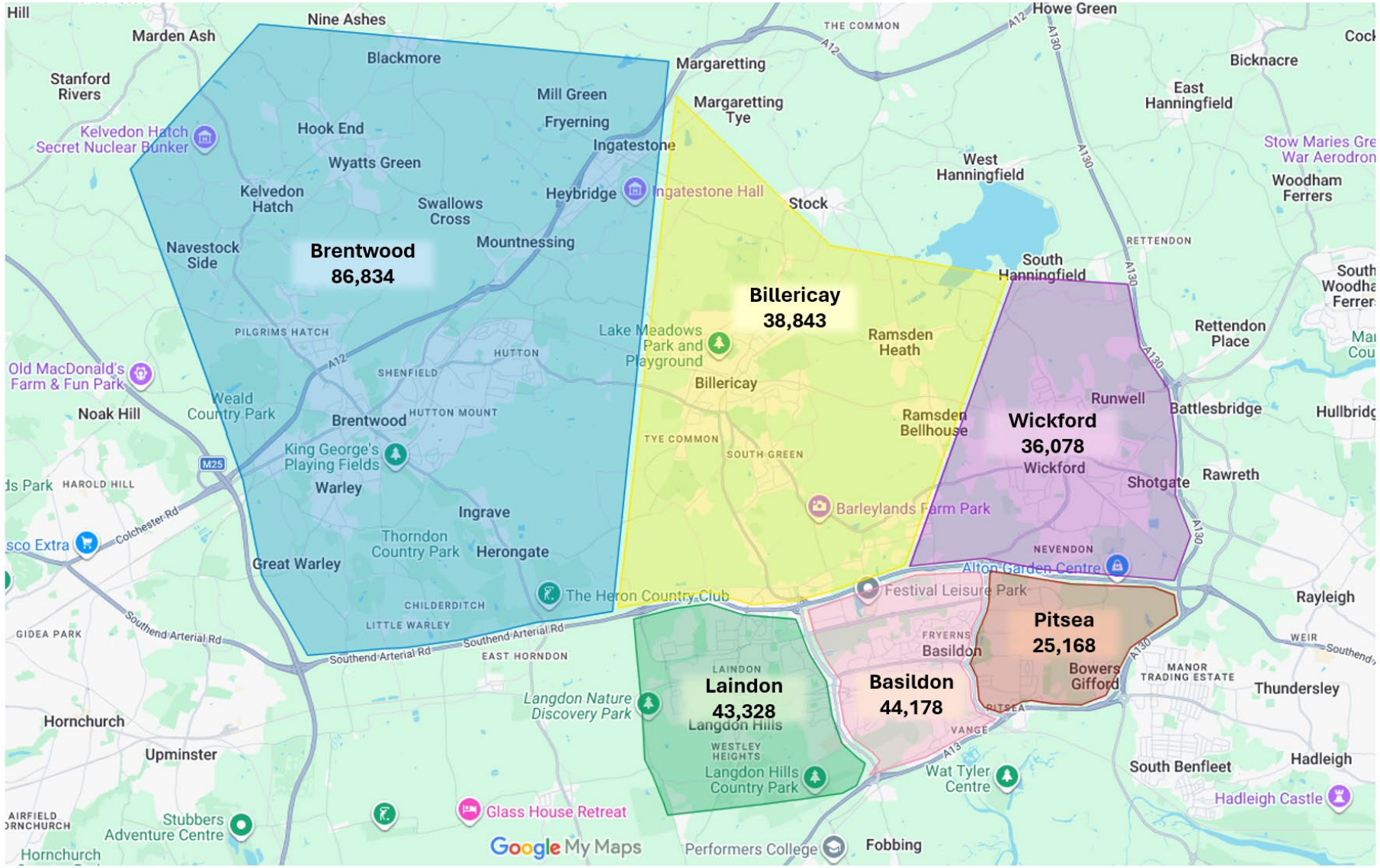
Dismantling the barriers to wellbeing and opportunity - Commit to preparing all our residents for the future world of work

Commit to vitalising community capacity by igniting the potential in civil society - Commit to prioritising prevention

Commit to reshaping decision making by ensuring that communities have an active role

Appendix 2 – Neighbourhood maps

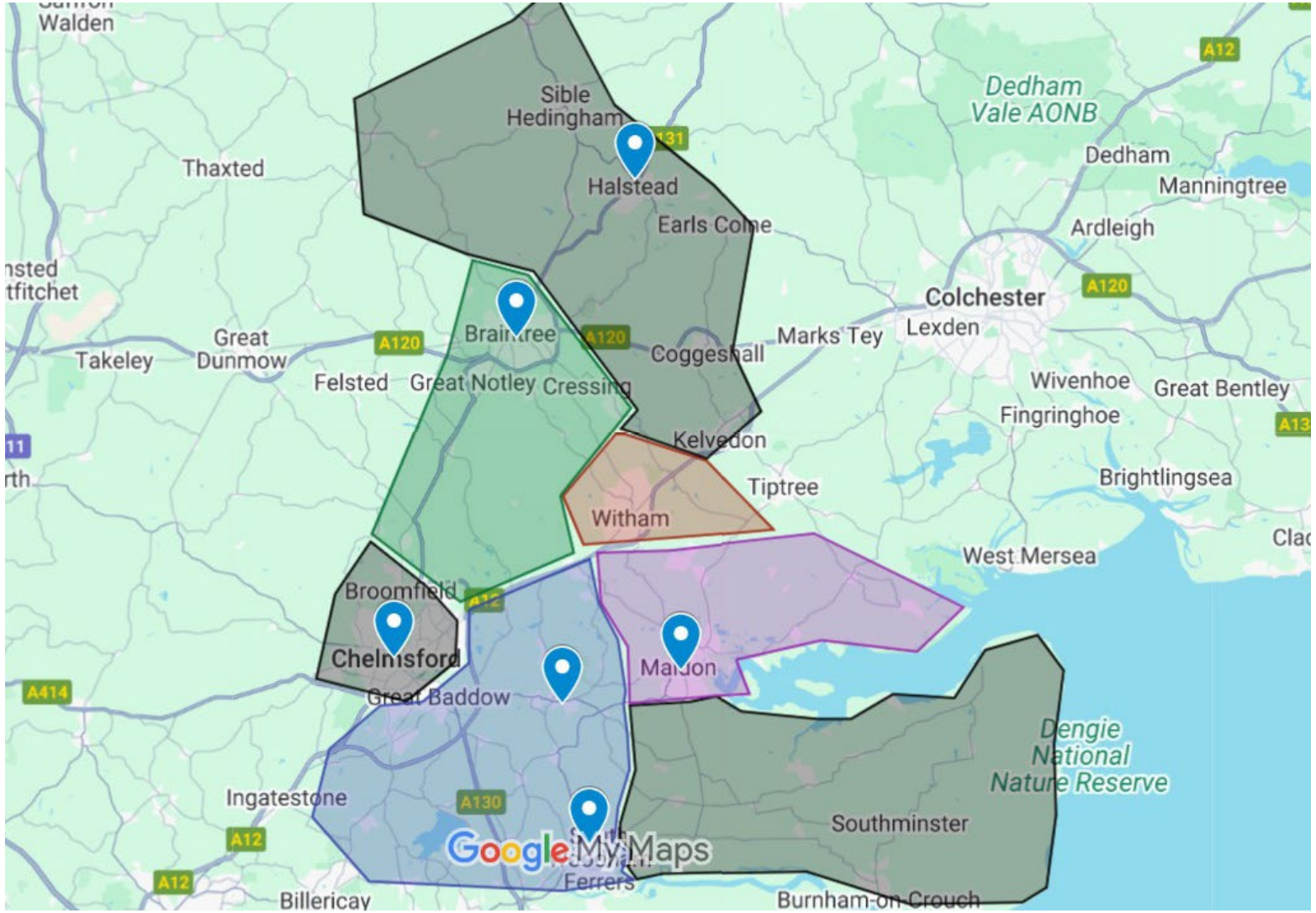
Basildon & Brentwood neighbourhoods



Key features

- No changes for Brentwood.
- Basildon configurated to the 5 original towns.

Mid Essex neighbourhoods

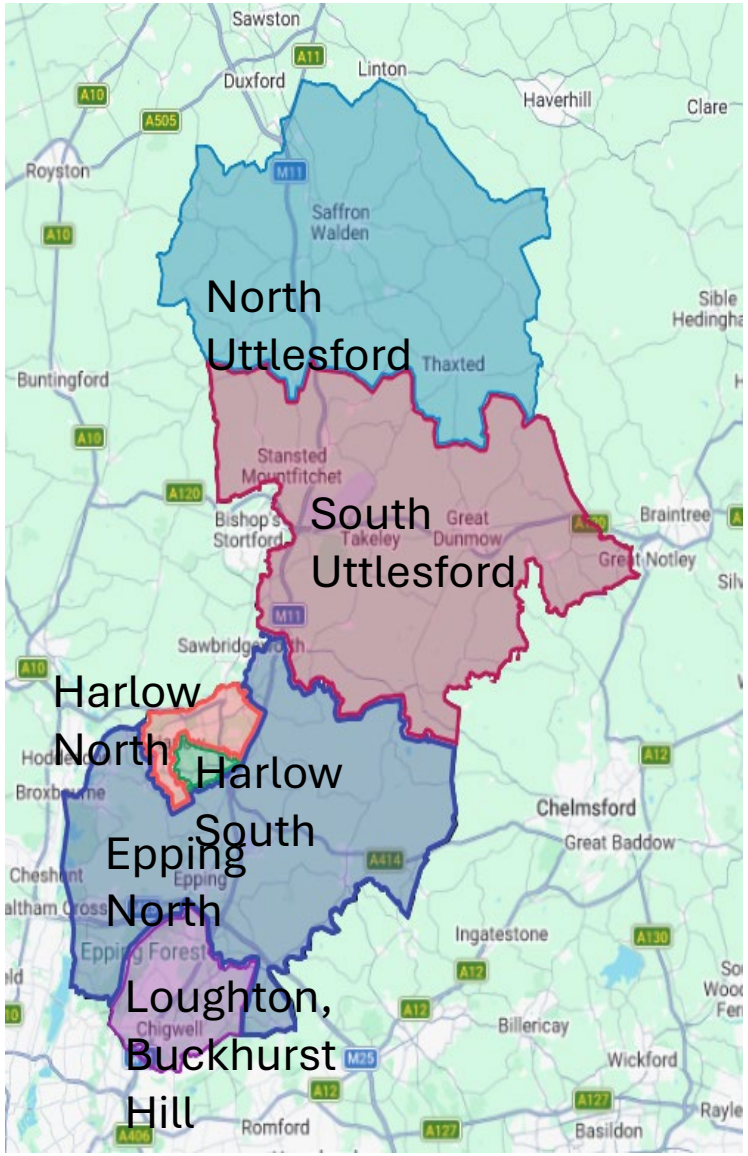


Key features

- Responding to colleagues in Chelmsford, we are allowing the city centre to remain intact. While this is 100k, there is no natural way to divide the city.

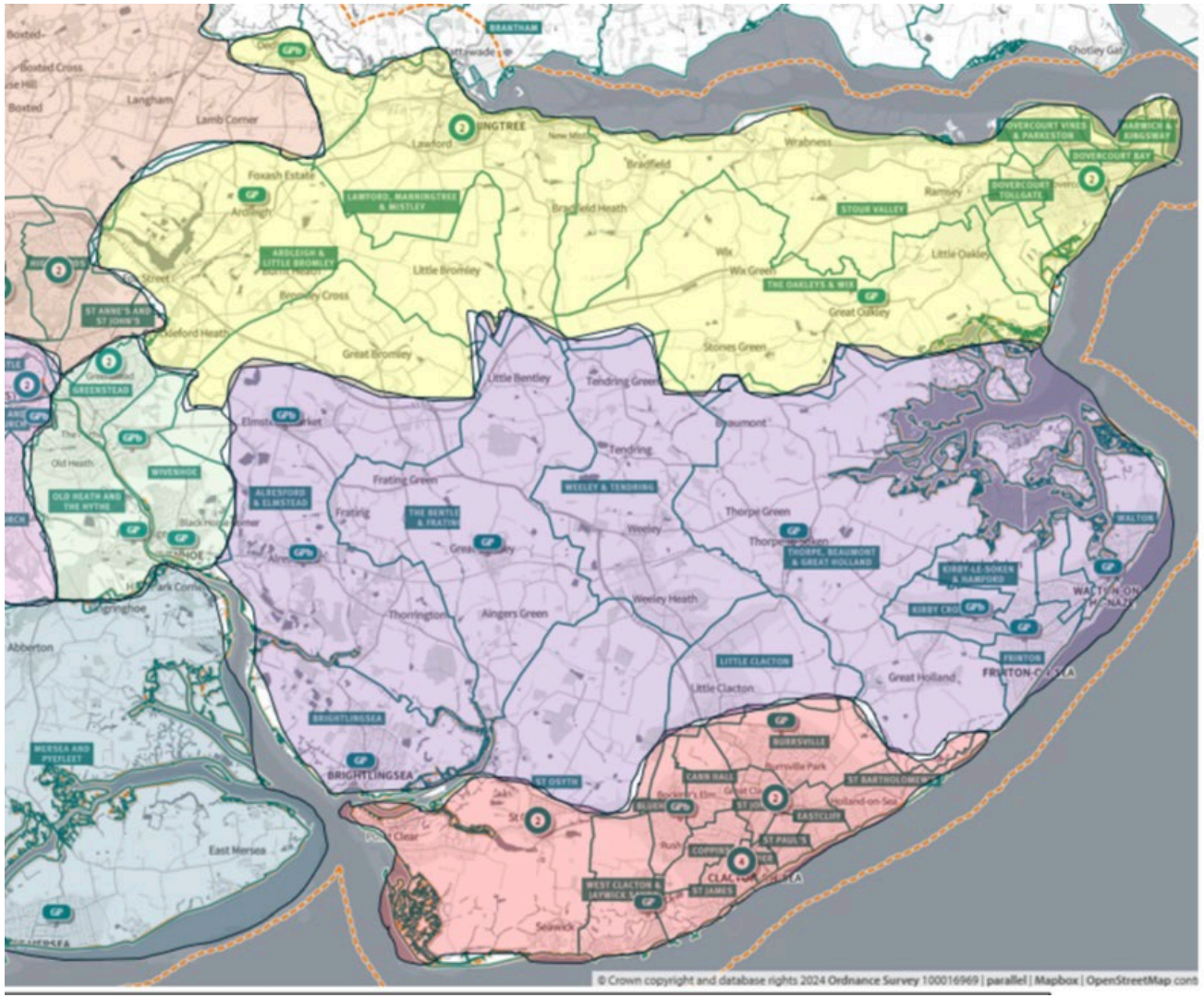
- In Maldon, we are separating out the Dengie. Even at just 26k, it is a clear community.

West Essex Neighbourhoods



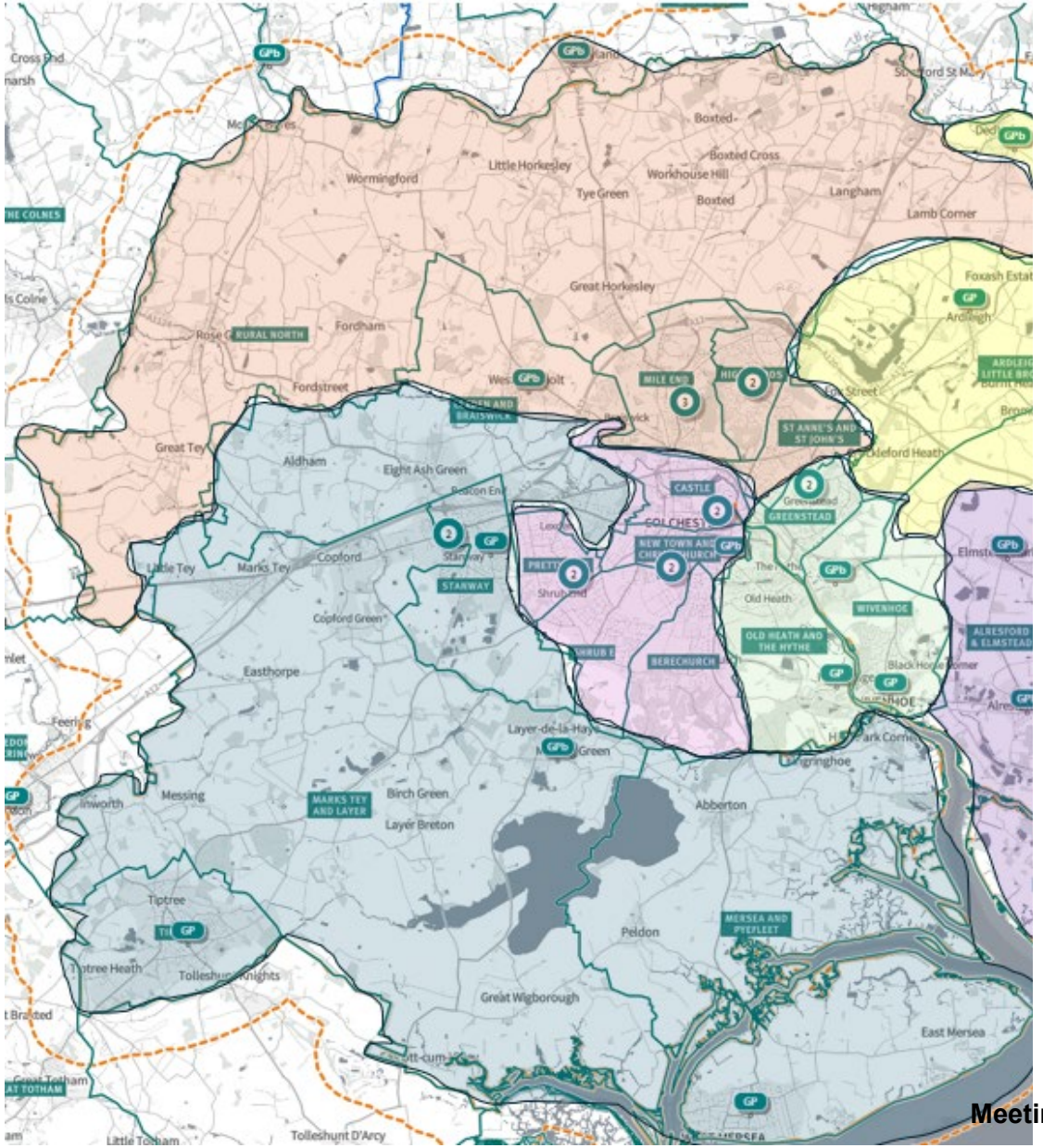
No changes proposed

Tendring neighbourhoods



- Tendring Council were concern with any option taking Great & Lt Clacton out of the South, and preferred an option which we crafted of Point Clear to Holland in the South, and a mid section of Brightlingsea to Walton in the middle. It is viewed that this is a more natural set of communities and give distinct areas their own focus, as well as matching their parishing consultation.

Colchester neighbourhoods

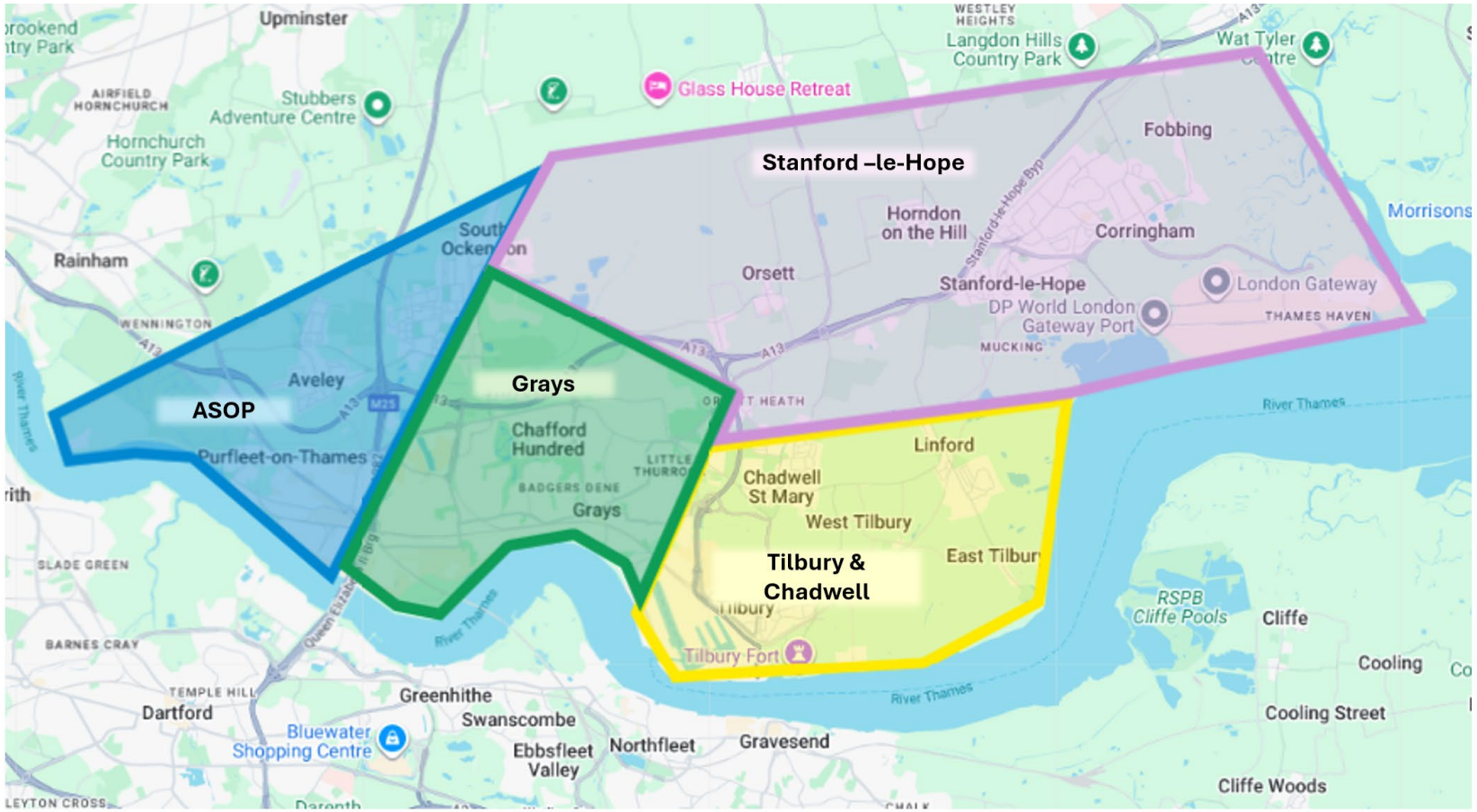


4 proposed neighbourhoods, with the following areas of note:

No significant changes

- Colchester to have its own neighbourhood separated from Greenstead on the basis that it is a natural divide.

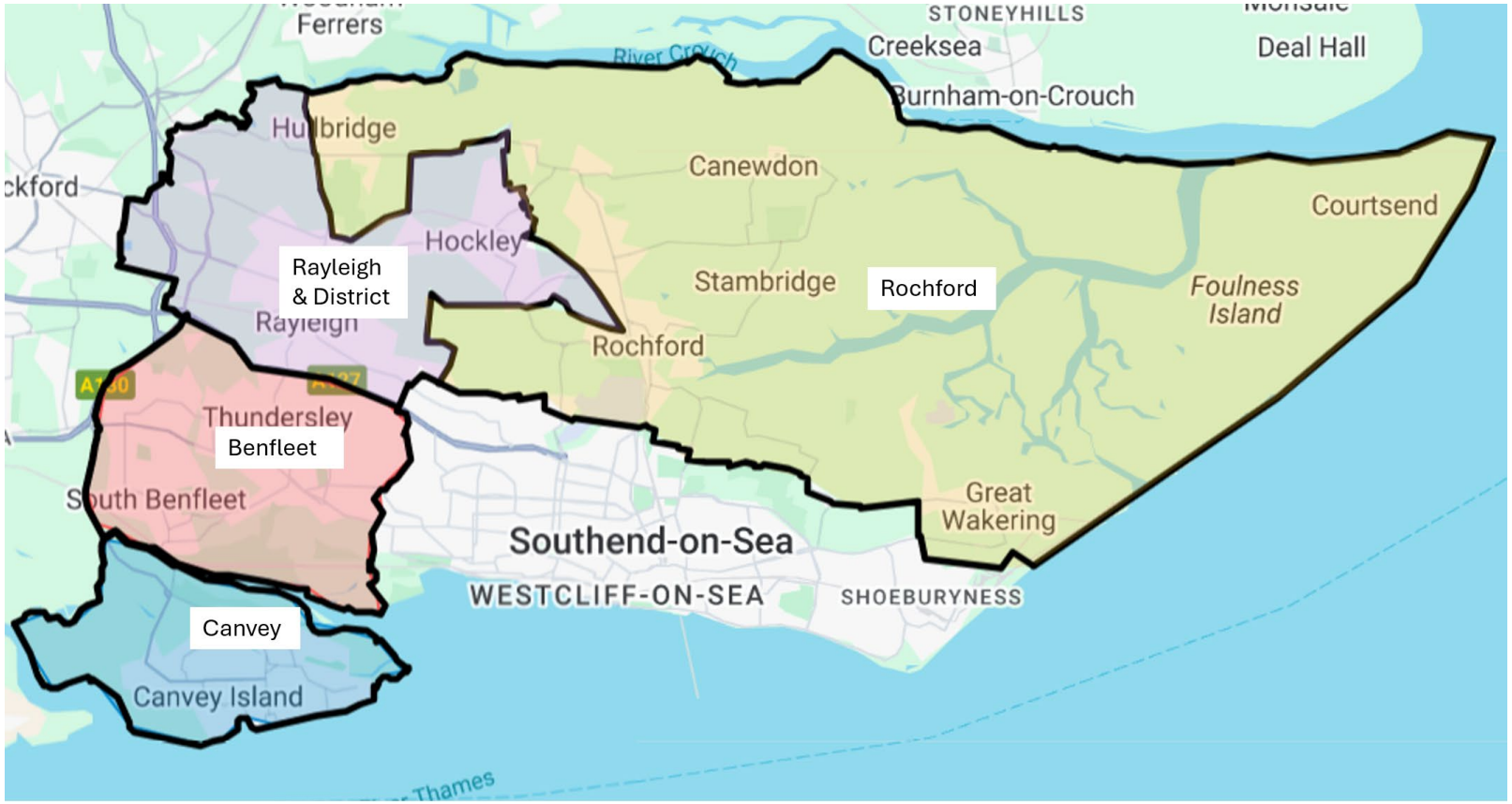
Proposed Thurrock neighbourhoods



Key features

No changes proposed

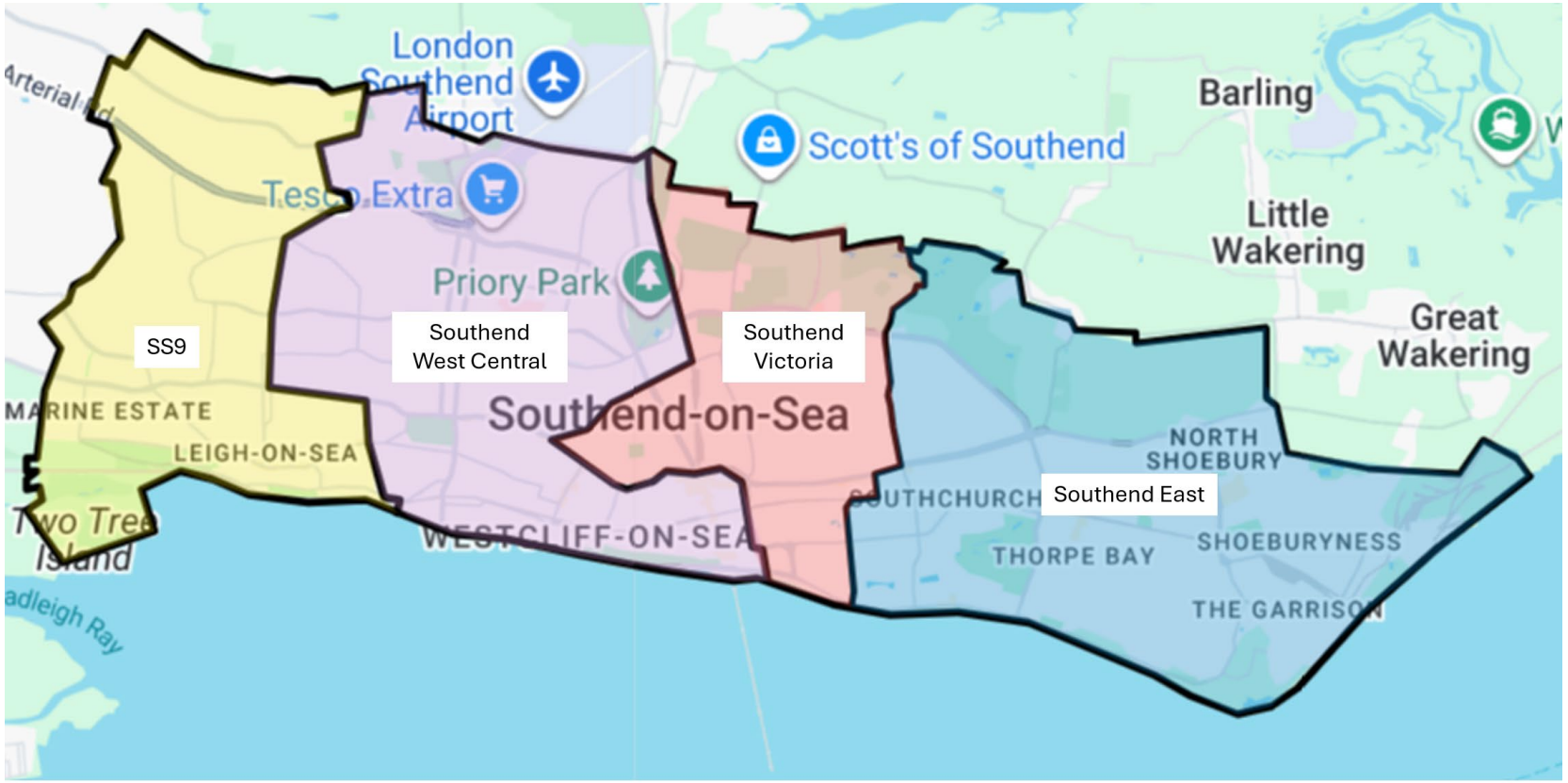
Castle Point & Rochford neighbourhoods



Key features

No changes proposed

Southend neighbourhoods



Key features

No changes proposed

NHS
Essex
Integrated Care Board

Part I Essex Integrated Care Board Meeting, 23 April 2026

Agenda Number: 11.1

Board Cycle of Business

Summary Report

1. Purpose of Report

To present the proposed ICB Board Cycle of Business for 2026/27 and to explain it has been developed to support the Board in discharging its statutory duties, governance responsibilities and assurance requirements.

2. Executive Lead

Michael Watson, Executive Director of Corporate Services

3. Report Author

Nicola Adams, Associate Director of Governance

4. Responsible Committees

The Board is responsible for ensuring it receives assurances as to the delivery of its corporate objectives from the Executive Team and through the sub-committee structure it creates.

5. Impact Assessments / Financial Implications / Engagement / Conflicts of Interest

Not applicable.

6. Recommendation/s

The Board is asked to note the proposed cycle of business for 2026/27 and that it will be updated throughout the year to reflect the business of the ICB.

Board Cycle of Business

1. Introduction

The Board Cycle of Business (Appendix A) sets out a structured annual programme of business for the ICB Board, ensuring that the Board receives timely information, makes required decisions, and gains appropriate assurance across its core responsibilities. It is a key governance tool that supports effective oversight, transparency, and compliance with statutory and regulatory requirements.

The Cycle of Business has been drafted to reflect:

- The assurances the Board needs in order to fulfil its role effectively.
- The requirements set out in the ICB Constitution.
- The matters reserved to the Board and those delegated in line with the Scheme of Reservation and Delegation.

This ensures that decisions and approvals are taken at the appropriate level, committees are held to account for delivery, and clear lines of accountability are maintained.

2. Main content of Report

A clear and structured Cycle of Business enables the Board to:

- Plan its agenda in a way that balances assurance, strategic oversight, and decision-making.
- Ensure statutory and constitutional requirements are met within appropriate timescales.
- Maintain effective oversight of quality, performance, finance, and transformation.
- Support informed decision-making by aligning key strategies, plans, and reports to the annual cycle.

By setting out when key strategies, reports, and decisions will be brought to the Board, the Cycle of Business also provides clarity for committees and executive teams on expectations and sequencing.

The proposed Cycle of Business has been developed by mapping:

- Core statutory responsibilities and governance requirements
- Board assurance needs, including quality, finance, people, and population health.
- Key committee escalation routes, ensuring alignment between Board and committee agendas.

This approach ensures that Board business is focused on areas of greatest risk, strategic importance, and system impact.

The Cycle of Business is intentionally designed as a living and iterative document. As the ICB continues to mature and as delivery plans are developed—particularly in relation to the Population Health Improvement Plan—the Cycle will be reviewed and refined.

As this work progresses:

- Some strategy headings may change in response to emerging priorities.
- Certain items may be combined to reflect integrated planning and delivery.
- Significant commissioning decisions will feature more prominently on the Board agenda as they arise.

The Cycle will therefore continue to evolve to ensure it remains aligned with ICB priorities, regulatory expectations, and the Board's assurance needs.

3. Findings/Conclusion

The Cycle of Business will be kept under review and updated as required, with any substantive changes brought back to the Board for information.

4. Recommendation(s)

The Board is asked to note the proposed cycle of business for 2026/27 and that it will be updated throughout the year to reflect the business of the ICB.

5. Appendices

Appendix A – Board Cycle of Business.

Item Name	Frequency	Executive Sponsor	Recommendation		Apr 1	Apr 23	July 16	Oct 15	Jan 21
				Month: / **Dates:**					
Standing Agenda Items									
Declarations of Interest	Every Meeting	Michael Watson	For Noting		C	P	P	P	P
Questions from Members of the Public	Every Meeting	Michael Watson	For Information Only			P	P	P	P
Approval of minutes from previous meeting	Every Meeting	Michael Watson	For Approval			P	P	P	P
Review of Action Log / Matters arising	Every Meeting	Michael Watson	For Noting			P	P	P	P
Chief Executives Report	Every Meeting	Tom Abell	For Noting			P	P	P	P
Commissioning, Quality & Resource Report	Every Meeting	Jen Kearton / Giles Thorpe	For Discussion			P	P	P	P
Neighbourhood Health Report	Every Meeting	Beverley Flowers	For Discussion			P	P	P	P
Board Assurance Framework	Every Meeting	Michael Watson	For Discussion			P	P	P	P
Chair Key Issues / Committee Escalations Report	Every Meeting	Michael Watson	For Discussion			P	P	P	P
Strategies / Plans for approval									
Population Health Improvement Plan	Annually	Emily Hough / Beverley Flowers	For Approval		A				
Finance Strategy	Annually	Jen Kearton	For Approval						
Quality Improvement Strategy	Annually	Giles Thorpe	For Approval						
Estates Strategy	Annually	Jen Kearton	For Approval						
Capital Resource Use Plan	Annually	Jen Kearton	For Approval						
Equality, Diversity Inclusion and Belonging Strategy	Annually	Michael Watson	For Approval				P		
People Strategy	Annually	Michael Watson	For Approval				P		
Organisational Development Strategy / Plan	Annually	Michael Watson	For Approval				P		
Financial Framework and Annual Budgets	Annually	Jen Kearton	For Approval						
Three-year Debt Management Strategy	Ad Hoc	Jen Kearton	For Approval						
ICB Engagement Framework (Communications Strategy)	Annually	Michael Watson	For Approval				P		
Commissioning Intentions	Annually	Tom Abell / Emily Hough	For Approval						P
Non-Standing Agenda Items for Decision									
Annual Report and Accounts	Annually	Michael Watson / Jen Kearton	For Approval				P		
Lampard Inquiry Update	Every Meeting	Matt Sweeting	For Noting			P	P	P	P
Talking Therapies	Ad Hoc	Sam Goldberg	For Approval						
Re-procurement of the Tollgate Practice	Ad Hoc	Beverley Flowers	For Approval				P		
Governance items									
ICB Constitution and Standing Orders	Annually	Michael Watson	For Approval		A				
Functions and Decisions Map	Annually	Michael Watson	For Approval		A				
Scheme of Reservation and Delegation	Annually	Michael Watson	For Approval		A				
Sub-Committee Terms of Reference	Annually	Michael Watson	For Approval		A				
Policy Approval	Ad Hoc	Michael Watson	For Approval		A				
Standing Financial Instructions	Annually	Jen Kearton	For Approval		A				
Risk Management Policy and Strategy	Annually	Michael Watson	For Approval		A				
Standards of Business Conduct Policy (Inc COI, F&H, CS)	Annually	Michael Watson	For Approval		A				
Risk Appetite Statement	Annually	Michael Watson	For Approval				P		
Items for Information									
Minutes of Committee Meetings						P	P	P	P
Committee Administration									
Effectiveness of Meeting			For Discussion						
Chair Key Issues / Risks to escalate			For Discussion						
Annual self-assessment of effectiveness			For Approval						
Review and approval of TOR			For Approval						

Key:

P - Planned
R - Received
D - Deferred
A - Approved
N - Not Approved
C - Complete

NHS Essex ICB Board Meeting of 23 April 2026

Agenda Number: 11.2

Board Assurance Framework update

Summary Report

1. Purpose of Report

1.1. To set out the vision, approach and development journey for establishing the Essex ICB's Board Assurance Framework (BAF) and supporting risk framework.

2. Executive Lead

2.1. Michael Watson, Executive Director of Corporate Services

3. Report Author

3.1. Nicola Adams, Associate Director of Governance

4. Responsible Committees

4.1. The ICB Board retains overarching responsibility for the management of the ICBs strategic risks.

4.2. The Audit Committee has responsibility for ensuring an appropriate risk framework is established and overseeing its implementation across the ICB.

5. Link to the ICB's Strategic Objectives

5.1. Objective 5 – An organisation that is up to the job, good to work for and good to partner with.

6. Impact Assessments

6.1. Not applicable.

7. Financial Implications

7.1. None.

8. Details of patient or public engagement or consultation

8.1. Not applicable.

9. Conflicts of Interest

9.1. None identified.

10. Recommendation/s

10.1. The Board is asked to note the Board Assurance Framework Update and the approach to developing and embedding a new risk framework in the Essex ICB.

Board Assurance Framework Update

1. Introduction

Essex Integrated Care Board was formally established on 1 April 2026. As a new statutory organisation, the ICB is in the early stages of embedding its governance, risk management, and assurance arrangements.

The Board has approved the Risk Management Policy and Strategy, which sets out the vision, principles, and operating model for risk management across the organisation, including the role of the Board Assurance Framework (BAF) and Corporate Risk Register.

While the Board Assurance Framework is a key mechanism through which the Board gains assurance over the delivery of strategic objectives, it is dependent upon:

- Clear articulation of strategic risks.
- An agreed risk appetite.
- Consistent identification and scoring of risks by risk owners.
- Alignment of controls and assurances to those risks.

These foundational elements are not yet sufficiently developed to support meaningful BAF reporting at this Board meeting. Early reporting at this stage would risk providing false assurance and undermine the integrity of the framework.

This paper sets out a plan to develop a comprehensive BAF which achieves the four areas identified above. The Board Assurance Framework will be operational for the Board meeting in July. In the interim, risks identified by the Essex Joint Committee prior to creation of the Essex ICB will continue to be managed in line with the previous approach.

2. Main content of Report

The vision for the Essex ICB Board Assurance Framework is set out within the approved Risk Management Policy and Strategy and is summarised as follows:

- The BAF will be the primary mechanism through which the Board gains assurance on the delivery of its strategic objectives and statutory duties.

- It will focus solely on strategic risks, distinct from operational risks held within Directorate and Corporate Risk Registers.
- It will provide clear line-of-sight between:
    - Strategic objectives
    - Principal risks to delivery.
    - Controls and mitigating actions.
    - Sources of assurance and assurance gaps.
- It will support the Annual Governance Statement and the Board's oversight of internal control effectiveness.

The BAF will be underpinned by the principles of the Orange Book, the NHS England Risk Management Framework, and the Three Lines Model, ensuring proportionate oversight, clarity of accountability and continuous improvement.

Importantly, the BAF is intended to be a live management and assurance tool, not a static report, enabling informed Board discussion and decision-making.

The organisation is currently in the establishment phase of its risk framework. The following critical components are still in development:

- Definition and agreement of the ICB's risk appetite.
- Identification and articulation of strategic risks aligned to the Population Health Improvement Plan.
- Consistent population of risks by risk owners across Directorates.
- Executive calibration and agreement of which risks meet the threshold for inclusion on the BAF.
- Training and capability building for staff, risk owners, Executive members and the Board.

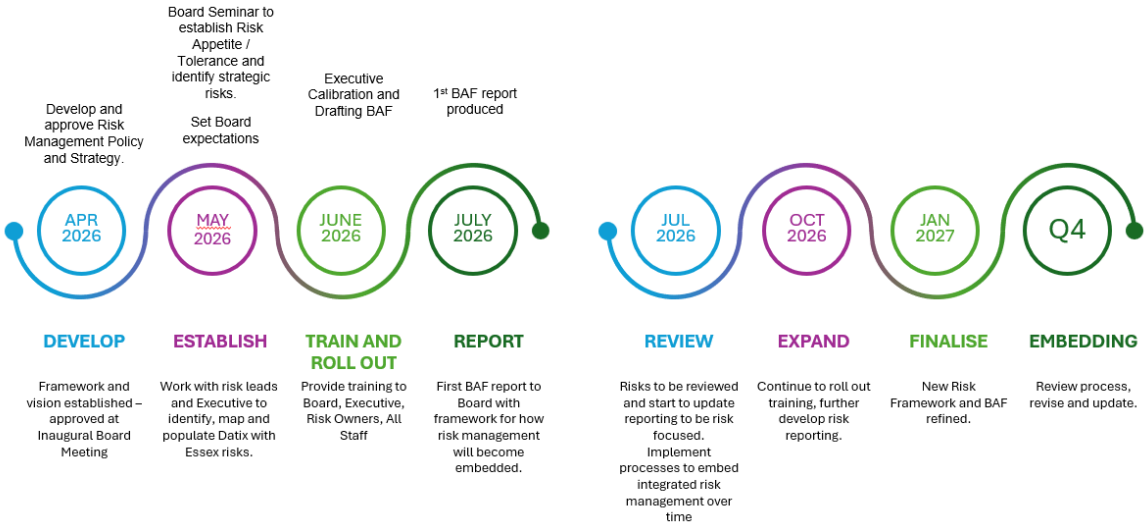
Reporting a BAF before these steps are completed would not provide the Board with reliable or meaningful assurance and would be inconsistent with good governance practice.

3. Findings/Conclusion

The governance teams of the ICBs working across Essex shared their respective risks to be considered as part of the Essex ICB. However, those risks needed to be reviewed and revised in light of the new Risk Management Policy and Strategy and also in the context of the new role of the ICB as strategic commissioner.

A structured, phased approach will be taken between April and July 2026 to document ICB risks and ensure the BAF is robust, credible, and embedded.

The diagram below shows the journey for developing and embedding a robust risk framework for our new ICB.



Stage 1 – Establish the Framework and Vision (April 2026)

- Approval of the Risk Management Policy and Strategy – complete.
- Communication of the risk framework and expectations.
- Confirmation of governance routes for risk escalation.

Stage 2 – Board Risk Appetite Seminar (May 2026)

- Facilitated Board seminar to:
    - Explore the organisation's risk context.
    - Agree risk appetite using the Good Governance Institute model.
    - Translate appetite into practical target risk scores.

  Outcome: Formally agreed Risk Appetite Statement

Stage 3 – Risk Identification and Population (May–June 2026)

- Structured engagement with:
    - Executive Directors.
    - Risk Leads and senior managers.
- Identification and documentation of Directorate and corporate risks in Datix.
- Mapping of risks to strategic objectives.
- Initial identification of potential strategic risks.

Stage 4 – Executive Calibration and BAF Development (June 2026)

- Executive review and challenge of proposed strategic risks.

- Agreement of:
    - Strategic risk set.
    - Ownership.
    - Controls, assurances and gaps.
- Development of the first draft Board Assurance Framework.

Stage 5 – Training and Capability Building (May–July 2026)

- Targeted training programme for:
    - All staff (risk awareness).
    - Risk owners and managers (risk quality and assurance).
    - Executive members (strategic risk oversight).
    - Board members (BAF interpretation and challenge).
- Ongoing support from Governance and Risk functions.

Stage 6 – First Formal BAF Reporting (July 2026)

- Presentation of the fully developed BAF to the Board.
- Establishment of routine reporting and review cycle.
- Agreement of future refinement and maturity actions.

The governance team will continue to review and revise the framework to ensure that it meets the requirements of our Board and is effective in managing our risks and ensuring that the ICB delivers the Population Health Improvement Plan.

4. Recommendation(s)

4.1. The Board is asked to note the Board Assurance Framework Update and the approach to developing and embedding a new risk framework in the Essex ICB.

NHS Essex ICB Board Meeting of 23 April 2026

Agenda Number: 11.3

Delegation to the Audit Committee

Summary Report

1. Purpose of Report

1.1. The purpose of the report is to seek the Board's delegation of authority to the Audit, Risk and Compliance Committee to approve the Annual Report and Accounts of the predecessor Mid and South Essex Integrated Care Board, as the Board's meeting schedule does not allow consideration of the final document prior to the submission deadline.

2. Executive Lead

2.1. Michael Watson, Executive Director of Corporate Services.

3. Report Author

3.1. Nicola Adams, Associate Director of Governance.

4. Responsible Committees

4.1. The Board retains responsibility for approval of the annual report and accounts but is asked to delegate this responsibility to the Audit, Risk and Compliance Committee to approve on its behalf prior to submission to NHS England.

5. Link to the ICB's Strategic Objectives

5.1. Objective 5 - An organisation that is up to the job, good to work for and good to partner with.

6. Impact Assessments

6.1. Not applicable.

7. Financial Implications

7.1. There are no financial implications.

8. Details of patient or public engagement or consultation

8.1. Development of the annual report includes engagement with key stakeholders. Once the final version has been approved, this will be shared in public at the July meeting of the Board and posted on the ICB website.

9. Conflicts of Interest

9.1. None identified.

10. Recommendation/s

10.1. The Board are asked to delegate approval of the Mid and South Essex ICB Annual Report and Accounts to the Audit, Risk and Compliance Committee.