NHS
Essex
Integrated Care Board

Meeting of the Essex Integrated Care Board

Thursday, 16 July 2026 at 2.00 pm to 3.30 pm

Marconi Room, Civic Centre, Duke Street, Chelmsford CM1 1JE

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, 23 April 2026	Approve	Attached	Prof. M Thorne	5
5.	2.13 pm	Matters arising (not on agenda)	Note	Verbal	Prof. M Thorne	-
6.	2.14 pm	Action Log	Note	Attached	Prof. M Thorne	13
7.	2.15 pm	Chief Executive's report (including update from Exec Committee and Board Seminars)	Note	Attached	T Abell	14
8.	2.25 pm	Strategic [Board] Assurance Framework	Note	Attached	T Abell	38
		Health Inequalities				
9.	2.35 pm	Health Inequalities Assurance Report	Note	Attached	B Flowers	51
		Shift to Neighbourhood Care				
10.	2.50 pm	Neighbourhood Health Assurance Report	Note	Attached	B Flowers	53
11.	2.55 pm	Neighbourhood Health Report	Note	Attached	B Flowers	55
		Access and Outcomes				
12.	3.05 pm	Access and Outcomes Assurance Report	Note	Attached	S Goldberg Dr G Thorpe B Flowers	71
13.	3.10 pm	Lampard Inquiry Update	Note		Dr M Sweeting	73
		Commissioning, Quality & Resources				
14.	3.15 pm	Finance and Quality Assurance Report	Note		J Kearton Dr G Thorpe S Goldberg	82
15.	3.20 pm	Commissioning, Quality and Resource Summary Report & CQRC Summary Report	Note	Attached	J Kearton Dr G Thorpe S Goldberg	84
		Trusted Partner				
16.	3.30 pm	Trusted Partner Assurance Report	Note		M Watson	104
17.	3.40 pm	Report from Audit Committee	Note	Attached	M Watson	106
18.	3.50 pm	Communications, Engagement and Involvement Strategy 2026-29	Approve	Attached	M Watson	110

No	Time	Title	Action	Papers	Lead / Presenter	Page No
19.	4.00 pm	General Governance:				
		19.1 Risk Appetite Statement	Approve	Attached	T Abell	156
		19.2 Governance report including: Revised Terms of Reference (NH, ARCC), updated functions map.	Approve	Attached	Prof. M Thorne	166
		19.3 New and Revised Policies	Note	Attached	Prof. M Thorne	175
		19.4 Updated Scheme of Reservation and Delegation	Approve	Attached	M Watson	178
		Other Business				
20.	4.10 pm	Mid and South Essex ICB Annual Report and Accounts 2025/26 and Health Inequalities Annual Report	Note	Attached	M Watson J Kearton	181 / Binder 2
		Closing Administration				
21.	4.20 pm	Approved Committee minutes	Note	Attached	Prof. M Thorne	186
22.	4.25 pm	Chairs Key Issues / Escalations Report	Discuss	Verbal	Prof. M Thorne	-
23.	4.28 pm	Effectiveness of Meeting	Discuss	Verbal	Prof. M Thorne	-
24.	4.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
25.	4.30 pm	Date and time of next Part I Essex Integrated Care Board meeting: Thursday, 15 October 2026, at 2.00pm, Southend Civic Centre, Committee Room 4A, Victoria Avenue, Southend On Sea, SS2 6ER	Note	Verbal	Prof. M Thorne	-

Essex Integrated Care Board
Register of Board Members' Interests - July 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.
Alex	Green	ICB Board Partner Member (Essex Partnership University Foundation Trust)	TBC								
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 Board Partner Member (Princess Alexandra Hospital Trust)	Princess Alexandra Hospital NHS Trust				Direct	Chief Executive			
Thomas	Lafferty	ICB Board Partner Member (Princess Alexandra Hospital Trust)	Passmore School Academy				Direct	Board Member			
Thomas	Lafferty	ICB Board Partner Member (Princess Alexandra Hospital Trust)	TWL Associates Limited				Direct	Director and Owner			
Sarah	Muckle	ICB Board 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.
Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Maynard Court Surgery NHS	x			Direct	GP Partner	Apr-2014	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.
Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Epping Forest North PCN		x		Direct	Member	Jul-2019	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.
Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Stellar Healthcare GP Provider	x			Direct	Shareholder	Apr-2015	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.
Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Medivys Health AI Technology	x			Direct	Shareholder	Oct-2025	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.
Robert	Persey	ICB Board 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.
Adam	Sewell-Jones	ICB Board Partner Member (MSEFT)	Mid and South Essex Foundation Trust	x			Direct	Chief Executive Officer	01/06/26	Ongoing	Interest will be declared if any any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.

Essex Integrated Care Board
Register of Board Members' Interests - July 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
Adam	Sewell-Jones	ICB Board Partner Member (MSEFT)	Fairleigh Hospice	x			Indirect	Spouse works in an admin role	01/06/26	Ongoing	Interest to be declared where any perceived conflict may arise and to be recused from the meeting.
Rex	Smith	Non-Executive Member - Audit Committee Chair	Gosfield School			x	Direct	Governor and Trustee	2022	Ongoing	None - there is unlikely to be any conflict.
Rex	Smith	Non-Executive Member - Audit Committee Chair	Helen Rollason Cancer Charity			x		Volunteer supporting charity	16/07/05	Ongoing	None - there is unlikely to be any conflict.
Trevor	Smith	ICB Board Partner Member (Essex Partnership University Foundation Trust)	TBC								
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.

Minutes of the Part I Essex Integrated Care Board Meeting

Held on Thursday, 23 April 2026 at 2.00pm – 3.05pm

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

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.
- Dr Matt Sweeting (MS), Executive Medical Director, EICB.
- Mark Bailham (MB), Non-Executive Member, EICB.
- Jo Churchill (JC), Non-Executive Member, EICB.
- Neha Issar-Brown (NIB), Non-Executive Member, EICB.
- Rex Smith (RS), Interim Non-Executive Member, EICB.
- Thomas Lafferty (TL), Partner Member, Princess Alexandra Hospital NHS Trust (PAH).
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Sarah Muckle (SM), Partner Member, Essex County Council.
- Mark Harvey (MH), Partner Member, Southend City Council.
- Robert Persey (RP), Partner Member, Thurrock Council.
- Natalie Hammond (NH), Director of Nursing, EICB (representing Giles Thorpe, Executive Chief Nursing Officer).

Other attendees

- Samantha Goldberg (SG), Executive Director of Performance and Planning, EICB.
- Michael Watson (MW), Executive Director of Corporate Services, EICB.
- Alex Green (AG), Executive Chief Operating Officer, EPUT.
- James Halden (JH), Chief of Staff, EICB.
- Nicola Adams (NA), Associate Director of Governance, EICB.
- Helen Chasney (HC), Governance Senior Officer, EICB (minutes).

Apologies

- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, EICB.
- Beverley Flowers (BF), Executive Director of Neighbourhood Health, EICB.
- Dawn Scrafield (DS), Partner Member, Mid and South Essex Foundation Trust (MSEFT).

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

MT welcomed everyone to the 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. The meeting was livestreamed to

accommodate members of the public who were unable to attend the meeting, and a recording of the livestream would also be available via the ICB website after the meeting.

A round of introductions was held. Noting it was his last meeting, MT expressed his thanks to PS for his work and valued contribution to both the Essex ICB and the Mid and South Essex ICB.

Apologies were noted as listed above.

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

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

No other declarations were made.

Note: The Board register of interests is available on the website.

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

MT advised that questions had been submitted by members of the public, as set out below, which would be addressed during the meeting. One question related to a personal matter and did not pertain to an item on the agenda; this would be responded to directly. Questions had also been submitted by the media and were being managed in accordance with the ICB's established process for media enquiries.

Two enquiries were received regarding the performance of Mid and South Essex Foundation Trust. TA advised that, from 1 April 2026, the Essex ICB had assumed the role of strategic commissioner, in line with national guidance, with responsibility for long-term planning, quality oversight and securing consistently high-quality care for the residents of Essex. The ICB would therefore work across the county and use all available commissioning levers, to drive service improvements across Essex.

Peter Blackman asked what patient and public two-way engagement was being set up for alliances / new proposed local authority areas and the thirty-eight new neighbourhoods. TA thanked PB for his question and emphasised that the ICB recognised that strong, two-way engagement with people and communities was essential to maintaining and rebuilding trust in NHS services, and the ICB was committed to ensuring the views of residents were at the centre of decision-making processes.

At neighbourhood level, the ICB was keen to strengthen partnerships with the Voluntary, Community and Social Enterprise (VCSE) sector and existing community networks to ensure residents can both shape and influence local priorities and build more collaborative relationships between NHS services and trusted community voices.

Following the local elections in May 2026, the ICB would begin wider engagement on the Population Health Improvement Plan to evaluate ICB ambitions with residents and ensure their experience informed plans at both system and neighbourhood level. A further update on the ICB approach to work with people and communities would be shared at a future Board meeting. In the meantime, thanks were formally given to groups such as South Woodham Ferrers Health and Social Care Group for their continued commitment to representing local

people, strengthening community voice, and supporting constructive dialogue with the NHS and other partners.

4. Minutes of the Part I Essex Integrated Care Board meeting held on 1 April 2026 (presented by Prof. M Thorne)

MT referred to the draft minutes of the Part I Essex Integrated Care Board (EICB) meeting held on 1 April 2026 and asked members if they had any comments or questions.

TL confirmed his attendance at the meeting and requested that it be appropriately reflected in the minutes.

There were no further comments or amendments.

Resolved: The Board approved the minutes of the Part I Essex ICB meeting held on 1 April 2026 as an accurate record, subject to the inclusion of TL in the attendance list.

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

There were no matters raised.

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

It was noted that there were no outstanding actions on the action log.

Resolved: The Board noted that there were no outstanding actions.

7. Population Health Improvement Plan (presented by T Abell)

TA presented the Population Health Improvement Plan (PHIP) and noted that the plan had been approved at the Board meeting on 1 April 2026. However, areas of inaccuracy had subsequently been identified which required amendment.

The purpose of presenting the PHIP again, was to provide assurance to the Board that those technical amendments had been completed. In addition, the Board was advised that a supporting PowerPoint presentation had been included within the papers. This would form part of ongoing engagement activity to ensure that the PHIP was informed by the views of local communities, patients, residents, and partner organisations across Essex.

MB confirmed that the Commissioning, Quality and Resource Committee (CQRC) had previously considered the PHIP and raised questions regarding how the plan would be monitored, including how delivery against its objectives would be tracked in a structured way. TA advised that work was underway to develop each element of the PHIP into clear delivery plans. It was intended that the Committee would receive regular progress reports, with updates also reflected through the Committee's reporting to the Board.

Resolved: The ICB Board noted the update on the Population Health Improvement Plan.

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

TA advised that good progress had continued in relation to the ICB transition, with the organisation now in the final stages of the organisational change process. Briefings had

commenced for new NHS Essex staff, covering the future role of the ICB, the PHIP, and the co-design of organisational culture and ways of working which were to be established.

In relation to 2026/27 planning, alongside the PHIP, an updated numerical plan had been resubmitted to NHS England, focussing on reducing the waiting list position, especially at Mid and South Essex Foundation Trust (MSEFT), with a target reduction of approximately 50,000 elective patients over the coming year. Improved positions against core access standards had also been submitted and would be reflected in future Board reporting.

The report noted recently published neighbourhood guidance, including developments relating to neighbourhood health centres.

Significant work had been undertaken to maintain safe and effective care across Essex during recent resident doctor industrial action. It was noted that there could be further industrial action by resident doctors, consultants and general practitioners, subject to ballot outcomes.

TA reported that five strategic objectives for the organisation had been agreed, as follows:

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

The objectives would inform Board discussions and underpin key frameworks, including the Board Assurance Framework.

Referencing areas of delivery highlighted in the CEO report, JC asked what could be scaled up and delivered at pace, including expected outcomes, delivery approach, patient and resident engagement, and alignment with the PHIP and wider objectives. Clarification was also sought on the evaluation arrangements of these initiatives and how the ICB listens to the patient voice. TA advised that initial analysis across Essex had identified strong performance in areas such as frailty identification, care planning, cardiovascular disease identification and prevention, and diabetes care, which offered opportunities for improvement in outcomes. In terms of evaluation, established metrics would be used to monitor progress. In addition, further work was required to develop more aspirational measures, including new metrics and approaches to evaluation. It was anticipated that a dual approach would be adopted, combining the rollout of proven interventions with parallel testing and evaluation of new approaches.

MW advised that further work was required to ensure that resident voices were fully incorporated into both strategic planning, including the PHIP, and specific commissioning decisions. Work was underway to develop a clear engagement model, which would be presented to the Board in due course. In relation to the PHIP, some cohorts within Essex were less likely to engage and would require targeted efforts to ensure their views were represented. Discussions were taking place with Healthwatch organisations, recognising that they were also undergoing a period of change, to explore a sustainable engagement model. Given the ICB's limitations in delivering comprehensive engagement alone, it had been considered important to establish an approach that enabled continued collaboration with Healthwatch to support engagement across the PHIP and wider priorities.

RP noted that, alongside formal engagement structures, a range of informal mechanisms already supported resident engagement. This included public health teams, which frequently

worked with harder to reach groups when addressing inequalities, and whose programmes could be used to strengthen engagement. Also, local and ward councillors had a strong interest in NHS services and were regularly approached by constituents on related issues.

MT noted the ICB reorganisation and acknowledged the departure of valued staff, recognising that these changes had been required nationally and had been managed as effectively as possible despite uncertainty. Thanks were extended to those involved in delivering the transition. MT also sought assurance on actions to improve staff satisfaction, including fostering a sense of belonging, and enabling staff performance. MW reported that an evidence-based organisational development (OD) programme and strategy had been developed. This would focus on understanding current staff experience and identifying opportunities for improvement, improving alignment with commissioned services and populations, strengthening line management to develop the desired organisational culture and ways of working, ensuring staff had a clear understanding of their accountability and contribution to PHIP delivery, and advancing equality, diversity and inclusion to create a more inclusive organisation, consistent with wider NHS priorities. A detailed delivery plan, combining staff engagement and organisational development activities, such as training, objective setting and appraisals, had been implemented, and progress updates would be provided to the Board in due course.

NIB emphasised the importance of developing the skills required for an effective strategic commissioning function, noting that while capabilities already existed, others would need to be strengthened. Clarification was sought on plans to ensure the appropriate framework and capabilities were established. MW advised that the organisation's function had significantly changed, and that there were staffing gaps within the new structure, particularly in areas such as analytics. These capabilities were essential to support strategic commissioning, alongside a wider focus on developing staff core skills, including data utilisation and consistent reporting.

Resolved: The Board noted the Chief Executive's Report.

Action: TA and MW to discuss the most appropriate level of reporting (within CEO report or separate report) with regards to a progress update on staff experience and the evidence based organisational development programme.

9. Commissioning, Quality and Resource Summary Report (presented by J Kearton, S Goldberg and N Hammond)

JK noted that the report reflected the transition to a strategic commissioning role and differed from previous Board reports. Future quarterly reporting would be provided through the Commissioning, Quality and Resource Committee (CQRC), including input from its Chair. JK sought feedback on the content and format of report, noting that illustrative data had been included.

The report set out the Essex context, including the £5.3 billion allocation for commissioning health services and the planned spend profile, which would be tracked in each report. The capital resource allocation plan was noted, including the uncommitted resources which were pending completion of due diligence and transition arrangements.

The executive summary provided an overview of key challenges, risks, progress and opportunities across commissioning, quality and resources. The financial section focused on trends, efficiency requirements, and risks, alongside increasing visibility of spend areas aligned to executive portfolios. Detail would be provided on current and projected

performance, including associated risks and mitigations, supported by technical annexes to provide closer scrutiny on cashflow, better payment practice code and debtors and creditors.

The update on capital and estates would include progress on Section 106 funding for planning, development and mitigation and neighbourhood health estate developments. It was also noted that contracted activity would be monitored using statistical process control (SPC) charts to support trend analysis and alignment between commissioned services, delivery and performance, with scope to expand the approach over time.

SG advised that the performance slides outlined the Board's responsibilities in relation to the National Oversight Framework (NOF) and operating plan metrics. Performance would be RAG rated and reported quarterly, supported by narrative highlighting trends and any positive or negative movement. The report would also identify any required remedial actions and provide an assessment of the ICB's performance both regionally and nationally.

MB reported that the CQRC had reviewed the report in detail and proposed additions. The report would become more effective as data was populated, enabling further insight and refinement. It was considered a strong starting point that would evolve over time.

NIB welcomed the alignment of the three strands within the report but noted that presenting all data together could risk obscuring key issues. It was suggested that a mechanism be introduced to highlight areas of concern, potentially through a focused theme at each meeting. NIB also sought assurance that patient satisfaction measures would be incorporated alongside national metrics to assess service quality. NH advised that effective report design and triangulation would support meaningful discussion, encouraging further exploration of patient experience. It was noted that this would be informed by Healthwatch, internal intelligence and partner input, alongside the development of a broader overview of patient satisfaction to support early identification of trends. JK advised that quality would be a key component of reporting, alongside separate assurance through the Audit, Risk and Compliance Committee (ARCC), and emphasised the need for appropriate metrics.

MT raised concern regarding quarterly reporting frequency; however, JK confirmed that the Executive Committee reviewed the actual position monthly and any emerging issues would be escalated.

PS noted the value of linking spend profiles to strategic intent and future planning. TA confirmed that this work would be developed further, with JK adding that CQRC would consider rolling two-year financial projections.

MT sought assurance on alignment with national priorities. TA advised performance reporting would be aligned with the forthcoming NOF and statutory duties, with further work required to strengthen metrics, including collaboration with local authorities and wider partners. TA also noted opportunities to draw on programmes such as 'Work Well' and existing public health measures. SM highlighted the overlap between 'Work Well' and the local authority programme 'Connect to Work,' suggesting greater coordination and shared learning.

RS queried data timeliness and national target reporting. JK explained that data flows were improving, with more robust reporting expected over coming months.

TA outlined plans to clarify accountability for metrics and advised that reporting would evolve separating performance and neighbourhood development reporting. JC emphasised the need to rethink metrics as service models shift, particularly in assessing reduced activity alongside improved outcomes. MS confirmed that national metrics would remain, supported by local measures to reflect clinical quality and outcomes.

In response to a query from MT, TA advised that delivery would be managed through agreed trajectories, with reporting focused on progress, risks and required actions. MT highlighted the importance of ensuring outpatient activity was clinically necessary.

Resolved: The Board noted the Commissioning, Quality and Resource Update Report.

10. Neighbourhood Report (Primary Care and Alliances) (presented by T Abell)

TA presented the neighbourhood report and advised that for future meetings, its data would be incorporated into the CQRC report, noting that this would be the final report in its current format.

It was reported that the national neighbourhood health improvement programme in North East Essex and West Essex was progressing well, with opportunities to apply learning across Essex. An update was also provided on the development of the primary care action plan in line with NHS England's requirements for ICBs.

Work had progressed in defining and scoping the community services review, with terms of reference to be submitted to a forthcoming Executive Committee. Ongoing progress would be reported to the Board at the next meeting. MT asked whether the review would be undertaken internally or with external support. TA advised that time-limiting roles within the neighbourhood structure had been established to lead the work, drawing on experience from similar programmes, including in Herts and West Essex. External expertise might be sought for specific elements, if required.

TL noted that effective neighbourhood health teams should include acute trusts alongside Primary Care Networks and community providers. Acute trusts had a clear incentive to support neighbourhood working, as this could reduce pressure on acute services and enable clinicians to focus on higher acuity care. TL further highlighted that acute providers often held significant resources which could support neighbourhood delivery, and that access to remote secondary care advice could help patients remain within community settings. It was therefore considered important that acute trusts were fully engaged in neighbourhood team development.

Resolved: The Board noted the Neighbourhood Report.

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

11.1 Board Forward/Work Plan

TA presented the proposed ICB Board cycle of business for 2026/27, outlining the planned activity for the year and ensuring that all statutory obligations would be met.

Resolved: The Board noted the proposed cycle of business for 2026/27 and agreed that it would be updated throughout the year to reflect ICB business.

11.2 Board Assurance Framework Update

MW advised that the Board Assurance Framework (BAF) had not yet been developed due to the early stage of the organisation. It was noted that key preparatory work, including a workshop, was required before a full BAF could be established. This paper provided assurance that development of the risk management framework was underway, with a more comprehensive BAF to be presented at the next Board meeting.

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

11.3 Delegation to the Audit, Risk and Compliance Committee

MT advised that, due to the timings of submission requirements to NHS England, the Board was asked to delegate approval of the Mid and South Essex ICB Annual Report and Accounts 2025/26 to the Audit, Risk and Compliance Committee. It was noted that other ICBs in the region were adopting a similar approach to ensure all elements were appropriately reviewed and approved.

Resolved: The Board approved to delegate approval of the Mid and South Essex ICB Annual Report and Accounts for 2025/26 to the Essex ICB Audit, Risk and Compliance Committee.

12. Effectiveness of meeting (presented by Prof. M Thorne)

RP suggested that greater emphasis should be given to children and young people within the prevention agenda, including areas such as mental health, weight management, substance misuse and healthy lifestyles. Improving outcomes at an early stage could deliver long-term benefits and consideration should be given to how performance and outcomes for this cohort were measured. MT agreed and advised that this could be incorporated into the Board's future programme of discussions.

13. Any Other Business

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

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

Thursday, 16 July 2026 at 2.00pm – 3.30pm in the Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford CM1 1JE.

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action	Lead	Deadline for Completion	Update	Status
1	23/04/2026	8	TA and MW to discuss the most appropriate level of reporting (within CEO report or separate report) with regards to a progress update on staff experience and the evidence based organisational development programme.	MW	May-26	Agreed that updates will be provided via the CEO report.	Completed

NHS
Essex
Integrated Care Board

ICB Board Meeting of 16 July 2026

Agenda Number: 7

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

2.1. Tom Abell, Chief Executive

3. Report Author

3.1. Tom Abell, Chief Executive

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

4.1. Not applicable.

5. Conflicts of Interest

5.1. None identified.

6. Recommendation/s

6.1. 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 noted on 23 April 2026. The report also provides a summary of activity of the Executive Committee.

2. Main content of Report

2.0 ICB transition

The organisational change programme to create NHS Essex has now completed, with our focus now turning to the work we need to do to establish a high performing organisation for the residents of Essex. This is initially focused on establishing a high-performance culture within the ICB and is being delivered through an evidence-based programme which involves 'change champions' from across every team across the ICB.

Alongside this work, we are also working to identify what skill gaps now exist within the ICB which will need to be addressed for us to successfully undertake our role as the Strategic Commissioner for NHS services in Essex. We will continue to update the Board on our work in this area as it develops.

2.1 Approach to strategic commissioning and public engagement in setting ICB priorities

We have now commenced our engagement activities around the ICB's Population Health Improvement Plan, which builds on our engagement activities associated with the development of the national 10-year plan for health.

This engagement is initially taking the form of a public survey to inform the actions we should take to build on those set out within the Population Health Improvement Plan to deliver on the priorities they have already told us they want through our 10-year plan work, these being:

- Faster access to care
- More care closer to home
- Better joined up services
- Stronger mental health support
- More focus on prevention and early help

The survey closed on 30 June 2026 and explores people's experiences of accessing services, how well services work together and what changes would make the biggest difference to local communities.

Alongside this work, we have now received our planning close-down letter from NHS England (included in Appendix B to this report) on our medium-term plan and our five-year strategic commissioning plan. In response to this and the areas of

focus identified we have aligned the activities set out within our plan to the national priorities set out by NHS England, these being set out in Appendix A to this report.

Progress on the delivery of the plan will be included in our routine reporting to the Board over the course of the year.

2.2 Neighbourhood Health Centre Submission

On 28 May, alongside all other ICBs in England, we submitted our proposed Neighbourhood Health Centre pipeline to NHS England, responding to the recently published Neighbourhood Health Centre guidance.

We engaged broadly with primary care, wider NHS partners, local government, and other stakeholders in the development of this pipeline, which resulted in five 'anchor' sites being identified, these being:

- St Peter's Hospital in Maldon.
- Clacton Hospital.
- Southend High Street.
- Thurrock Community Hospital.
- St Margaret's Hospital, Epping.

Alongside these five sites, nine further sites were identified through our engagement activities which were included within our submission.

We are now awaiting further information on the next steps following this submission and when decisions will be made on how schemes will be prioritised and approved.

6.3 Essex Special Education Needs Inspection

On 20 May, Ofsted and the Care Quality Commission published its report on the outcome of its inspection of the Essex Special Educational Needs and Disabilities (SEND) Local Area Partnership.

The report highlighted areas of positive experience and good practice, acknowledging our current work to improve access to health services in areas including:

- transformation work to integrate therapy offers across speech and language therapy in Essex, Southend, and Thurrock
- improving access to assessment for neurodiversity and autism through a transformation programme
- enhancing partnership work with local authorities so families and professionals can better access the Essex Local Offer
- addressing health inequalities, including specialist hearing and eye testing services for SEND schools
- reducing variation in service provision and improving equity of access to services for children and young people with complex health needs

However, the findings also highlight important challenges which we are beginning to address through current work but need to go further. This included:

- reducing variation in access to key services, including community nursing provision, speech and language therapies, emotional wellbeing, and mental health services
- reducing long waits for neurodevelopmental assessments
- improving the sustainability of attention deficit hyperactivity disorder (ADHD) medication pathways
- reducing gaps that patients face when moving from children to adult services
- improving awareness among professionals of the local support offer to improve effective signposting

We have written to our health stakeholders to share our response to the report and are working closely with our local authority partners and health providers to address the recommendations in full.

2.4 NHS Modernisation Bill

The NHS Modernisation Bill was introduced to Parliament in the King's Speech on 13 May 2026, this being the bill to facilitate the changes previously announced by the Government including the abolition of NHS England and to the changes to the role and responsibilities of Integrated Care Boards.

Key proposals within the bill include:

- The abolition of NHS England and transferring its functions to the Department of Health and Social Care and ICBs.

- Giving ICBs additional commissioning functions which are currently undertaken by NHS England, alongside changes to the composition of ICB Boards and abolishing Integrated Care Partnerships.

- Making changes to the governance of Foundation Trusts, which include the removal or transfer of the statutory functions of Councils of Governors to the Secretary of State. These changes also include restoring ministerial powers to deauthorise Foundation Trusts.

- Enacting the recommendations made in the Dash Review to streamline the patient safety landscape by abolishing Healthwatch and merging the Health Services Safety Investigations Body into the Care Quality Commission.

- Establishing the Single Patient Record, with an initial focus on those receiving maternity or frailty care in 2028.

These changes have previously been well signalled and align with the planning work, which was undertaken in designing NHS Essex, however we will continue to monitor the progress of the Bill through parliament to understand any changes so we can adjust, as necessary.

6.5 National Oversight Framework

NHS England has now published the NHS Oversight Framework for 2026/27. The framework has been developed since the initial framework which was in operation last financial year and has now been extended to apply to Integrated Care Boards in England.

The intention of the Framework is to set out a more transparent, rules-based approach to oversight of both providers and ICBs. It brings together delivery segmentation, organisational capability assessment, and wider intelligence to determine the level of oversight, support or intervention required. For ICBs, the framework is particularly important because it reinforces the shift towards our role as strategic commissioners: improving population health, reducing inequalities, allocating resources effectively, assuring commissioned services and supporting the development of neighbourhood health.

For NHS Essex, the framework is well aligned with the direction already agreed through our Population Health Improvement Plan, Medium Term Plan, and emerging neighbourhood model. It also provides a clear external lens through which our progress will be assessed during 2026/27, including delivery against national priorities, financial sustainability, quality, access, productivity, workforce, and our ability to commission and assure services effectively.

At the time of writing much of the data against the ICB specific indicators was not available for NHS Essex as work is still ongoing nationally to align the various datasets from our predecessor organisations. However, we have undertaken an initial analysis and have identified a number of areas where we believe there will need to be focused improvement work undertaken, encouragingly, this work does align to that already set out within our Population Health Improvement Plan.

A summary of these areas for improvement alongside the actions in place to secure improvement is set out in Appendix C to this report which was work already underway to respond to the request of the Board at its' last meeting to set out how our objectives will be delivered, alongside those areas for priority action.

We will use the framework to inform our Board Assurance Framework, performance reporting, and executive oversight arrangements, ensuring that we are not simply responding to national oversight requirements, but using them to drive improvement, strengthen accountability and support our ambition of making NHS services better in Essex.

6.6 Other news and developments

- A new blood testing facility opened in Harlow Town Centre on 27 April alongside the new Community Diagnostic Centre in Epping, which was opened on 8 May, projects led and delivered by Princess Alexandra NHS Trust which will improve the accessibility of diagnostic services across west Essex.

- We announced that Bright Sight, delivered by Primary Eyecare Services and commissioned by NHS Essex will begin to bring specialist eye care into special schools later this year, providing enhanced eye tests, spectacle dispensing and other support to pupils in special schools and their families, tackling historic access issues.

- We approved the development of the new Hedingham Medical Centre in Sible Hedingham, and the new Halstead Heights Clinic has opened at Halstead Hospital which is being operated as a new branch surgery of Elizabeth Courtauld Practice.

- Recently released data showed that over 400 people in Essex received an earlier diagnosis of Lung Cancer because of the roll out of the Lung Cancer Screening Programme, meaning that those diagnosed can get earlier treatment, with the screening being extended further to cover Chelmsford in April.

- We launched a new pilot alongside Hamelin Trust designed to improve the uptake of health checks and quality of health action plans for people with learning disabilities, initially targeted in areas with lower uptake. The aim of this pilot is to understand whether by jointly working with the voluntary sector we can address some of the significant health inequalities faced by people with learning disabilities.

- The Cardiovascular Disease 'Lipids Initiate and Optimise Programme' was launched across mid and south Essex, which will build on the progress made last year with the 'Detect and Prevent Programme,' forming a system-wide approach to improving cardiovascular health and prevention. We are undertaking work to explore the opportunities to extend this further across west and north east Essex.

  Collectively, the activity described above demonstrates progress against the ICB's strategic objectives and the delivery of its Population Health Improvement Plan. The Board will continue to receive updates through the Board Assurance Framework, performance reporting arrangements and future Chief Executive reports.

3. Essex Executive Committee Decisions

The Essex ICB Executive Committee has been established to transact operational business of the ICB and provide oversight of work undertaken.

The Executive Committee has a structured workplan which provides regular oversight of the ICB's requirements within the National Oversight Framework (NOF) and its statutory duties.

Since establishment, the Executive Committee has held ten (10) meetings. The Executive Committee approved the following decisions:

- Review of ICB Strategic Capital Plan for 2026/27.
- Review of Integrated Urgent Care Services across Essex and future provision.
- Approval of national submission to the Steps to Safety Programme.
- Review of legal provision for the ICB's input into the Lampard Inquiry.
- Approval of plans for new Hedingham Medical Centre development in Sible Hedingham.

- Approval of plans for Better Care Funds (BCF) funding across three upper-tier local authorities covering Essex.
- Approval of short-term grant to continue Castle Point Association of Voluntary Services (CAVS) Befriending service.
- Approval of annual East of England Specialised Commissioning Collaborative Agreement.
- Approval of the ICB's Primary Care Action Plan (national submission).
- Approval of future strategic communications plan for the ICB.
- Review of SEND Reform Plans across the three upper-tier local authorities covering Essex.
- Approval of Terms of Reference (ToR) for Executive Committee sub-groups, including People Group, Inclusion & Belonging Group, Staff Partnership Forum, Strategic Delivery Group, and the Senior Leadership Team.
- Review of ICB's approach to staff training and associated internal approval processes.
- Re-procurement of Orthodontic activity across Essex.
- Approval for Dental Providers to deliver additional contracted activity (up to 110%), utilising existing budgets and underspend to support access to dental provision across Essex.

4. Board Development Programme

A Board Development Programme has been established to ensure that Board members collectively have the skills, knowledge and experience required to discharge the Board's statutory and governance responsibilities effectively. Monthly Board seminars have therefore been scheduled to support ongoing development and provide Board members with regular updates from the Chief Executive's Office between formal Board meetings.

The seminar held on 23 April 2026 focussed on Neighbourhood Health and the plans for NHS Essex as a newly established Integrated Care Board.

On 21 May 2026, the Board received a briefing on Local Government Reform and participated in a workshop to develop its risk appetite framework.

The seminar scheduled for 25 June 2026 was cancelled, with planned topics redistributed across the remaining programme for 2026/27.

Future seminars will support the development of the Board Assurance Framework, strategic commissioning capability, neighbourhood health, and other priority areas aligned to the Board's annual development programme.

5. Recommendation(s)

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

6. Appendices

Appendix A – ‘Big ticket’ commissioning activities in 2026/27

Appendix B – 2026/27 planning close down letter

Appendix C – Summary of areas of improvement for NHS Essex against the 2026/27 National Oversight Framework

Appendix A – 'Big ticket' commissioning activities in 2026/27

Programme	Commissioning action in 2026/27	Link to national priorities
Neighbourhood Health	- Strategic review of existing community service provision in Essex to agree standardised core provision and to prepare for transition of services into Multi-Neighbourhood Contractual arrangements. - Scale existing good practice which exists in parts of Essex in frailty and cardiometabolic to secure consistently better outcomes and reliance on secondary care services. - Scale existing good practice that already exists in other areas of community services, such as end-of-life care and the hospice sector to improve outcomes and support service sustainability.	- Eliminating un-necessary outpatients and outpatient transformation (frailty, cardiometabolic specialities) - Step change in reducing hospital bed days for highest risk cohorts (frailty, crisis event presentation)
Sustainable Hospital Services	- Scaling recently commissioned community-based services to transform dermatology and Musculoskeletal (MSK) access across Essex and extending this approach to further pathways with the greatest imbalance: Ear, Nose and Throat (ENT), Gynaecology, Urology to eliminate un-necessary outpatient appointments. - Establishment of Single Point of Access arrangements for target specialities as set out within national planning guidance. - Consider decommissioning / recommissioning opportunities for services where there are viable alternative provision models and/or will support left shift.	- Eliminating un-necessary outpatients and outpatient transformation (MSK, Dermatology, ENT, Gynaecology, Urology) - Step change in reducing hospital bed-days for highest risk cohorts (frailty, others), reducing length of stay, Urgent Community Response Team (UCRT) – crisis event re-direction, reducing discharge delays, stroke service strengthening) - Scheduling access reform for urgent care (iUEC procurement)

Programme	Commissioning action in 2026/27	Link to national priorities
	- Ensuring the delivery of previously agreed commissioning decisions on service centralisation and optimisation, in 2026/27 specifically focusing on stroke services and developing proposals for the future of other fragile services. - Active management / redistricting of patient flows within Essex to support faster access to treatment and support the sustainability of local acute services. - A strategic partnership with the Independent Sector to create flexible capacity to support access improvement and overall waiting list reduction in Essex. - Developing and commissioning new model Urgent Treatment Centre (UTC) provision to reduce reliance on Emergency Departments in Essex, alongside Integrated Urgent and Emergency Care (iUEC) (111, Urgent Community Care Hub (UCCH), GP out of hours services). - Ensuring that the benefits of Community Diagnostic Centres are fully realised through the establishment and launch of the associated pathway changes alongside the additional core capacity that will be created through the new buildings and equipment. - Scale the successful Integrated Care Transfer Hub across Essex and across Mental Health services which has significantly reduced discharge delays and length of stay.	- Technology enabled productivity improvements (investment in consultant connect, Patient Knows Best (PKB), securing timely access to Advice & Guidance (A&G), digitally enabled referral and communication mechanisms)

Programme	Commissioning action in 2026/27	Link to national priorities
Mental health and neurodiversity	- Re-procurement and recommissioning of Talking Therapies across Essex to ensure consistently good access, outcomes, and value. - Review and respecify community mental health services across Essex for implementation during 2027/28. - Commissioning of urgent mental health services in Harlow and Colchester.	
Complex Care	- Review and respecify perinatal services, with a view to the potential reconfiguration of these services in Essex. - Optimise all age continuing care services to ensure most appropriate care is being delivered at appropriate cost. - Scale the current model of ADHD services across all Essex to improve access and facilitate better support for patients. - Pilot a new model of Learning Disabilities Primary Care support, utilising neighbourhood principles to improve uptake of health checks, the quality of health action plans and associated follow-through to improve outcomes for this cohort of patients.	

NHS England – East of England
2-4 Victoria House
Camlife
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Cambridge
CB21 5XB

Tom Abell
Chief Executive Officer
Essex ICB

22 April 2026

Dear Tom,

NHS Essex Integrated Care Board
Acceptance Status: Conditional

I am writing in response to the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year Strategic Commissioning Plan**, and to set out next steps. Thank you for the extensive work across the organisation that has contributed to the development of these plans. Annex One of this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term- transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years- to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years means that planning does not end with submission of your plan; the focus on delivery will also be accompanied by ongoing foundational work as you continue to work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has in place the development and improvement support needed to strengthen capability and capacity, drawing on national resources where available.

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

Partially Compliant; conditions to achieve full compliance are set out in Annex One.

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. Primary responsibility for this sits with your Board. NHSE will review progress against these plans through our regional governance arrangements to ensure that there is continuous oversight, alignment across organisations, and transparent governance.

The region will operate a risk-based escalation process, from routine oversight through enhanced monitoring to full regional executive escalation, with clear triggers for senior involvement at each stage to ensure timely intervention. Organisations are expected to monitor performance routinely, pro-actively identifying and escalating issues.

It is essential that ICBs ensure population health improvement remains a central purpose of commissioning, with a strong focus on both improving population health outcomes and reducing health inequalities. Delivering the NHS health inequalities legal duties, including the requirements outlined in the NHS England statement on information on health inequalities, and prioritising a shift to prevention will be key in delivering the mission of halving the gap in healthy life expectancy to ensure more people live in good health for longer, thereby reducing demand on health and care services. As a region, we will continue to with work you and other partners, including NHS providers and local authorities, to support delivery of population health improvement.

Please share this letter with your full Board and let me know if you wish to discuss any of the above.

Yours sincerely,

Clare Panniker
Regional Director
NHS England – East of England

Annex One

The table below shows your full submission and compliance against the key ambitions within the three years until 2028/29.

- The ICB must deliver in line with its planned performance commitments.
- Where the plans are not fully compliant the ICB is expected to work towards delivering compliance within year.
- Where plans do not currently show compliance with national expectations in years 2 and 3 the ICB is expected to further develop these during year 1. Specifically in elective care a targeted and detailed recovery plan is required to mitigate the current shortfalls.
- Where Trusts within the ICB have submitted plans that are not fully compliant, the ICB is expected to work with those Trusts to move towards delivering compliance.
- The ICB is expected to report on its progress towards compliance over the year.
- The ICB has made good progress in contract discussions with Trusts and is close to full alignment. A small number of residual issues remain, and these should be resolved promptly to ensure contracts are agreed in full and in line with national planning guidance.
- In line with national planning the ICB are required to submit an initial metric for General Practice clinically urgent same day appointments by 29 April 2026 and a Primary Care Action Plan (PCAP) by the 28 May 2026. The plan should provide further specificity on actions and outcomes across General Practice, Dental, Community Pharmacy and Optometry services.
- Noting the absence of historic dental data measured at new ICB level, discussions about further development of plans for dental performance and activity are ongoing.
- ICBs are required to assure themselves that relevant providers comply with all national Community Sitrep and Faster Data Flow (FDF) reporting requirements, including RTT and 52-week waits for community services, and with all national MHSDS reporting requirements for non-urgent mental health community waits (where relevant to the services provided). This includes implementing plans to improve data completeness and quality and ensuring data flows to the appropriate national dataset.
- ICBs should ensure that commissioning and contracting arrangements for the planning period support all mental health and community service providers (including community interest companies) to build on progress made in 2025/26 in reducing excessive waiting times.
- For community services, this includes achieving 78% of patients waiting less than 18 weeks in 2026/27, increasing to 79% in 2027/28 and 80% in 2028/29. For CYP mental health services, providers are expected by the end of 2026/27 to deliver plans resulting in no CYP referral spells (breakdown d, ‘other’) waiting over 104 weeks for a full clock stop whilst continuing to monitor 78 and 52-week waits, with an ambition to reduce these in parallel. The longer-term aim, which will be the focus of future planning rounds,

is to eliminate 78- and 52-week waits entirely. The region will continue targeted work with providers reducing the longest waits with a focus from April 26 on patients waiting more than 40 weeks for assessment and treatment.

- The plan articulates a clear left-shift ambition aligned with national expectations, supported by a mature understanding that delivery depends on changes to commissioning, workforce, estates and neighbourhood-level data. Greater clarity is needed on how resources and activity will shift from acute to neighbourhood settings over time, including alignment with BCF and financial planning, transition risks.

Headline metrics

		2026/27				2027/28				2028/29			
Document Section	Planning Metric	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance
3.1 ECD	Percentage of RTT waiting list within 18 weeks (national target 70%)	Mar-27	69.6%	63.2%	-6.39%	Mar-28	80.6%	74.1%	-6.49%	Mar-29	92.0%	84.5%	-7.46%
	28-day cancer Faster Diagnosis Standard	Average across 2026/27	80.0%	70.2%	-9.82%	Average across 2027/28	80.0%	77.3%	-2.68%	Average across 2028/29	80.0%	80.1%	0.14%
	Percentage of patients receiving a first definitive treatment for cancer within 62 days	Mar-27	80.0%	70.7%	-9.28%	Mar-28	82.5%	75.1%	-7.43%	Mar-29	85.0%	85.0%	-0.03%
	Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Mar-27	94.0%	91.0%	-3.00%	Mar-28	96.0%	95.1%	-0.90%	Average across 2028/29	96.0%	95.9%	-0.11%
	Percentage of patients waiting for a diagnostic test or procedure for 6 weeks or over	Mar-27	14.8%	13.7%	-1.13%	Mar-28	9.3%	9.4%	0.07%	Mar-29	1.0%	1.0%	-0.02%
3.2 UEC	4-hour A&E performance	Mar-27	82.0%	76.4%	-5.63%	Average across 2027/28	83.0%	77.8%	-5.17%	Average across 2028/29	85.0%	80.6%	-4.41%
	12-hour breaches	2026/27 Annual Total	44,027	45,303	2.90%	2027/28 Annual Total	45,303	44,349	-2.11%	2028/29 Annual Total	44,349	43,331	-2.30%
3.3 Primary Care	Urgent Dental Appointments	2026/27 Annual Total	127,691	127,539	-0.12%	2027/28 Annual Total	127,691	127,534	-0.12%	2028/29 Annual Total	127,691	127,534	-0.12%

3.4 Community Health Services	Percentage of people on waiting list for Community Services per system who are waiting 18 weeks or less	Mar-27	78.0%	59.4%	-18.64%	Mar-28	79.0%	47.4%	-31.63%	Mar-29	80.0%	39.7%	-40.33%
3.5 Mental Health	Mental Health Support Team coverage of total pupils/learners (annual metric)	2026/27 Annual Total	77.0%	74.2%	-2.79%	Mar-28	89.0%	84.8%	-4.19%	Mar-29	94.0%	92.8%	-1.25%
	Reliable recovery rate for those completing a course of treatment and meeting caseness (monthly metric)	Mar-27	51.0%	52.0%	1.03%	Mar-28	52.0%	52.0%	0.01%	Mar-29	53.0%	53.0%	0.01%
	Reliable improvement rate for those completing a course of treatment (monthly metric)	Mar-27	69.0%	69.0%	-0.03%	Mar-28	70.0%	70.0%	0.02%	Mar-29	71.0%	71.0%	0.04%
	No. completed courses of treatment (monthly metric)	2026/27 Annual Total	21,470	21,471	0.00%	Mar-28	22,848	22,848	0.00%	Mar-29	24,484	24,484	0.00%
	Number of patients accessing Individual Placement Support services (12-month rolling metric)	2026/27 Annual Total	1,694	1,694	0.02%	Mar-28	1,871	1,871	0.02%	Mar-29	1,967	1,967	0.01%
	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period	Mar-27	17	24	7	Mar-28	24	0	-24	Mar-29	0	0	0
3.6 Learning Disability and Autism	Reliance on mental health inpatient care for adults with a learning disability	Mar-27	19	24	26.32%								
	Reliance on mental health inpatient care for autistic adults	Mar-27	8	24	200.00%								

Supporting metrics

		2026/27				2027/28				2028/29			
Document Section	**Planning Metric**	**Time point**	**Baseline /Target**	**Plan**	**Variance**	**Time point**	**Baseline /Target**	**Plan**	**Variance**	**Time point**	**Baseline /Target**	**Plan**	**Variance**
3.1 ECD	Total Waiting List	Mar-27	223,102	236,659	6.08%	Mar-28	183,411	226,433	23.46%	Mar-29	145,164	216,013	48.81%
	The number of diagnostic tests or procedures carried out in the period	2026/27 Annual Total	1,019,354	982,985	-3.57%	2027/28 Annual Total	1,116,170	994,636	-10.89%	2028/29 Annual Total	1,130,400	1,009,357	-10.71%
3.2 UEC	Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED)	Average across 2026/27	00:31:11	00:28:25	- 02:46	Average across 2027/28	00:28:25	00:28:52	+ 00:27	Average across 2028/29	00:28:52	00:28:46	- 00:06
	Percentage of Handovers over 45 Minutes	Average across 2026/27	0.0%	8.5%	8.53%								
	Percentage of Handovers over 15 Minutes					Mar-28	0.0%	24.2%	24.19%	Average across 2028/29	0.0%	13.7%	13.75%
	Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer for Children	Sep-26	95.0%	94.6%	-0.44%	Average across 2027/28	95.0%	95.0%	0.00%	Average across 2028/29	95.0%	95.0%	0.00%
3.3 Primary Care	Count of Pharmacy First Consultations	2026/27 Annual Total	206,118	223,488	8.43%								

3.5 Mental Health	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	Mar-27	0	0	0.0								
	Number of Children And Young People (0-17) accessing (1+ contact) mental health services (12-month rolling metric)	Mar-27	24,267	24,451	0.76%	Mar-28	24,267	24,451	0.76%	Mar-29	24,267	24,451	0.76%
	Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)	Mar-27	2,738	2,181	-20.34%	Mar-28	2,738	2,225	-18.73%	Mar-29	2,738	2,270	-17.09%
	Number accessing Mental Health Support Teams for Children And Young People (age 0-17) (12-month rolling metric)	Mar-27	5,524	10,987	98.90%	Mar-28	10,987	13,309	21.13%	Mar-29	13,309	16,361	22.93%
	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 month rolling metric)	Mar-27	53.6	40.0	-13.6	Mar-28	40.0	40.0	0.0	Mar-29	40.0	35.7	0.0
	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 month rolling metric)	Mar-27	106.3	75.0	-31.3	Mar-28	75.0	75.0	0.0	Mar-29	75.0	60.0	0.0
3.6 LDA	People with a learning disabiliy and autistic people in mental health hospital with the longest lengths of stay	Q4 2026/27	30.0%	19.0%	-11.03%	Q4 2027/28	11	9	-18.18%	Q4 2028/29	9	9	0.00%
	12-month admission rate for adults with a learning disability and autistic adults	Q4 2026/27	48.8	47.4	-1.4	Q4 2027/28	47.4	42.0	-5.4	Q4 2028/29	42.0	41.3	-0.7
	12-month admission rate for under 18s with a learning disability and autistic under 18s	Q4 2026/27	114.6	99.6	-15.0	Q4 2027/28	99.6	92.1	-7.5	Q4 2028/29	92.1	84.7	-7.5

	Reliance on mental health inpatient care for under 18s with a learning disability and autistic under 18s	Q4 2026/27	17	10	-41.2%								
	Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan	2026/27 cumulative total	72.6%	78.3%	5.76%	2027/28 cumulative total	78.3%	81.4%	3.06%	2028/29 cumulative total	81.4%	84.5%	3.17%

Appendix B – NOF Metrics – Areas for improvement

Metric for improvement	ICB actions in this area
% of eligible population supported by obesity programmes.	• **Data recording and reporting (NOF)** The ICB is working to the NOF technical definition of this indicator, which combines (a) eligible referrals into NHS and local authority weight management programmes and (b) starts on the Diabetes Prevention Programme. Work is underway to ensure consistent capture and reporting of referrals, eligibility and programme starts across primary care and partner systems (Q2 2026/27). • **Primary care delivery (QOF)** Implementing the new Obesity QOF in primary care, supported by clear guidance to GPs on identification, coding, and referral to onward programmes, to drive improved and more consistent referral rates (rolled out from Q1 2026/27). • **Trajectory and planning assumptions** Engaging with NHSE to confirm expectations on system trajectories between baseline and allocation, to inform local planning and performance management approach (confirmation expected Q2 2026/27). • **Improving referral quality and access** Updating GP guidance on available behavioural support programmes, including eligibility criteria, identification of suitable patients and referral routes, to increase appropriate uptake and reduce variation (Q2 2026/27). • **Service capacity and equity (Tier 3)** Reviewing the Tier 3 Specialist Weight Management Service to improve equity of access and ensure sufficient capacity to meet demand across Essex, with options being developed for implementation this year (in development, Q2–Q3 2026/27). • **Integrated pathway development with local authorities** Exploring joint commissioning opportunities with local authority public health partners to enable earlier access to appropriate pathways and more personalised, integrated support, improving overall pathway efficiency and outcomes (initial proposals in development during 2026/27).

% change in overall waiting list size vs previous year	• The ICB has committed up to £20m of additional funding to reduce waiting list size in Essex, including 7.5k more hospital capacity. • The ICB has launched new dermatology and MSK pathways in mid and south Essex to reduce referral volumes into hospital. We are looking to adapt specifications in west and north east Essex to align to those established in mid and south. • Indicative data from MSEFT indicates that the waiting list has reduced by c.3k between end March and end May (c.2%).
% patients who receive all 8 diabetes care processes	• **Measure and variation** The ICB is working to the national definition of the 8 diabetes care processes (QOF indicator DM037). Analysis across Essex shows variation in delivery, with stronger performance in areas where additional support and incentive schemes are in place. We are using this insight to inform a targeted approach to improvement. • **In-year action to address variation** The ICB is reviewing completion of the 8 care processes across Essex and developing a targeted proposal to improve performance in areas of greatest need and reduce unwarranted variation and inequalities in care (business case in development for Q2 2026/27). • **Primary care support and improvement approach** This includes consideration of how best to support primary care to deliver the QOF indicator consistently, including targeted support, education and potential local incentives aligned to need, to drive improvement within 2026/27. • **Data and population health management** Work is underway to strengthen use of population health management data to identify gaps in delivery, support practices to target cohorts at risk of missing care processes and improve consistency of coding and reporting. • **Longer-term cardiometabolic approach (PHIP alignment)** This work forms part of wider system plans to improve cardiometabolic outcomes, including diabetes, cardiovascular disease and obesity, through a more integrated prevention and long-term condition management approach as set out in the NHS

	Essex ICB Population Health Improvement Plan, with a focus on improving long-term condition management and reducing inequalities.
% patients rating their experience of GP access as good	• Indicator is multifaceted in its determinants. • Through the Primary Care Action Plan, the ICB will be undertaking a number of specific actions at both a pan Essex level (e.g. sharing good practice on triage models, promotion of Pharmacy First etc.) and actions targeted at outlier practices. • We have protected our Connected Pathways Team to spearhead this work programme. This team have a demonstrable track record of delivering improvements in outcomes/supporting Modern General Practice implementation in MSE – they will now cover an Essex footprint. • More broadly, through the PHIP, there are a number of transformative developments which will improve experience of primary care services
% patients with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance.	• The ICB has launched a 'CVD Lipids Initiate and Optimise' programme across mid and south Essex, building on the CVD detect and prevent programme which has underpinned improvement over the course of the past year on the detection and management of hypertension. Work is underway to explore further opportunities for CVD prevention across west and north east Essex.
% of patients over 14 years old on GP learning disability registers to receive a full physical health check and action plan in the last 12 months.	• The ICB launched a pilot in June 2026 with Hamelin Trust aimed at addressing poor uptake in learning disability health checks and to improve the quality of health action plans, initially focused in the Billericay and Tendring areas, this will be monitored and if successful at driving up both uptake and the quality and follow through of health action plans we will look to extend this.
% of children aged 9 and under prescribed antibiotics	• The ICB is applying a population health approach by using behavioural change training, supported by a decision-making template, to guide consultations and drive a shift in antibiotics prescribing habits. The impact of this intervention will be assessed using quantitative research, and the draft survey is scheduled to be piloted in June 2026.

	• The ICB is targeting the 'top 20' highest-prescribing practices with deep-dive audits and tailored peer support, with a view to expand this across the system. • The ICB is strengthening AMR leadership via Champions and promoting consistent use of the Ardens template to support evidence-based prescribing and reduce inappropriate antibiotic use in 0–9s. • The ICB has commissioned MOLES (Meds Op LES) with particular reference to AMS.
GP headcount per capita	• The Primary Care Training Hub has in place a number of schemes to increase GP headcount across both recruitment and retention. Core to this is the establishment of Learning Organisations and placements. This has rapidly expanded in the last four years. • Meetings have been held with the 10 outlier practices (GP/Patient Ratio) to discuss issues and concern and agree action plans to increase GP capacity (NB. In some cases, this is a data quality issue). • We are actively promoting the GP Reimbursement Scheme across General Practice. Strong engagement from practice so far. • NB. Currently West Essex and North East Essex core Primary Care Training Hub commissioned by NHS E resides with Central East and Suffolk and Norfolk ICBs. We are actively exploring how an Essex footprint might be achieved in a shorter timeline than the current national plan. • At an individual practice level, we have noted and are actively addressing with practices, data quality concerns. Significant outlier practices are subject to discussions led by our Connected Pathways Team. Those with ratios above 4k cannot utilise the GP Reimbursement Scheme until the Connected Pathways team is assured of the overall workforce plan for the practice.

ICB Board Meeting of 16 July 2026

Agenda Number: 8

Strategic Assurance Framework (Board Assurance Framework) Overview Report

Summary Report

1. Purpose of Report

1.1. The purpose of this report is to introduce the Strategic Assurance Framework (SAF), which has been developed by the Executive Committee to support the Board in overseeing delivery of the NHS Essex strategic objectives and to strengthen the Board's approach to strategic risk and assurance.

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 retain responsibility for ensuring it achieves its corporate objectives. The Audit, Risk and Compliance Committee are responsible for oversight of the system of internal control and the risk framework of the ICB.

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 / Financial Implications / Engagement

6.1. Not applicable.

7. Conflicts of Interest

7.1. None identified.

8. Recommendation/s

8.1. The Board is asked to note the report and use the framework to inform its assessment of the risks, controls and assurances presented throughout the remainder of the Board agenda.

Strategic Assurance Framework (Board Assurance Framework) Overview Report

1. Introduction

The establishment of NHS Essex as a single Integrated Care Board creates an opportunity to mature the way strategic assurance is presented to the Board. As the organisation evolves into its role as a strategic commissioner, the Board requires a framework that provides a clear line of sight between strategic ambitions, principal risks, delivery programmes, assurance arrangements and Board decision-making.

The Strategic Assurance Framework has therefore been developed to align the Board Assurance Framework with:

- The five NHS Essex corporate objectives. (see Appendix B)
- The Population Health Improvement Plan (PHIP).
- The nine strategic priority programmes for 2026/27. (see Appendix B)
- The Board's strategic risks and risk appetite.

Unlike traditional Board Assurance Framework reports, the Strategic Assurance Framework is designed to be embedded throughout the Board agenda rather than considered as a standalone item. This approach aims to ensure that discussion of strategic risks and assurance is directly linked to the detailed reports supporting delivery of each objective.

2. Main content of Report

Historically, Board reporting has often reflected organisational structures, programmes or statutory functions. While these remain important, they do not always provide a clear answer to the questions a Board should be asking:

- Are we on track to achieve our strategic objectives?
- How confident are we that delivery plans will achieve the intended outcomes?
- What are the principal threats to success?
- Is the assurance received proportionate to the level of risk?

As NHS Essex matures as a strategic commissioner, the emphasis of Board oversight must increasingly focus on outcomes, population impact, system leadership and strategic delivery. The Strategic Assurance Framework has therefore been developed to support a more outcomes-focused discussion and to strengthen Board-led scrutiny and challenge.

How the Framework Supports the Board

The Strategic Assurance Framework is intended to support Board members in forming their own judgement regarding:

- The likelihood of achieving strategic objectives.
- The adequacy of existing controls.
- The effectiveness of delivery programmes.
- The extent to which risks remain within the Board's agreed appetite.
- Whether further Board intervention, escalation or challenge is required.

The framework therefore does not replace detailed Board reports. Instead, it provides a consistent strategic lens through which those reports should be interpreted.

Integration Within the Board Agenda

The Strategic Assurance Framework has been deliberately structured to sit alongside the Board agenda rather than separate from it.

A Strategic Assurance Framework slide (assurance report) for each corporate objective will be positioned immediately before the detailed reports relevant to that objective.

For example:

Corporate Objective: A Decisive Shift Towards Neighbourhood Care Delivery and Prevention

The SAF Assurance Report at agenda item 10, precedes the Neighbourhood Health report so that the detailed Board report for the relevant area can be read in the context of the organisation’s risk and delivery profile for that area.

This ensures that strategic risks, key delivery programmes and assurance assessments are considered before the Board reviews the detailed evidence on which those assessments are based.

Appendix A provides an Executive Assurance Dashboard that summarises the key assessments and alerts from each corporate objective.

Alignment to the PHIP and Strategic Priorities

The framework aligns directly to the five NHS Essex corporate objectives and the PHIP delivery architecture. Each objective identifies the key PHIP programmes which contribute most significantly to delivery of the strategic outcome and therefore to achievement of the objective itself.

The nine strategic priorities for 2026/27 act as the principal delivery mechanism through which the objectives will be achieved. Consequently, Board reporting moves beyond monitoring individual programmes and instead focuses on whether these programmes collectively provide sufficient assurance that the strategic objective will be achieved.

Understanding the Strategic Assurance Framework

Each slide is designed to provide a concise one-page summary of the Board's strategic position for a specific corporate objective. Appendix C provides more specific detail on interpreting the SAF.

Risk Narrative

The risk narrative articulates the strategic risk, the key causes, and the potential consequences if the objective is not achieved.

PHIP Deliverables

These represent the most significant delivery programmes contributing to achievement of the objective and provide an assessment of delivery confidence for each programme.

The full PHIP programme is overseen by the respective programme boards overseen by the Executive Committee.

Alert, Advise, Assure, Celebrate (AAAC)

The Executive Team's strategic judgement is summarised through the AAAC framework:

- Alert – issues requiring intervention or posing a material threat to delivery.
- Advise – emerging risks, dependencies or decisions requiring Board awareness.
- Assure – evidence that controls, governance and delivery arrangements are operating effectively.
- Celebrate – significant milestones or achievements demonstrating progress.

Each judgement highlights the top 3 messages the Executive wish to highlight to the Board and is therefore not a comprehensive list of all issues currently experienced. This ensures the Board retain their strategic focus.

Statements should be 'action focussed' to facilitate Board understanding of the actions being taken to address the issues identified.

Leading Indicators

Leading indicators provide an early indication of whether delivery remains on track and are intended to complement rather than replace detailed performance reporting.

Assurance Narrative

The assurance narrative explains the rationale for the overall assurance assessment and provides context regarding the Executive Team's confidence in delivery.

Interpreting the Assessments

The framework distinguishes between delivery confidence and assurance level. Both the confidence and assurance level are measured at a point in time to determine the expected performance at that time, thus the levels of confidence do not reflect the final outcome of a three-year project, but rather whether the ICB is delivering the expected milestones of the project.

Delivery Confidence

Delivery confidence reflects the Executive Team's assessment of whether programmes, actions and interventions are likely to be delivered successfully.

A programme may demonstrate strong delivery confidence whilst uncertainty remains regarding achievement of the long-term strategic outcome.

Assurance Level

Assurance level reflects the extent to which evidence exists that the objective itself will be achieved.

This distinction is particularly important for long-term ambitions such as reducing health inequalities, where evidence of successful delivery may emerge significantly earlier than evidence of improved outcomes.

Trend

Trend reflects movement since the previous reporting period and provides an indication of whether confidence and assurance are improving, remaining

stable or deteriorating. As this is the first report, objectives are currently shown as baseline positions.

Risk Appetite

Each objective is also assessed against the Board's agreed risk appetite, helping Board members understand whether current levels of exposure remain acceptable or warrant additional intervention. The associated risk appetite (agreed by the Board) will be used to determine target risk scores for each objective, thus focussing the efforts of the Executive to perform within the risk appetite of the Board.

3. Findings/Conclusion

This Strategic Assurance Framework represents the first iteration of a revised approach to Board assurance, aligning oversight and scrutiny with the NHS Essex corporate objectives, strategic priorities and Population Health Improvement Plan. It is intended to support the Board in forming its own assessment of strategic risk, delivery confidence and the adequacy of assurance provided by the Executive, whilst providing a clearer line of sight between strategic objectives and the reports presented throughout the agenda.

As the framework is embedded, it is expected to evolve and mature over time in response to Board feedback, emerging organisational priorities and lessons learned from its application. The associated Board reports and supporting assurance arrangements will also continue to develop to ensure they provide the evidence and insight required to support this increasingly strategic and outcomes-focused approach to assurance.

Board Considerations

Board members are encouraged to use the Strategic Assurance Framework throughout the agenda to consider:

- Whether the assurance being presented is sufficient.
- Whether the reported level of confidence is reasonable.
- Whether the principal risks are adequately understood and managed.
- Whether additional assurance, escalation or intervention is required.
- Whether the organisation is making sufficient progress towards delivery of the PHIP and corporate objectives.

4. Recommendation(s)

The Board is asked to note the report and use the framework to inform its assessment of the risks, controls and assurances presented throughout the remainder of the Board agenda.

5. Appendices

Appendix A – Executive Assurance Dashboard (Board Overview)
Appendix B – Essex ICB Strategic Objectives and Strategic Priorities
Appendix C – Interpreting the SAF

Appendix A – Executive Assurance Dashboard (Board Overview)

Corporate Objective	Delivery confidence	Overall Assurance	Trend	Principle Risk Rating	Board Attention (AAAC)
1. Health inequalities narrowing year on year	MC / LC	MC	N	4 x 4 = 16	• Health outcome gaps remain stubborn in our most deprived communities. • Delivery remains dependent on system partners and wider determinants beyond direct ICB control. • Ockendon and Amos 2026 reports requiring improvements in Maternity services.
2. A decisive shift towards neighbourhood care delivery and prevention	MC / LC	MC	N	4 x 4 = 16	• Clarity from the ICB in our provider market commissioning intentions. • NHS Providers (including Primary Care) capability, capacity, readiness and ability to change, adapt to new models of care to lead neighbourhoods across Essex. • Risk that activity shifts more slowly than planned from acute to community settings.
3. Timely access and excellent outcomes across services	MC / HC	MC	N	4 x 4 = 16	• Working with providers to meet demand growth that continues to place pressure on waiting times and service standards at pace. • Identifying where long waits increases risk to patient outcomes and experience. • Managing intractable variation between services and providers, leading to persistent health inequalities.
4. Financially and clinically sustainability services across Essex which are safe and high quality	MC / HC	MC	N	4 x 4 = 16	• Delivery of financial plans remains challenged whilst balancing transformation against recovery. • Operating in an environment of national uncertainty impacts pace of change. • Service review activities may lead to unknown quality risks being surfaced leading to enhanced scrutiny and ability to deliver pace of change required.
5. An organisation that is up to the job, good to work for and good to partner with	MC / HC	MC	N	4 x 4 = 16	• Need to ensure that organisation is sufficiently focused on priorities to deliver with limited capacity post change process. • Workforce retention and capability remain critical risks. • Targeted development required to increase strategic commissioning capabilities

Appendix B – Essex ICB Strategic Objectives and Strategic Priorities

Strategic Objectives

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

Strategic Priorities

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

Appendix C – Interpreting the SAF

BAF Heading	Definition
Assurance Assessment	Describes overall assurance level, the trend (movement from the previous meeting), and whether the risk is within or outside the Board risk appetite.
PHIP Deliverables	3-5 delivery programmes linked to the achievement of the objective (as outlined within PHIP and of the nine strategic priorities).
Alert	Action statements describing strategic issues requiring intervention / key threats to delivery of the objective.
Advise	Emerging risks or issues, dependencies or decisions that the Board should be aware of.
Assure	Evidence that controls, governance and delivery arrangements are working.
Celebrate	Notable achievements or milestones
Leading Indicators	3-5 metrics only to track delivery of the objective.
Assurance Narrative	A short paragraph describing the rationale for the assurance rating.

Delivery Rating	RAG	Definition	Typical Characteristics
High Confidence	H	The objective is **highly likely to be achieved** within planned timescales and resources	Delivery milestones are on track; performance indicators are favourable; risks are controlled and within appetite; dependencies are being effectively managed
Moderate Confidence	M	The objective **remains achievable**, but there are material risks, issues or dependencies that require active management	Some milestones are delayed or under pressure; performance is mixed; certain risks remain outside appetite; corrective actions are in place
Low Confidence	L	**Significant concerns** exist regarding achievement of the objective and substantial intervention may be required	Multiple milestones are off track; performance is deteriorating; major risks or dependencies threaten delivery; existing mitigations may be insufficient
Very Low Confidence	VL	The objective is **unlikely to be achieved** in its current form without fundamental change, additional resource, or Board intervention	Major delivery failure risk; significant programme slippage; key dependences unresolved; objectives, scope or timescales may need to be reconsidered

Assurance Level	RAG	Definition	Board Interpretation
High Assurance	H	Strong evidence that the **objective will be achieved**. Risks are controlled and assurance sources are consistent	Board can be confident delivery is on track
Moderate Assurance	M	**Reasonable confidence**, but some significant risks, gaps or dependencies require management attention	Objective remains deliverable but needs monitoring.
Limited Assurance	L	**Significant concerns** regarding delivery, controls, performance or assurance	Board intervention or additional oversight may be required.
No Assurance	N	**Insufficient evidence to conclude** the objective is likely to be achieved	Immediate action required

Trend Status	RAG
Improving	▲ I
Stable	▶ S
Deteriorating	▼ D
New / Baseline	N

NHS Essex

Strategic Assurance Framework Report

(Board Assurance Framework)

16 July 2026

1. Health inequalities narrowing year on year

Risk Narrative: Datix Risk Ref: TBC	There is a risk that the Essex ICB does not achieve its strategic objective of narrowing health inequalities year on year. This is caused by the scale and complexity of inequalities across Essex, variation in access and outcomes between communities, dependence on partner action across the wider system, and insufficient pace or effectiveness of PHIP delivery programmes targeted at populations experiencing the greatest disadvantage. This could lead to worsening inequalities in life expectancy, premature mortality and healthy life outcomes, failure to deliver PHIP ambitions, increased demand for healthcare services, and reduced confidence from patients, partners and regulators in the ICB's ability to improve population health.
Risk Owner/Lead:	Beverley Flowers, Executive Director of Neighbourhood Health Dr Matthew Sweeting, Executive Medical Director Cross cutting objective applies to all Executive Directors
PHIP Deliverables and RAG Status: **Link to:** 5. Convener Model 2. INT development	Integrated neighbourhood team support to priority cohorts **LC** Improve secondary prevention measures, e.g. Cardiometabolic **MC / LC** 'Workwell' approach across Essex **MC** Earlier diagnosis of cancers **MC** Improved community Mental Health services **MC**

Current Risk Score: (impact x likelihood) **Target Score** **Risk Appetite Category**	**4 x 4 = 16 (Red)** **4 x 2 = 8 (Amber)** **Quality: 4 (Seek)** **Regulatory: 3 (Open)**
Directorate: Board Committee:	Neighbourhood Health (NH). NH Committee / Health Inequalities Group
Overall Assurance Level: Trend: Risk Appetite Position:	**Assessment:** **MC / LC** **N** Outside Appetite

Alert

- Health outcome gaps remain stubborn in our most deprived communities.
- Delivery remains dependent on system partners and wider determinants beyond direct ICB control.
- Ockendon and Amos 2026 reports requiring improvements in Maternity services.

Advise

- The emerging Health Inequalities Group presents an opportunity to strengthen system coordination.
- Neighbourhood Health Centre development provides a vehicle of targeted interventions.
- Need to ensure patient voice, VCSFE, complaints, lived experience and population intelligence are effectively triangulated.

Assure

- PHIP includes dedicated inequalities outcomes and Core20PLUS5 priorities.
- Population health intelligence arrangements continue to mature.
- Governance arrangements through the NH Committee and PHIP programme structures are strengthening.

Celebrate

- Secured funding for the Workwell programme £6m delivery over next three years, commencing November 2026.
- Health inequalities embedded as a strategic objective within PHIP.
- Greater alignment between neighbourhood, prevention and inequalities programmes.

Leading Indicators	Target	RAG
Premature mortality inequality gap.	XX%	**LC**
Core20PLUS5 Performance.	XX%	
Reduction in access inequalities	XX%	
Screening and Vaccination uptake in deprived communities	XX%	

Assurance

Moderate assurance is provided through established governance arrangements, PHIP delivery programmes and emerging population health intelligence. While programmes are in place, achievement of measurable reductions in inequalities remains dependent on long-term system action and broader social determinants.

Strategic Assurance Framework Report

(Board Assurance Framework)

16 July 2026

2. A decisive shift towards neighbourhood care delivery and prevention

Risk Narrative: Datix Risk Ref:	There is a risk that the ICB does not achieve a decisive shift towards neighbourhood care delivery and prevention. This is caused by the scale of service transformation required, competing operational pressures, workforce and financial constraints, and an inability to move activity, resource and investment from reactive hospital-based care into proactive neighbourhood and preventative services. This could lead to missed opportunity on improving population health outcomes, continued growth in demand for acute services, reduced financial sustainability, and failure to deliver the intended benefits of the PHIP.
Risk Owner/Lead:	Beverley Flowers, Executive Director of Neighbourhood Health
PHIP Deliverables and RAG Status:	Develop Essex-wide Frailty case management approach **MC** Develop Neighbourhood Health service model **MC / LC** Community Commissioning Review **MC / LC** Strengthen access and capacity in Primary Care and access to dentistry **MC** Outpatient left shift plan for agreed specialties **LC** Increase capacity for community urgent care services **MC**

Current Risk Score: (impact x likelihood) **Target Score** **Risk Appetite Category**	**4 x 4 = 16 (Red)** **4 x 3 = 12 (Amber)** **Quality: 4 (Seek)**
Directorate: Board Committee:	Neighbourhood Health (NH). NH Committee / NH Programme Board
Overall Assurance Level: Trend: Risk Appetite Position:	**Assessment:** **MC** **N** Outside Appetite

Alert

- Clarity from the ICB in our provider market commissioning intentions.
- NHS Providers (including Primary Care) capability, capacity, readiness and ability to change, adapt to new models of care to lead neighbourhoods across Essex.
- Risk that activity shifts more slowly than planned from acute to community settings.

Advise

- Community Commissioning Review will be a critical enabler of future neighbourhood models, Community provider sustainability and capacity should be monitored closely.
- Sustainability of Hospice provision remains under review.
- Neighbourhood Health Centre programme remains dependent on estate and capital delivery.

Assure

- On track to complete move to new place structures from previous Alliances.
- Integrated Neighbourhood Team (INT) development is progressing across Essex, taking examples of best practice (National Neighbourhood Health Implementation Programme (NNHIP)).
- Better understanding of current investment patterns provides a stronger baseline for transformation, including agreement of Better Care Fund.

Celebrate

- National team positive feedback on strong foundations for NH model following creation of the new Essex ICB.
- Neighbourhood Health Centres Plan submitted.

Leading Indicators	Target	RAG
Reduction in non-elective admissions.	XX%	**LC**
Growth in NH service capacity and activity.	XX%	
% of patients with urgent need seen on the same day (General Practice).	90%	**MC**
% shift of expenditure from acute to NH settings.	XX%	
Delivery of INTs and neighbourhood care models.	XX%	

Assurance

Moderate assurance is provided through clear strategic intent, active programme delivery and improving governance arrangements. However, realisation of benefits remains dependent on transformational change, readiness of Providers, workforce availability and successful transfer of activity and investment from traditional models of care.

NHS
Essex
Integrated Care Board

ICB Board Meeting, 16 July 2026

Agenda Number: 11

Neighbourhood Report (Primary Care / Alliances)

Summary Report

1. Purpose of Report

To provide assurance to the Board on progress in delivering the Neighbourhood Health strategic objective and associated commitments within the Population Health Improvement Plan (PHIP), Operational Plan and National Oversight Framework.

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

Neighbourhood Health Committee.

5. Impact Assessments / Financial Implications / Public Engagement or Consultation

Not applicable to this report.

6. Conflicts of Interest

None identified.

7. Recommendation/s

The members of the Board are asked to note the assurances provided in this report.

Neighbourhood Report (Primary Care / Alliances)

1. Introduction

The purpose of this report is to provide assurance to the Board regarding the development of the Neighbourhood Directorate and progress in delivering the Board's strategic objective of a decisive shift towards neighbourhood care delivery and prevention.

The report provides an overview of the governance arrangements, programmes and partnerships established to support delivery of those elements of the Population Health Improvement Plan (PHIP) that relate to Neighbourhood Health. It also describes progress against key commitments within the NHS Essex Operational Plan and the development of programmes intended to improve performance against relevant National Oversight Framework (NOF) measures and population health outcomes.

The report is intended to provide assurance that appropriate arrangements are in place to support delivery of the Neighbourhood Health objective, that programmes remain aligned to the PHIP, Operational Plan and wider organisational priorities, and that progress is being made towards achieving improved outcomes, reducing health inequalities and delivering more integrated care closer to home for the people and communities of Essex.

Achievements to date: June 2026

The Directorate has continued to make progress in establishing the core foundations required to support the delivery of Neighbourhood Health across Essex. The following section provides assurance that the Directorate remains on plan in developing its neighbourhood model.

Directorate Capacity:

The Directorate has established its core leadership and programme capacity required to support delivery of its work programme. Recruitment to Neighbourhood Locality Clinical Lead roles is in progress and will further strengthen clinical leadership and engagement at neighbourhood level.

Neighbourhoods:

The agreed neighbourhood footprints have been mapped by GP practice and Lower-Layer Super Output Area (LSOA), defining single neighbourhood populations and providing consistent geography for planning, performance monitoring and population health management across Essex. A map of the neighbourhood footprints is shown in Appendix 1.

This represents a significant milestone, enabling population health, activity and outcome data to be aligned consistently at neighbourhood level and providing the foundation for future performance reporting, resource allocation and service planning.

General Prioritisation Neighbourhood Framework

A neighbourhood-level prioritisation framework has been developed providing a data-driven comparative view of population need across Essex ICB neighbourhoods.

The framework provides a simple, evidence-based way to compare all neighbourhoods across Essex and understand where investment, service redesign and Left Shift will have the greatest impact. It brings together a wide range of information, including levels of deprivation, long-term conditions, emergency demand, access barriers (such as transport and digital exclusion), and population size and growth, into a single priority score for each neighbourhood. This gives the system a clear, consistent view of where underlying need is highest and where neighbourhood-based care could most improve outcomes and reduce pressure on other services.

The framework will be used to guide strategic planning and investment decisions at a neighbourhood or multi-neighbourhood level to identify where interventions are most likely to improve outcomes, reduce inequalities and support delivery of neighbourhood-based care. It is a baseline tool to give a clear, data-driven foundation for planning neighbourhood-level transformation across the system and supporting fair, transparent decision-making, underpinning the delivery of the PHIP and Neighbourhood Health strategy. The framework will need to be interpreted alongside local insight, estates, finance and workforce considerations.

Neighbourhood Health Committee:

The Neighbourhood Health Committee held its inaugural meeting on 18 May 2026 and has begun providing strategic oversight of the Neighbourhood Health agenda on behalf of the Board.

The key outcomes of the meeting included:

- Agreed to establish a structured programme of Neighbourhood Health seminars/deep-dives (covering areas such as primary care services, data, estates, primary care performance and variation, including metrics and benchmarking) in non-committee months.
- Approved Primary Care Commissioning Group (PCCG) Terms of Reference
- Supported the Neighbourhood Health Centre submission in principle, noting the early stage of development and the need for ongoing iteration as further national guidance and local analysis emerge.
- Noted escalations from PCCG including a Partnership Dispute in North East Essex. It was confirmed that a detailed report, supported by legal advice, would be presented to Executive Committee and an extraordinary PCCG meeting for decision.

There were no items of escalation to alert to the Board.

Neighbourhood Programme Board:

The Neighbourhood Programme Board has been established to provide co-ordination and delivery oversight for key neighbourhood programmes.

The inaugural meeting took place on 28 May 2026 to consider its terms of reference and how it links to enabler functions e.g. Contracts/Communications Team.

The Board approved its first business case, supporting an extension to the Community Assessment and Treatment Centre contract in Epping funded through the Better Care Fund (BCF).

The Board also agreed an approach to the development of outcome measures and proxy indicators, supporting future performance monitoring and assurance reporting.

Better Care Fund (BCF) 2026/27:

Work is taking place between the three Place Associate Directors and Essex County Council to review the existing posts that are jointly funded via the Better Care Fund to see how there can be greater integration and alignment to support the delivery of the Neighbourhood work at Place.

At time of preparing the report formal approval of the BCF submissions from NHS England was awaited.

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

North East Essex have approved their operating model, which has been shared with Partners; work is progressing on the mobilisation plan.

West Essex work remains focused on the frailty cohort, with additional investment supporting expansion of proactive care capacity through recruitment of additional case managers. Recruitment for these is underway by EPUT.

These programmes continue to provide valuable learning and practice experience that will inform the wider development of Neighbourhood Health across Essex.

National Primary Care Network Pilot:

In North East Essex there are three Primary Care Networks (PCNs) which are part of the national pilot programme. On 17 June 2026, Professor Claire Fuller visited to understand the progress of the National PCN Pilot sites.

Work is underway to share the learning from this pilot to inform next year's enhanced primary care offer.

Neighbourhood Directorate Quarter One Plan: June 2026 update.

The following update provides assurance regarding progress against the Directorate's quarter one priorities and the development of the programmes required to support delivery of the Neighbourhood Health objective, relevant PHIP commitments and Operational Plan requirements.

Neighbourhood Health:

With the forming of the new Directorate, the intention for quarter one 2026/27 has been to transition the legacy Alliance Governance to the new Essex Neighbourhood governance by the end of quarter two.

During June 2026, the three Neighbourhood Place teams have held workshops with partners to begin to progress to the new governance arrangements which should be ready for the planned September 2026 launch. These meetings will support oversight, accountability and delivery through reporting to the Neighbourhood Health Committee.

Further workshops are planned for July 2026 to finalise governance arrangements and support transition to the new operating model.

Primary Care:

Primary Care Action Plan:

The ICB has submitted its response to the Primary Care Action Plan. This sets out how the ICB intends to deliver national requirements set out by NHS England to improve access and sustainability of primary care services. Implementation has commenced and feedback from NHS England on our proposed approach is awaited.

The Action Plan provides an important delivery mechanism for several PHIP and Operational Plan priorities and will support future improvements in access, experience and outcomes across primary care services.

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

Dental

- Urgent and unscheduled care access
- Maximising and optimising use of dental resources
- Implementing contract reforms.
- Support for SEND pupils in a residential and day special educational settings.

Optometry

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

GP Reimbursement Scheme

In June 2026, the ICB was able to roll-out the GP Reimbursement Scheme to practices. This national scheme uses money previously aligned to the Capacity and Access Improvement Payments (Network Direct Enhanced Service (DES)). It provides funding at practice level for the reimbursement of additional GP capacity. Through our Connected Pathways team, the ICB is meeting with those practices with the highest patient to GP ratios to ensure that they have a general plan for workforce development.

This work is intended to support improved access to primary care services and address variation in workforce capacity across Essex.

Premises Development

The Estates Team, Neighbourhood Team and Primary Care Team are working through a prioritisation process for the investment in primary care premises. This work will include the engagement with general practice. The aim of this exercise will be to determine priorities for investment into primary care estate (alongside the development of Neighbourhood Health Centres). A workshop is planned for July 2026.

This work will help ensure future estates investment is aligned to population need, neighbourhood development priorities and the emerging Neighbourhood Health Centre Programme.

New commissioning approaches

The Neighbourhood Health Committee Seminar meeting in June focussed on the development of our approach to commissioning new services in a primary care setting. Discussion considered a range of commissioning approaches and opportunities to broaden engagement with provider representation from across the system.

Collective Action

The ICB has received standard letters from 20 practices across Essex regarding potential withdrawal from data sharing agreements. This follows the British Medical Association (BMA) discussions regarding Collective Action. The ICB has provided a standard response to this and continues to monitor the situation. The ICB has identified potential risks particularly around the development of Integrated Neighbourhood Teams and case-finding should practices withdraw from Data Sharing Agreements. Mitigation actions are being considered with a further report being presented to the Executive Committee in July.

At this stage, impacts remain manageable; however, the position continues to be actively monitored given the potential implications for neighbourhood working and integrated care delivery.

Consultations

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

April Consultation (NHS Digital)	April 2025 (thousand consultations)	April 2026 (thousand consultations)
Essex ICB	861	929

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

April 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**
Essex ICB	44.6%	7.6%	16.5%	12.2%	19.1%

Overall consultation activity continues to increase and access performance shows signs of improvement. These trends provide early assurance that activity and capacity across primary care remain sufficient to respond to growing demand.

Dental Services

Unscheduled Care

The dental team have taken the necessary contractual action to ensure we comply with the national contractual change protecting 8.2% of contracted activity for the delivery of unscheduled care. This sits alongside the ICB's

Urgent Access Scheme which aims to improve access by increasing provision in the evenings and at weekends/bank holidays.

These arrangements support improved patient access whilst ensuring compliance with national contractual requirements.

Quality Improvement

The ICB is working with the Local Dental Committee and others to ensure a process is in place for the Quality Improvement elements of contractual reform. To support this, alongside our wider dental programme, the ICB has appointed a Dental Professional Advisor.

The appointment strengthens clinical leadership and supports implementation of contractual reform and service improvement priorities.

110% Activity

The ICB is seeking to make provision that will enable our dental and orthodontic providers to deliver up to 110% of contracted activity in 2026/27. This is an approach that predecessor organisations put in place and appears to maximise available capacity and improved access to dental services across Essex.

Community Pharmacy

Community Pharmacy Contractual Framework (CPCF)

In June, the 2026/27 CPCF was published. Key changes include:

- 10.3% (£340m) funding uplift to £3,636 million for the CPCF and Pharmacy First budgets (which will be combined).
- That includes a £200m uplift to retained margin to £1.1bn.
- Plus, a write-off of net over-delivery of contract funding (margin) earned up to the end of 2025/26 – up to £239m.
- The Single Activity Fee will increase to £1.52.
- Independent Prescribing to be added to Pharmacy First in the autumn.
- £20m Pharmacy Quality Scheme with 80% Aspiration payment payable on 1 September 2026.
- Agreement to allow late payment claims for Pharmacy First and New Medicine Service (NMS)
- Pharmacies to be able to close for training for up to 4 hours a month.
- A reform agenda to inform a Community Pharmacy Strategy.

Community Pharmacy Prescribing Services

A national update on the implementation of independent prescribing within community pharmacy was provided by NHS England in mid-June. This set out the ambition to launch community pharmacy prescribing services from Autumn 2026 (Oct target). This is backed by £10m of investment nationally alongside new pathways, prescribing management functions and a competence framework and specification. ICBs will be provided with up to £50k to support

the roll-out and early adoption of this programme. The ICB has established a Community Pharmacy Transformation Group to oversee the implementation of this programme locally and support early adoption of the new service model.

The programme represents a significant opportunity to increase prescribing capacity within neighbourhood settings and support more integrated primary care delivery.

Community and Neighbourhood Development:

WorkWell

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 has secured full three-year funding, with progress continuing at pace to move towards delivery.

Work is ongoing with the Department for Work and Pensions and system partners to refine the Essex approach ahead of the national delivery framework. This includes ensuring alignment with existing employment, health and wellbeing programmes across Essex, building on the established system-wide approach to programme integration to ensure complementary delivery and avoid duplication.

Early mobilisation planning has commenced to support a coordinated and deliverable model. Nationally, some areas have reported challenges in procurement and mobilisation; however, early planning in Essex positions the system well to move forward at pace.

Subject to final confirmation of the national template, a full delivery plan will be developed over the coming months, with mobilisation on track to commence from November, in line with national expectations and to maximise opportunities to improve employment and health outcomes.

Health Inequalities & Prevention

The team is focusing on improving delivery against the key NOF indicators and understanding and tackling variation across Essex. Collectively, these programmes support a more coordinated, population health-based approach to prevention and are expected to contribute to improvements in the NOF outcomes over time.

- **Weight management:** Strengthening the local offer and increasing access to evidence-based obesity programmes, aligned to prevention priorities and population need.
- **Diabetes:** Progressing system actions to improve delivery of the eight care processes, reducing unwarranted variation and supporting more consistent, proactive management of long-term conditions

- **Cardiovascular Disease (CVD):** Targeted work to improve CVD outcomes is progressing in line with NOF indicators.
- **Hypertension:** Performance is above the England average (70.5% vs 69.5%), with significant improvement in system ranking from 41st (March 2024) to 11th (December 2025).
- **Lipid management:** Treatment coverage is strong (85.6% vs 85.4% nationally); however, optimisation remains a key gap, with only 48.9% of patients achieving target cholesterol levels (below 50.6% nationally, December 2025).
- **Primary prevention:** Slightly below the England average (62.5% vs 64.3%, December 2025), indicating further opportunity for early intervention.

Alongside this, work is progressing to strengthen clinical leadership and support a more integrated, cardiometabolic approach, including:

- Aligning programmes across diabetes, weight management and related long-term conditions (e.g. chronic kidney disease (CKD))
- Enabling a more coordinated, population-focused approach to prevention
- Supporting more joined-up delivery and improved outcomes across key risk factors.

Community Commissioning (Pan-Essex)

The Community Services Review continues as a strategic assessment of community-based health services across Essex, aligned to the NHS Long Term Plan, Medium-Term Plan and the Neighbourhood Health Framework. The review is focused on ensuring services are clinically sustainable, responsive to population health needs and deliver value for money, while supporting integrated neighbourhood models and reducing unwarranted variation.

Progress since last report includes:

- Executive Committee approval secured for the review scope and programme plan.
- Internal engagement completed (May 2026), establishing shared understanding of scope, priorities, and key dependencies across the system.
- Stakeholder engagement commenced (June 2026), setting the strategic context and testing risks, opportunities and delivery considerations with partners.
- Baseline review underway across approximately 129 core service specifications within the three Essex community health service contracts.

Next steps:

- Complete baseline review and data collection phase.
- Develop initial findings on variation, opportunities and potential early improvements.
- Identify opportunities to strengthen prevention, neighbourhood care and population health outcomes through future service models.

- Continue structured internal workshops to evaluate emerging findings and maintain alignment across workstreams.
- Undertake further stakeholder engagement to inform future commissioning options and service model development.

In parallel, work is underway to establish a consistent Essex-wide baseline across priority community services, including hospice, equipment and wheelchair provision. This will inform future commissioning decisions and support a more equitable and joined-up approach to access and service delivery across the system.

Progress remains aligned to the agreed programme plan and no significant delivery issues requiring escalation have been identified at this stage.

Neighbourhood Health Centres

Essex ICB submitted the Essex-wide Neighbourhood Health Centre (NHC) proposal to NHSE, setting out 14 potential NHC sites across all geographies in Essex. This was shaped through strong multi-disciplinary input from the ICB-, estates, finance, primary care, unplanned and planned care, mental health and strategy- and informed by population need and local insight from PCNs and partners. The submission received strong support from local partners and stakeholders.

This remains an early iteration, with schemes at a formative stage. Assumptions on cost, deliverability, activity and workforce are continuing to be refined, alongside more detailed neighbourhood-level analysis and development of the neighbourhood service model, including the ‘left shift’ approach.

There are several areas now progressing as part of the next phase, particularly developing the pipeline and timeframes for delivery, clarifying funding and affordability assumptions and strengthening alignment across all ICB delivery programmes to ensure a coherent estate and service offer. The focus now is to move from concept to planning and then deliverability, including further developing the clinical and service model, progressing site identification and estates options, understanding workforce implications, and further developing the prioritisation framework to support model development and decision making.

Overall, we have a strong Essex position with good system engagement, and a clear plan to further develop this into a deliverable and sustainable programme. We expect to receive further information from NHSE in the summer but will be further developing and refining plans locally in the meantime.

Delivery confidence remains moderate, reflecting the early maturity of the programme and the dependency on further national guidance regarding funding and prioritisation.

Appendix 2 – Letter to Stakeholders

Dashboard and Reporting:

Work is underway to develop a Directorate performance dashboard which will be presented to future meetings of the Board. This will provide assurance regarding delivery against Directorate objectives, National Oversight Framework metrics and operational planning requirements.

The proposed measures are:

- Improved access to primary care.
- Improved experience of accessing GP services.
- Reduced waits for community services
- Increased 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 numbers on the frailty register.
- Reduced avoidable emergency admissions for people aged over 65.
- Increased achievement of preferred place of death.
- Increased numbers recorded on end-of-life registers.

2. Findings/Conclusion

The Directorate has made good progress during Quarter 1 in establishing governance arrangements, including setting up and holding the inaugural meeting of the Neighbourhood Health Committee and Neighbourhood Programme Board, strengthening system partnerships and progressing key programmes supporting the strategic objective of a decisive shift towards neighbourhood care delivery and prevention.

Significant progress has also been made in relation to the Community Services Review, Primary Care Action Plan, Neighbourhood Health Centres programme and the development of a population health-based prioritisation framework.

Work is now underway to develop a comprehensive performance and assurance dashboard, which will support future Board reporting by providing greater visibility of delivery against agreed objectives, outcome measures and operational plan requirements.

No significant issues requiring Board escalation have been identified at this time.

3. Recommendation(s)

The members of the Board are asked to note the assurances provided in this report.

4. Appendices

Appendix 1 – Neighbourhood Footprint Map

Appendix 2 – Letter regarding Neighbourhood Health Centres in Essex

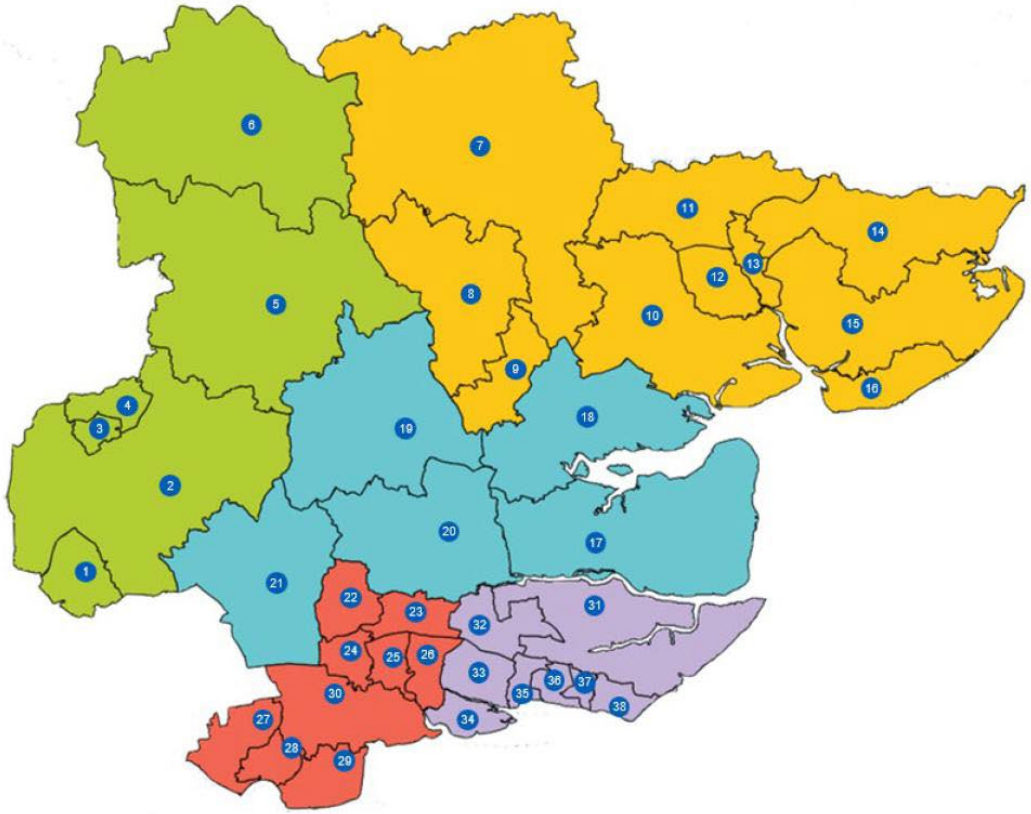
Appendix 1 – Neighbourhood Footprints Map

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

1. Loughton, Buckhurst Hill and Chigwell
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

ICB multi-neighbourhood contracts, unitary councils, convener model

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



Chief Executive
eicb.chiefexecutive@nhs.net

3 June 2026

NEIGHBOURHOOD HEALTH CENTRES IN ESSEX

I wanted to write to update you regarding the national expression of interest process for Neighbourhood Health Centres which was submitted to NHS England and the Department of Health and Social Care (DHSC) on 28 May.

Thank you to everyone who offered ideas for potential sites and for colleagues across local government, stakeholders and elected members who offered letters of support to demonstrate the strength our joint commitment to make the NHS better in Essex.

What happens next

We do not know what the timescales are for any next steps or when a decision will be made by NHS England and Department of Health and Social Care on the submissions that all ICBs in England will have made.

As soon as we have further detail on the process we will let you know.

What did we submit

As you know, we are focused on 1 “anchor” site of a core+ or core++ in each of our 5 multi neighbourhood areas (Table A below). We have also identified a further 9 core and core+ sites (Table B). Our work was based on where we have logical estate opportunities which aligned to identified patient need. This was not a perfect process, given the timescale, so I am sure there will still be revisions to be made.

However, we are confident that our plans are reasonable and not excessive, clearly link to need, and have broad support from the community, local government and beyond. As part of this process, we also received many submissions from PCN’s and other partners to enhance local service offers. We are reviewing all these proposals and will be responding to everyone in the coming weeks.

Table A – Anchor Sites

- St Peter’s Hospital, Maldon
- Clacton Hospital
- Southend High Street
- Thurrock Community Hospital
- St Margaret’s Hospital, Epping

Table B – Other sites included within the submission

- Brentwood Community Hospital
- Chelmsford High Street
- Turner Road Primary Care Centre, Colchester
- Braintree Community Hospital or Manor Street Livewell Hub
- Fryatts and Mayflower Medical Centre, Harwich
- Canvey Primary Care Centre
- Pitsea
- Harlow High Street
- Saffron Walden Community Hospital

Although there has been significant focus on this submission over the last two months due to the national deadline, there is much else we know we need to progress in terms of improving NHS community and primary care estate across the county. We know that we need to do better at engaging in new ideas from partners and building infrastructure faster and this process has identified a number of additional opportunities which we are exploring.

For any questions, the best point of contact remains our neighbourhood assistant directors;

- West and north-east Essex (including Braintree): Karen Wesson (karenwesson@nhs.net)

- South-east and Mid Essex (including Brentwood): Jennifer Speller (jenniferspeller@nhs.net)

- South-west Essex: Lynn Stimson (lynn.stimson3@nhs.net)

Thank you again, and we look forward to continuing to work with you.

Yours sincerely,

Tom Abell
Chief Executive

Strategic Assurance Framework Report

(Board Assurance Framework)

16 July 2026

3. Timely access and excellent outcomes across services

Risk Narrative: Datix Risk Ref:	There is a risk that that Essex ICB does not commission and transform services to ensure timely access and excellent outcomes across services. This is caused by changing demand for healthcare services, capacity constraints to deliver multiple programmes of change with provider organisations, long-standing intrinsic variation in service performance, and regulatory oversight requiring involvement of ICB teams. This could lead to patients experiencing delays in access to care, poorer clinical outcomes and patient experience, and a failure to achieve expected standards to address inequality gaps in access and outcomes, reducing confidence of patients, partners and regulators in Essex health and care system.
Risk Owner/Lead:	Sam Goldberg, Executive Director of Performance and Planning Dr Giles Thorpe, Executive Chief Nursing Officer
PHIP Deliverables and RAG Status: **Link to:** 2. NH Community Commissioning Review / Strengthen Primary Care	Reduction in long waiting lists for elective care (all age) **MC** Improvements & left shift for priority elective pathways (focus on OPs) **MC** Implementation of agreed cancer recovery plans **HC** Increase community diagnostics through CDCs and NHCs **HC** Support delivery on ERP for children and young people **MC** Implement the SEND Quality Assurance framework **MC**

Current Risk Score: (impact x likelihood) **Target Score** **Risk Appetite Category**	**4 x 4 = 16 (Red)** **4 x 2 = 8 (Amber)** **Quality: 4 (Seek)** **Regulatory: 3 (Open)**
Directorate: Board Committee:	Strategy Commissioning, Quality and Resource Committee
Overall Assurance Level: Trend: Risk Appetite Position:	**Assessment:** **MC** **N** Outside Appetite

Alert

- Working with providers to meet demand growth that continues to place pressure on waiting times and service standards at pace.
- Identifying where long waits increases risk to patient outcomes and experience.
- Managing intractable variation between services and providers, leading to persistent health inequalities.

Advise

- Managing increased scrutiny on maternity, neurodevelopmental pathways and mental health services requires continued focus.
- Service reviews in dermatology, ophthalmology, urgent care and community services may identify unknown quality/outcome issues affecting pace of redesign.
- National expectations continue to evolve, requiring focus of internal teams.

Assure

- Multiple improvement programmes in place across elective, cancer, diagnostics and mental health pathways.
- Commissioning concluded to increase provider capacity to support diagnosis & treatment for ASD and ADHD.
- Dermatology and Musculoskeletal (MSK) re-procurements starting to realise benefits to improve access to services.

Celebrate

Notable achievements. Maximum 3

- Local Area Inspections for SEND concluded across all 3 UTLAs, and Local Area SEND Reform Plans submitted.
- Progress on Talking Therapies procurement and pathway redesign.
- Concluded re-organisation of All Age Continuing Care teams by pathway areas improving responsiveness and compliance

Leading Indicators	Target	RAG
Delivery of National Access Standards	XX%	**LC**
Reduction in Long Waits	XX%	
Reduction in diagnostic waiting times	XX%	
Patient Outcomes	XX%	
Patient Experience and Access	XX%	
PHIP Access and Outcomes Programme Delivery	XX%	

Assurance

Moderate assurance is provided through active recovery programmes, strengthened governance and focused performance oversight. However, achievement of sustainable improvements remains dependent o managing increasing demand, workforce pressures and provider capacity constraints.

ICB Board Meeting of 16 July 2026

Agenda Number: 13

The Lampard Inquiry Update

Summary Report

1. Purpose of Report

1.1. To update the ICB Board on the ICB arrangements and progress for continued support to The Lampard Inquiry.

2. Executive Lead

2.1. Dr Matthew Sweeting, Executive Medical Director.

3. Report Author

3.1. Phil Read, Associate Director of Delivery.
Olivia Burrows, Lampard Project Manager.

4. Responsible Committees

4.1. Essex ICB Executive Committee.

5. Link to the ICB's Strategic Objectives

6. Financially and clinically sustainable services across Essex which are safe and high quality.

7. Impact Assessments / Engagement

7.1. Not applicable.

8. Financial Implications

Legal and programme costs within allocated budget.

9. Conflicts of Interest

9.1. None identified.

10. Recommendation/s

10.1. The Board is asked to note the content of this report and the arrangements supporting the ICB's ongoing response to The Lampard Inquiry.

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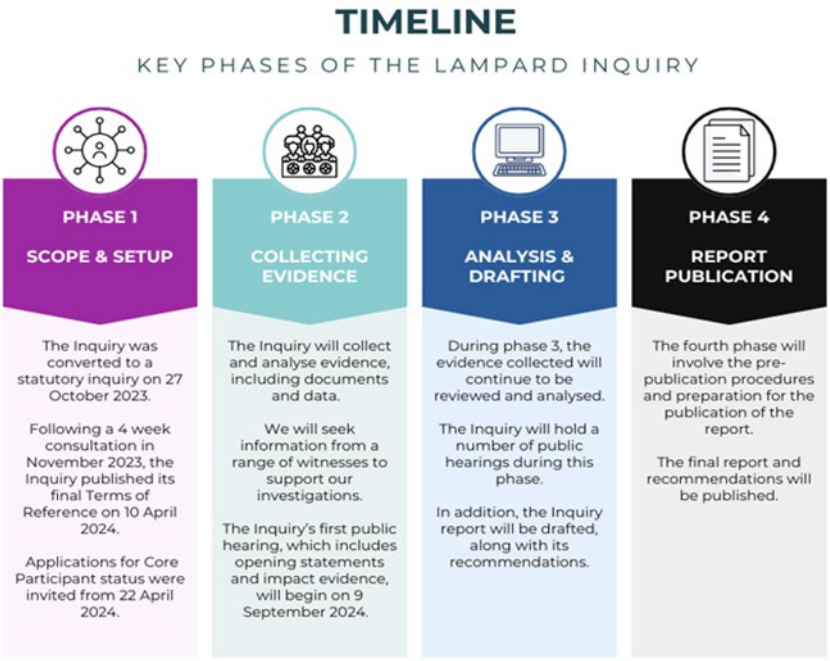
The Lampard Inquiry Update

1. Introduction

In June 2023 it was announced that the Essex Mental Health Independent Inquiry (established in 2021) would be granted statutory status (Public Inquiry) under the Inquiries Act 2005. In April 2024 final Terms of Reference were published, and the first public hearings began on 9 September 2024. The purpose of the Inquiry is to investigate the circumstances surrounding the deaths of mental health in-patients under the care of NHS Trust(s) in Essex ("the Trust(s)") between 1 January 2000 and 31 December 2023.

A schematic of the phases of the Inquiry is shown below.



2. Main content of Report

2.1 The Approach of the ICBs

Following the reorganisation of ICBs in April 2026, NHS Essex ICB, NHS Central East ICB and NHS Norfolk and Suffolk ICB continue to work collaboratively to support The Lampard Inquiry. This reflects the shared accountability arising from the former Essex commissioning arrangements and ensures continuity and stability in managing this important programme of work.

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

NHS Essex ICB will lead on the response from the ICBs to the Lampard Inquiry. Mills & Reeve LLP have been appointed as Legal advisers. Samantha Broadfoot King's Counsel (KC) is appointed as legal representation to the Lampard Inquiry representing the three ICBs. We continue to work within our allocated budget with incurred legal and programme costs monitored and reported through each of the ICBs.

The 3 nominated ICB Executive Leads are:

- Dr Matthew Sweeting, Executive Medical Director, NHS Essex ICB (Senior Responsible Officer)
- Lisa Nobes, Chief Nurse, NHS Norfolk and Suffolk ICB
- Sarah Stanley, Executive Clinical Director Total Quality Management, NHS Central East ICB

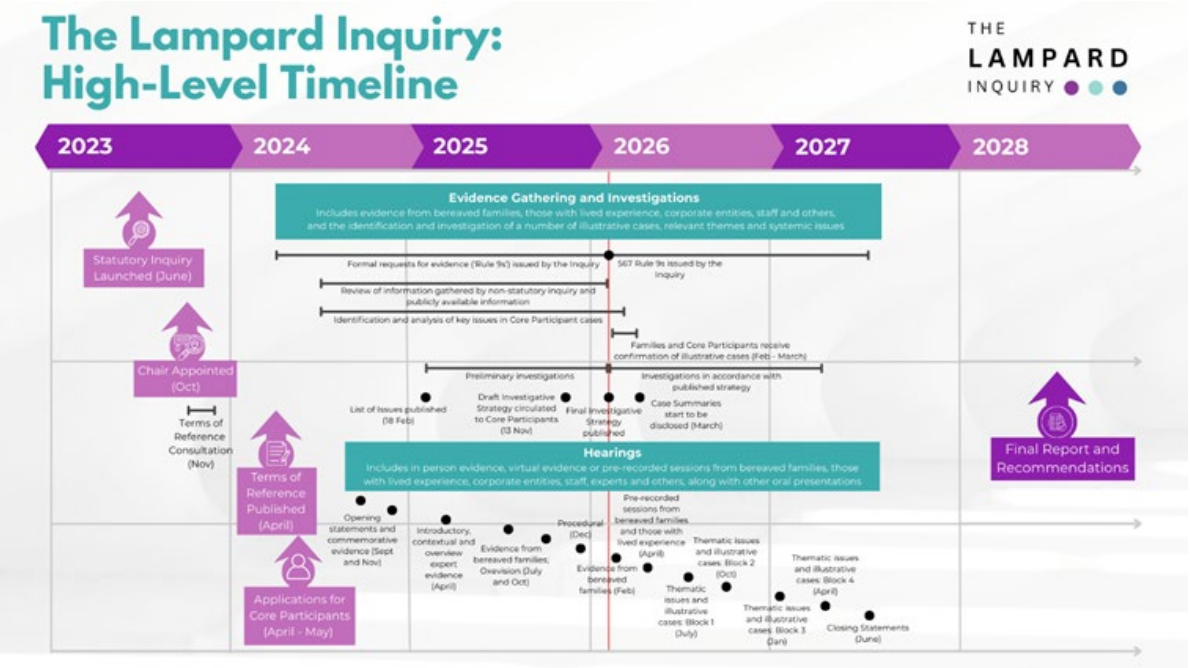
Each of the ICBs will continue to have a designated lead to work alongside the project team.

2.2 Inquiry Updates

Hearings and Inquiry Timeline

There have been delays in the Inquiry receiving witness statements and documents across several areas, which have impacted the ability of the Inquiry to progress as previously indicated. No delays are related to the work of the ICBs.

As a result, the Inquiry has provided an updated timeline, indicative hearing plan, and areas of work to meet the Inquiry's Terms of Reference. The Inquiry will now hold hearings until June 2027, with a final report and recommendations due in 2028. A revised Inquiry timeline has now been published (see below):



The indicative public hearing plan has set dates for future hearings and described both content and required evidence for each of the hearings. This may be subject to change, by agreement of the Inquiry Chair, as the Inquiry reviews and prioritises the evidence it gathers to meet the agreed terms of the Inquiry. The dates for future hearings are:

2026 Scheduled Hearing Dates:

- 6 to 23 July 2026
- 5 to 22 October 2026

2027 Scheduled Hearing Dates:

- 25 January to 11 February 2027
- 26 April to 13 May 2027
- 14 to 24 June 2027

These hearings will be held at Arundel House, London, except for the hearings in October 2026, which will be in Chelmsford, Essex. The hearings will also be streamed with a ten-minute delay.

Inquiry Investigative Phase

From March 2026, the Inquiry moved to its substantive 'investigative phase' to consider systemic issues and the concerns raised by bereaved families in the evidence gathered to date. In this phase, evidence is being obtained from members of staff and healthcare professionals. The Inquiry is considering if any additional steps are needed regarding undertakings for those providing evidence.

The Inquiry have published a FAQ section on their website for staff witnesses. The ICBs have processes in place to provide support to anyone contacted by the

Inquiry regarding evidence related to the ICBs (or former Clinical Commissioning Groups and/or Primary Care Trusts) and have an established protocol for providing legal support which has been agreed by the Inquiry.

F*eedback from Core Participants*

The Inquiry held 2 additional sessions in November and December 2025 to provide opportunity for core participants to address the Chair on procedural issues and the draft investigative strategy. Feedback was given to the Inquiry directly from bereaved families in the form of a Q&A session, as well as several oral and written submissions of evidence from core participants.

The ICBs were not required to and did not make a formal submission as part of this feedback. The Chair's formal response to the submissions has been published alongside a final version of the Inquiry's investigative strategy.

Statement of Approach – Investigating Illustrative Cases

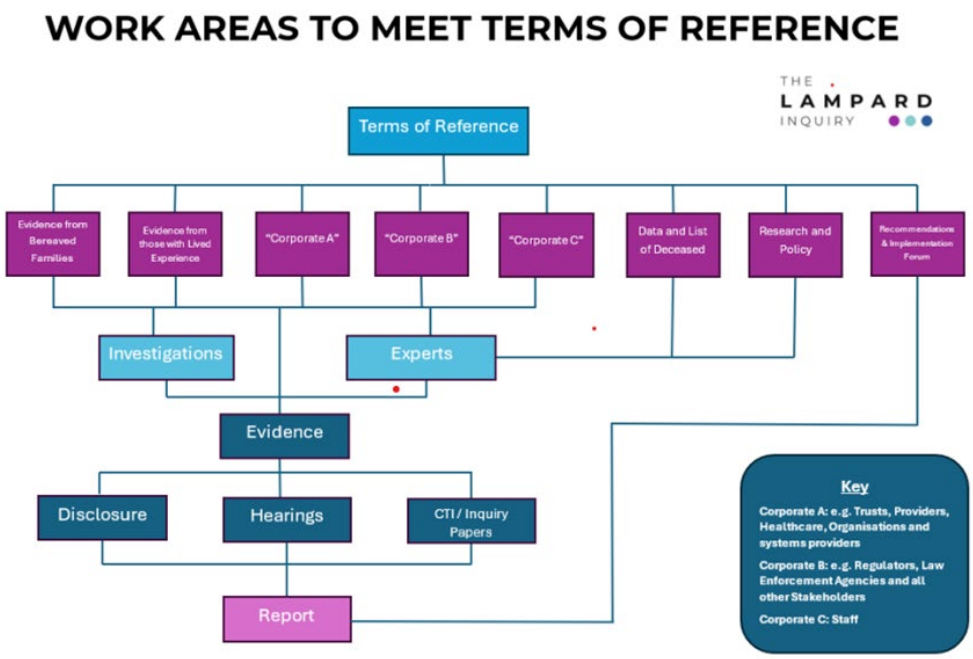
The Chair considered all suggestions and submissions received in relation to the draft investigative strategy, which has now been finalised as the Inquiry's Statement of Approach – Investigating Illustrative Cases.

The Inquiry will take the approach to investigating cases in 'clusters', rather than considered chronologically. However, a chronological review of issues in each cluster will still take place, with a particular focus on what changes have been made to better provision of mental health care, and what impact the change has had.

The clusters for cases are subheadings within Thematic Issues and Illustrative Cases Blocks 1 – 4 of the hearings. This list will be kept under review by the Inquiry, a full overview for each cluster is detailed in the investigative strategy.

More information regarding the investigative approach can be found on the Inquiry website or by following this link: Statement of Approach - Investigating Illustrative Cases - The Lampard Inquiry - investigating mental health deaths in Essex

The Inquiry has also provided a diagram setting out how its current work areas are operating together to meet the Inquiry Terms of Reference:



2.3 Public Hearings

The Inquiry continues to progress through its public hearings programme, with recent changes to the hearing schedule reflecting emerging themes identified through evidence gathering. In October 2025 and February 2026, the Inquiry heard evidence from bereaved families.

The Inquiry held pre-recorded evidence sessions between 20 April 2026 and 7 May 2026 to hear evidence from a number of bereaved families who have provided written statements to the Inquiry. These sessions have not yet been made public but will be available on the Inquiry website in due course.

On 24 April 2026, the Inquiry confirmed that the July hearings would be refocused on 'urgent emerging matters' identified in evidence. The July 2026 hearings will now focus on:

- Observations and Use of Technology;
- Resuscitation;
- Further Evidence from bereaved families;
- Core Participant Submissions; and
- Essex Partnership University NHS Foundation Trust (EPUT) Engagement and Compliance Issues.

The Chair has confirmed she is prepared to make interim recommendations on observations and the use of technology, and resuscitation. Should any recommendations be made, the ICBs' project team will be a position to ensure the ICBs respond and engage with the Inquiry.

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

2.4 Inquiry Rule 9 Requests for Information

Since the last Board update, the ICBs have received 3 further Rule 9 requests from the Inquiry, the first in December 2025 and more recently in May and June 2026. The ICBs have received five Rule 9 requests to date which vary in content and the numbers of questions raised.

A 'Rule 9 request' is a written request for information, including witness statements in response to specific questions, and/or relevant documents. This is made under Rule 9 of the Inquiry Rules 2006 and sets out exactly what information the Inquiry is requesting, as well as a deadline for the request.

The December 2025 Rule 9(2) request related to previous requests made to the ICBs, as well as additional requests for further information. Following ongoing discussions with the Inquiry, a final draft statement was submitted to the Inquiry on 13 March 2026, as well as a significant number of appendices and exhibited documents.

The May 2026 Rule 9(3) request relates to the ICBs' involvement in a provider led investigation. A final draft statement was submitted to the Inquiry on 16th June 2026, as well as a number of appendices and exhibited documents.

The June 2026 Rule 9(2a) request relates to the December 2025 Rule 9(2), submitted 13 March 2026, and requests further clarification as well as additional commissioning specific questions to support the Inquiry scope and investigative approach. A response to the Inquiry is being prepared with a due date of 30 June 2026.

All Rule 9 requests received to date have been responded to within agreed timescales, or agreed extensions have been secured where required.

2.5 Updated ICB Programme

Following the ICB changes in April 2026, the project team completed a governance review to refocus the ICB's programme of work and objectives for 2026/27. The project team will meet with key ICB individuals on a monthly basis from May 2026 to provide updates on the Inquiry work and what may be required going forward.

The review has also identified 3 primary objectives for the project team to lead, alongside responding to the Inquiry accurately, without delay, and in line with parameters set by the Inquiry:

1. Supporting the Inquiry and providers with current safeguarding and quality concerns raised via the Inquiry.
2. Supporting individuals impacted by the Inquiry.

3. Learning from the Inquiry through formal recommendations and internally identified learning.

As part of the programme, NHS Essex ICB will review historic documentation related to mental health and other programmes such as the Mental Health Task Force, which was set up collaboratively between the 7 Essex CCGs in 2020. This review aims to assess all recommendations and learning, which will then be revisited to ensure implementation is built into the work plan of the ICBs if not already done so.

ICB Boards will continue to receive 6 monthly progress reports with any areas of immediate concern escalated to Executive Officers for their consideration and oversight.

3. Findings/Conclusion

The three newly formed ICBs continue to work collaboratively to support the work of The Lampard Inquiry. Robust programme arrangements are in place including senior leadership oversight and assurance.

The Executive Leads remain satisfied that appropriate governance, legal, programme management and reporting arrangements are in place to support the Inquiry. Current programme delivery remains within the approved budget and no issues requiring Board escalation have been identified at this time.

4. Recommendation(s)

The Board is asked to note the content of this report and the arrangements supporting the ICB's ongoing response to The Lampard Inquiry.

5. Appendices

No appendices for this paper.

NHS Essex

Strategic Assurance Framework Report

(Board Assurance Framework)

16 July 2026

4. Financially and clinically sustainable services across Essex which are safe and high quality

Risk Narrative: Datix Risk Ref:	There is a risk that NHS Essex is unable to secure the long-term financial and clinical sustainability of services across Essex whilst maintaining high standards of quality and safety. This is caused by growing population demand, variations in population group needs (such as coastal communities), insufficient pace of strategic commissioning approaches across the system, and increased demand on ICB resources. This could lead to increased financial instability, reduced service resilience, poorer quality services and outcomes for residents, and a failure to deliver the strategic ambitions set out within the PHIP.
Risk Owner/Lead:	Jennifer Kearton, Executive Director of Finance and Commercial Dr Giles Thorpe, Executive Chief Nursing Officer
PHIP Deliverables and RAG Status:	Develop Neighbourhood Health service model **MC** Community Services Review & Perinatal services quality review **HC / MC** Development of Estates strategy **HC** Approach to commissioning Integrated Urgent Care **HC** Reduce unwarranted variation in delivery and cost of AACC services **MC** Data driven, value-based approach to commissioning decisions **MC**

Current Risk Score: (impact x likelihood)	**4 x 4 = 16 (Red)**
Target Score	**4 x 3 = 12 (Amber)**
Risk Appetite Category	**Financial: 4 (Seek)** **Quality: 4 (Seek)**
Directorate: Board Committee:	Finance / Nursing Commissioning, Quality and Resource Committee
Overall Assurance Level: Trend: Risk Appetite Position:	**Assessment:** **MC** **N** Outside Appetite

Alert

- Delivery of financial plans remains challenged whilst balancing transformation against recovery.
- Operating in an environment of national uncertainty impacts pace of change.
- Service review activities may lead to unknown quality risks being surfaced leading to enhanced scrutiny and ability to deliver pace of change required..

Advise

- Productivity opportunities and benchmarking required continued focus.
- Leadership changes across provider landscape may lead to divergent strategic plans for change, ongoing dialogue required.
- Ability of the system to mobilise the requirements of new quality strategy and framework, in addition to national directives for service change (e.g. Ockenden).

Assure

- Delivery of financial accounts, clean audit offers positive assurance on financial controls.
- Successful transition of strengthened governance of contract management into Board sub-committees across Essex providers
- Strengthened triangulation of quality, finance and performance across ICB teams.

Celebrate

- Establishment of Executive Resource Review meetings, include finance and contracts.
- Local Quality Requirements agreed across all providers through Contract Variation aligned to Quality Account priorities.
- Estates engagement and leadership in recent Neighbourhood Health Centre submission

Leading Indicators	Target	RAG
Delivery of the financial plan	XX%	HC
Quality and Safety	XX%	LC
Delivery of PHIP transformation benefits	XX%	MC
Workforce sustainability / vacancy rate	XX%	LC
Service sustainability – provider and service resilience	XX%	LC

Assurance

Moderate assurance is provided through established financial governance, quality oversight and structured transformation programmes. Long-term sustainability remains dependent on successful delivery of productivity improvements, service redesign and workforce stabilisation.

Commissioning, Quality and Resource Committee.

Executive Director Report to the Board

July 16th, 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 position 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 functions, providing an opportunity for the Board to shape future reporting arrangements. Detailed reporting will be reviewed at the Commissioning, Quality and Resource Committee (CQRC) prior to the Board. The CQRC is supported, by the Estates and Capital Group, Medicines Commissioning Group, Quality, Contracting and Performance Review Meetings and the 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***
Following endorsement by the CQRC, it was recommended that the Board approve progression to market, including the publication of the Contract Notice on Find a Tender and commencement of the competitive procurement process to award a new GMS contract for the Tollgate Practice. It is also recommended the Board approve an amendment to the Scheme of Reservation and Delegation (SoRD) to increase the authorisation limits for staff responsible for complex care.	

1a. Recommendation

The Board are asked to:

- Note the assurances provided within the report regarding commissioning, quality and resource performance,
- Note the areas requiring continued monitoring and oversight,
- Provide feedback on the proposal for future reporting.

CQR Performance Updates – Month 2

2. Executive Summary

Commissioning

- The Essex contract data for month 2 is currently being validated in line with the timelines set out nationally.
- Risks and opportunities are discussed at the monthly Contract, Quality and Performance meetings which the ICB holds with each of the key providers of healthcare services in Essex.
- At month two the National Oversight Framework has been developed and an update on progress is provided.

Delivery remains aligned to plan. Contract performance and activity reporting continue to be validated, with no significant issues currently requiring Board escalation.

Quality

- Despite delays with the National Quality Strategy, work continues with providers through our contractual governance and our System Quality Group.
- The report summarises the position across our key Acute providers and includes summary quality information for General practice, community providers and the independent sector.

Quality risks remain subject to active oversight through provider governance arrangements and the System Quality Group, with no new system-wide risks identified requiring Board intervention at this time.

Resources

- Overall significant progress is being made to establish the baselines across the new Essex ICB.
- At month 2 the ICB is in line with its planned financial position.
- All major contracts are agreed, and capital plans are progressing.
- We have seen a small improvement in the level of unidentified efficiencies.
- Work continues with the Executive Director leads to align budgets and improve our collective understanding of the risks and opportunities in each area.

The ICB remains on its planned financial trajectory at Month 2, although delivery of efficiencies and further budget alignment activity will require ongoing management.

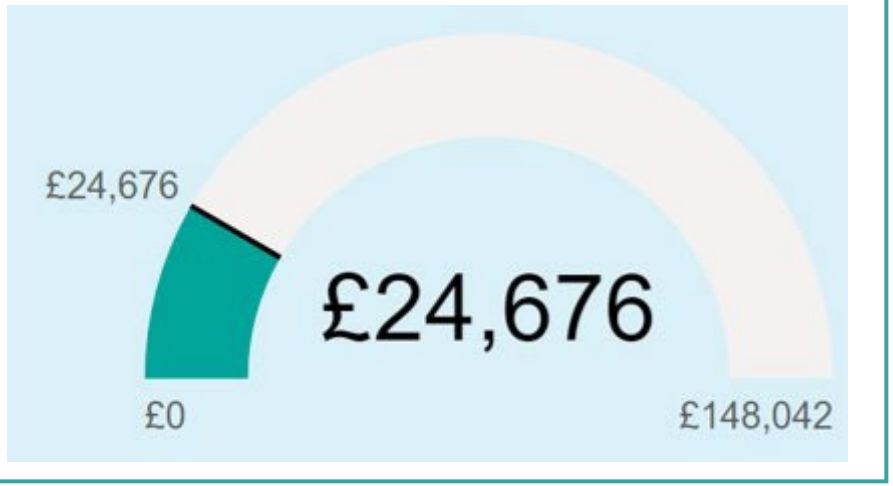
3. Key Financials

REVENUE ALLOCATION	£5.3bn	£5.4bn	5.6bn
PLANNED POSITION	BREAKEVEN	BREAKEVEN	BREAKEVEN
EFFICIENCY TARGET	2.8% (£148m inc national tariff)	2.5%	2.5%
MHIS	PLANNED to DELIVER	PLANNED to DELIVER	PLANNED to DELIVER
FUTURE SHIFTS & RECOVERY	2.7% £68m	2.5%	2.5%

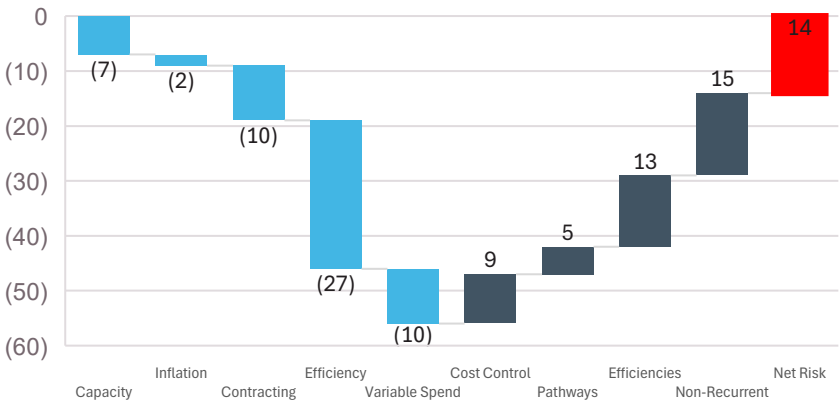
The ICB has a plan to break-even, in each year of the planning round. This will require efficiencies of c2.5% annually and in year one unmitigated risk of £14m has been identified.

The ICB is committed to both Elective recovery and Future Shifts and recognises the need to invest to alter the current spend portfolio.

At month 2 our financial position is on track. We are finalising the assimilation of financial and contractual information across the 3 ICBs and identifying risks and opportunities at Directorate level.



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		



Net Risk	£m
Plan position	(14)
Current Month	0

	£m
Movement	
Trend	

4. Focus on spend areas (1 of 2)

Spend Area	Annual Plan £m	CURRENT PERIOD PERFORMANCE Month 2 Plan £m	Actual £m	Variance £m	CURRENT PERIOD RAG	TREND	PROJECTED PERFORMANCE 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)*	2,542	414	414	-	G		2,542	-	G	54	-	There are no key movements to note at month 2. All major contract values are now agreed and aligned, with Executive budget holder responsibility and delegations in place. The majority of efficiencies associated with the Acute budgets are driven by the technical requirements set out in national guidance relating to inflationary uplifts.
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)*	468	78	78	-	G		468	-	G	9	-	There are no key movements to note at month 2. All major contract values are now agreed and aligned, with Executive budget holder responsibility and delegations in place. The ICB has applied the relevant adjustments to contracts as outlined within national guidance, which represents the efficiency shown in the table. The ICB maintains its commitment to the Mental Health investment standard
Specialist Commissioning *(Commissioning of services to support individuals with rare and complex needs)*	541	90	90	-	G		541	-	G	24	-	There are no key movements to note at month 2. All major contract values are now agreed and aligned, with Executive budget holder responsibility and delegations in place. The ICB has applied the relevant adjustments to contracts as outlined within national guidance, which represents the efficiency shown in the table.

4. Focus on spend areas (2 of 2)

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)*	398	66	66	-	G		398	-	G	9	-	There are no key movements to note at month 2. Efficiencies in this area of spend are mainly driven by the inflation guidance, however some service changes and procurements across the Essex footprint have taken place which have delivered a change to the budget envelope.
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)*	1,010	168	168	-	G		1,010	-	G	18	-	There are no key movements to note at month 2. Efficiencies in this area of spend are related to investments made previously, and a resetting of budgets based on run rates across key spend areas. Primary Care prescribing efficiencies are also included in this figure and directly relate to the productivity opportunities shared as a result of national benchmarking.
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.*	287	46	46	-	G		287	-	G	11	-	There are no key movements to note at month 2. A significant amount of work is in progress to align the information across care packages for the new Essex footprint. The efficiencies aligned, directly relate to the productivity opportunity identified within the ICB based on national benchmarking. Savings have been removed from the budget. Non delivery will present a risk to the budget.
Running Costs *(The cost of running the integrated care board. Staffing, Estates, legal and statutory).*	31	5	5	-	G		31	-	G	-	-	There are no key movements to note at month 2. The ICB was subject to an opening adjustment to its funding, this adjustment reduced the amount available to spend on ICB running costs and represented Essex ICBs contribution to the overall national ambition. The ICB is not holding the savings associated with the recent restructuring across the commissioning organisations.
Other Commissioned Services and Programme Budgets	24	4	4	-	G		24	-	G	-	-	There are no key movements to note this month.

5. Capital and Estates

S106 Progress Update

Focused on expiry dates and moving forward with opportunities within the current constraints. Further work with Local Authorities in progress, alongside Primary Care Estate prioritisation.

Neighbourhood Health Estates Progress

A proposal for 14 Neighbourhood Health Centres of varying scale and locality has been submitted. The ICB is awaiting national feedback on next steps.

6. Contracted Activity – *Information from Month 3*

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

DUMMY DATA

7. ICB National Oversight Metrics

Metric	Previous		Quarter 1 -		Commentary
Domain 1 – Population Health, Prevention & Reducing Inequality					
Under 75s cancer mortality rate	NA	🟢	To be released	🟢	
Under 75s cardiovascular disease mortality rate	NA	🔴	To be released	🔴	
Cervical screening rate	NA	🟡	To be released	🟢	
Bowel screening rate	NA	🟡	To be released	🟡	
Breast screening rate	NA	🔴	To be released	🟡	
MMRV (measles, mumps, rubella & varicella) uptake rate	NA	🟡	To be released	🟡	
% of eligible people supported by obesity prevention programmes	NA	🔴	To be released	🟢	
% of pregnant women who quit smoking	NA	🟢	To be released	🔴	
Deprivation gap in early cancer diagnosis	NA	🔴	To be released	🟡	
Deprivation & ethnicity gap in pre-term births	NA	🟢	To be released	🟢	
Deprivation gap in lipid management	NA	🟢	To be released	🟡	
Deprivation gap in hypertension management	NA	🔴	To be released	🔴	
Domain 2 – Allocating Resources					
% change in overall waiting list size versus previous year	NA	🟡	To be released	🟢	
Level of growth in community care contacts	NA	🟡	To be released	🟡	
% of cancers diagnosed at stage 1 or 2	NA	🟢	To be released	🟡	
% of acute adult mental health admissions with no contact with community mental health services in the previous year	NA	🔴	To be released	🟡	
Occupied bed days per 100,000 head of population	NA	🟢	To be released	🟢	
% of clinically urgent appointments that happen on the same day	NA	🔴	To be released	🟡	
Units of dental activity delivered as a % of commissioned	NA	🔴	To be released	🔴	
% of people with a learning disability & autistic people in mental health hospital with the longest length of stay	NA	🟢	To be released	🟢	
Domain 3 – Experience of Care					
% of pts rating their experience of GP access as easy	NA	🟢	To be released	🟡	
% of pts with a preferred general practice professional able to see that professional	NA	🔴	To be released	🟡	
% of complaints open beyond 6 mths	NA	🔴	To be released	🔴	
12 mth adult admission rate for people with a learning disability & autistic people	NA	🟢	To be released	🟢	
% of commissioned adult inappropriate out of area placement bed days as a proportion of all commissioned bed days	NA	🔴	To be released	🟡	
Average No. of days between discharge ready & actual discharge date	NA	🔴	To be released	🟡	

DUMMY DATA

7. ICB National Oversight Metrics continued.

Metric	Previous		Quarter 1 -		Commentary
Domain 4 – Effectiveness of Care					
% of NHS Talking Therapies pts completing a course of treatment & achieving reliable recovery	N/A	🟡	To be released	🟢	
% of people with 3 or more emergency admissions in the last 90 days of life	N/A	🟢	To be released	🟡	
Over 65s bed days per 100,000 head of population	N/A	🔴	To be released	🔴	
% of pts who receive all 8 diabetes care processes	N/A	🟢	To be released	🟡	
No. of pts with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance	N/A	🔴	To be released	🟡	
No. of pts with GP recorded hypertension whose blood pressure is managed to NICE guidance	N/A	🟢	To be released	🟡	
% of pts on GP severe mental illness registers to receive a full physical health check in the last 12	N/A	🔴	To be released	🔴	
% of pts over 14 years old on GP learning disability registers to receive a full physical health check & action plan in the last 12 mths	N/A	🟢	To be released	🟡	
Domain 5 – Patient Safety					
% of children aged 9 & under prescribed antibiotics	N/A	🔴	To be released	🟡	
No. of neonatal deaths & stillbirths per 1,000 total births	N/A	🟢	To be released	🟢	
Domain 6 – Finance, Productivity & Innovation					
Planned surplus or deficit	N/A	🟢	To be released	🟢	
Variance to plan year-to-date	N/A	🔴	To be released	🔴	
Implied productivity growth	N/A	🟡	To be released	🟢	
% of clinical trials set up within 90 days	N/A	🟢	To be released	🟢	
Domain 7 – People					
Sickness absence rate	N/A	🟢	To be released	🟡	
NHS staff survey engagement theme score	N/A	🔴	To be released	🔴	
GP headcount per capita	N/A	🟡	To be released	🟡	

DUMMY DATA

7. ICB Operating Plan Metrics

Metric	Previous Quarter		Month x		Commentary
Elective & outpatient activity					
Consultant-led first outpatient attendances (NHS / ISP / total)	N/A	🟢	To be released	🟢	
Consultant-led follow-up outpatient attendances	N/A	🔴	To be released	🔴	
Follow-up outpatient procedures	N/A	🟡	To be released	🟢	
Elective day case spells	N/A	🟡	To be released	🟡	
Elective ordinary spells	N/A	🔴	To be released	🟡	
RTT clock starts and completed pathways	N/A	🟡	To be released	🟡	
Detailed RTT measures					
Number of 52+ week RTT waits	N/A	🟡	To be released	🟢	
RTT waiting list 18 weeks and under	N/A	🔴	To be released	🔴	
RTT waiting list – total	N/A	🔴	To be released	🔴	
RTT % within 18 weeks	N/A	🟡	To be released	🟡	
Cancer activity volumes					
Absolute numbers of patients diagnosed / treated	N/A	🟢	To be released	🟡	
Diagnostics (activity-level)					
Total number of diagnostic tests or procedures carried out	N/A	🟡	To be released	🟢	
Mental health services activity					
Access to Mental Health Support Teams in schools	N/A	🟢	To be released	🟡	
CYP waits over 104 weeks	N/A	🔴	To be released	🟡	
Adult acute & PICU total bed days, discharges and average length of stay	N/A	🟢	To be released	🟡	
Older adult mental health bed days, discharges and length of stay	N/A	🟡	To be released	🟢	
Perinatal mental health access volumes	N/A	🔴	To be released	🔴	
CYP accessing mental health services	N/A	🟢	To be released	🟡	
Individual Placement Support (IPS) access	N/A	🔴	To be released	🔴	
Community & recovery measures					
Reliable recovery numbers	N/A	🔴	To be released	🟡	
Reliable improvement numbers	N/A	🟢	To be released	🟢	
Pharmacy & primary care					
Pharmacy First consultations	N/A	🟢	To be released	🟢	
Urgent dental appointments	N/A	🟡	To be released	🟢	
Clinically urgent appointments (counts and same-day %)	N/A	🔴	To be released	🔴	

8a. Quality Overview – National Update/ System Quality Group Escalations

National Quality Board/Department of Health and Social Care/NHS England

1. Delayed National Quality Strategy – progressing quality improvement priorities through existing contractual and system governance arrangements – CV in place to align with Quality Account priorities from providers for 2026/27 – monitoring through QCPRM process quarterly.
2. National Mental Health host/placing commissioner visit guidance consultation – response returned to consultation team – concerns regarding capacity to deliver given level of Essex-wide and OOA activity (all age)

System Quality Group – Escalation

1. Terms of Reference drafted for approval at CQRC
2. Date set late June for first meeting with new membership
3. Deep dive topics to be led by EPUT. Physical healthcare delivery in mental health settings/Learning from Deaths

8b. System Quality Position– Quarter 1 (1 of 2)

NHS Provider Position

Mid and South Essex NHS Foundation Trust (MSEFT)

- Remain in NOF 4-with quality summits in place
- Incident Management Team's (IMT) in place relating to ongoing incidents
    - Paraprotein
    - Radiology
- Section 29a in place for Basildon & Broomfield Children & Young People (CYP)
- Section 31 in place for Basildon Urgent Emergency Care and Broomfield maternity

Essex Partnership University NHS Foundation Trust (EPUT)

- 3 incidents raised relating to deaths of patients known to EPUT
- CQC report relating to Ardleigh to be published- regular action plan meetings were in place to address concerns; these have now stood down as CQC are assured
- Section 29a in place for Ipswich Road

The Princess Alexandra Hospital NHS Trust (PAH)

- Awaiting CQC report to be published relating to well-led and medicine
- IMT's in place relating to ongoing incidents
    - Maternity – Entonox
    - Radiology delays

East Suffolk and North Essex NHS Foundation Trust (Colchester) (ESNEFT)

- Ongoing discussion with region regarding children surgery and orthopaedics
- Section 29a remains in place for elderly medicine and UEC

8b. System Quality Position– Quarter 1 (2 of 2)

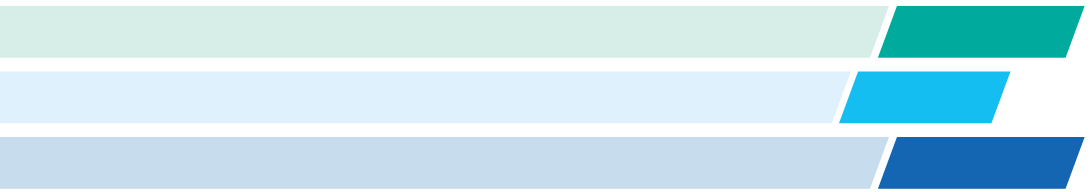
Collaborative/Primary Care/Independent Sector	
General Practice • CQC report published for practice in West Essex now rated RI • Warning notices in place for Lister Medical Centre (West), The Hollies (South-East) and The Limes medical Centre (West)	**Community Ophthalmology** • Nil to report
Community Dentistry • 3 providers have not met regulation 12 or 17 of CQC regulations. Themes are being collated and shared with the General Dental Council	**Independent Sector Providers/Other** • **Ramsay Healthcare-** Patient Safety Incident Investigation initiated and Freedom to speak up concern raised to CQC • **Provide CiC-** Essex council to work with Provide in relation to the number of inappropriate safeguards raised • **EEAST-** Fatal harm reported to ICB - failure to recognise VF rhythm- thematic review underway
Community Collaborative • Regional review of collaboratives waiting list over 52 weeks (BCYP), due to conclude in 8 weeks with actions for commissioner and provider	

Glossary

Acronym	Explanation
CQRC	Commissioning, Quality and Resource Committee
NOF	National Oversight Framework
SPC	Statistical Process Control (chart)
UEC	Urgent and Emergency Care
IMT	Incident Management Team
CQC	Care Quality Commission
OOA	Out of Area
B/CYP	Babies / Children and Young People
VF	Ventricular Fibrillation
CV	Contract Variation
RI	Requires Improvement (CQC rating)
CiC	Community Interest Company

NHS
Essex
Integrated Care Board

Thank you



Chair's Key Issues
Committee Summary / Escalation Report

NHS Essex Integrated Care Board

Reporting route:	Commissioning, Quality and Resource Committee (CQRC) – Meetings held on 21 April 2026 and 7 July 2026, reporting to the ICB Board.
Executive and Committee/Group Sponsor:	Sponsoring Executives: Sam Goldberg, Executive Director of Commissioning Dr Giles Thorpe, Executive Director of Nursing Jen Kearton, Executive Director of Finance and Commercial Chair of CQRC – Mark Bailham, Non-Executive Member
Report Author:	Emma Seabrook, Business Manager
Confidentiality and Conflicts of Interest:	There are no confidentiality concerns or conflicts of interest to note.
PHIP Delivery / Risk:	Sustainable Hospital Services - Planned Care Sustainable Hospital Services - Unplanned Care and Flow Mental Health and Neurodiversity - Adult Mental Health Services Complex Care Planned surplus or deficit Variation to plan YTD Implied productivity growth

Agenda items covered	<u>21 April 2026</u> Setting the Standard: Committee Role and Expectations Establishing sub-committees and approving their terms of reference Provider Accreditation Policy Patient Group Direction Policy Population Health Improvement Plan

	Executive Director Report Urgent Treatment Service <u>7 July 2026</u> Re-procurement of Orthodontic Services Tollgate Medical Practice Re-procurement. Service Restriction Policies Changes to the Scheme of Reservation and Delegation Executive Director Report Updates from Sub-Committees: Capital & Estates Group and Essex Medicines Commissioning Group Establishing sub-committees and approving their terms of reference Commissioning, Quality and Resource Committee Workplan 2026/27
	Key discussion points and matters to be escalated from the meeting:
Alert: Matters that need the Boards attention or action	Following endorsement by the CQRC, it was recommended that the Board approve progression to market, including the publication of the Contract Notice on Find a Tender and commencement of the competitive procurement process to award a new GMS contract for Tollgate Practice. The Board was recommended to endorse an amendment to the Scheme of Reservation and Delegation (SoRD) to increase the authorisation limits for staff responsible for complex care. The current annualised authorisation limits set out in section 9 of the SoRD result in a significant number of approvals being escalated to senior staff, creating delays in arrangement of short-term care packages. Increasing these limits would streamline decision-making, improve operational efficiency, and support the timely provision of care for patients.

Chair's Key Issues
Committee Summary / Escalation Report

NHS Essex Integrated Care Board

Advise: Matters the Board should be aware of	The Committee received the Executive Director's Report, providing updates on Commissioning, Quality and Resources, and awarded it 'partial' assurance. While noting good progress since April 2026, the Committee recognised that it was still early in the financial year to fully assess performance data, and that the reporting pack would continue to develop as further information became available.
Assure: Positive assurance	The Committee approved the Terms of Reference for all sub-committees reporting to CQRC. The Committee noted the progress made by its sub-committees since April 2026 and recognised that their development would continue over the coming months.
Celebrate Success:	The Committee noted the significant work undertaken by the Medicines Management Team to review more than 100 Service Restriction Policies as part of a programme to harmonise policies inherited from the former Mid and South Essex, Hertfordshire and West Essex, and Suffolk and North East Essex ICBs into a single, coherent suite of commissioning policies for NHS Essex ICB by December 2026.

Actions required:	The System Quality section of the Executive Director Report would be updated to provide greater clarity on the actions in place and progress against those actions in future reports.
Date of next meeting:	6 October 2026

NHS Essex

Strategic Assurance Framework Report

(Board Assurance Framework)

16 July 2026

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

Risk Narrative: Datix Risk Ref:	There is a risk that NHS Essex is not sufficiently capable, resilient and well-connected to deliver its strategic objectives and fulfil its role within the Essex health and care system. This is caused by limitations in organisational capacity, capability, leadership, culture, governance, partnership maturity and organisational development. This could lead to ineffective commissioning, reduced ability to influence system outcomes, failure to deliver the PHIP and corporate objectives, loss of stakeholder confidence, and failure to meet statutory duties.	**Current Risk Score: (impact x likelihood)** **Target Score** **Risk Appetite Category**	**4 x 4 = 16 (Red)** **4 x 2 = 8 (Amber)** **People: 5 (Significant)** **Regulatory: 3 (Open)** **Reputational: 5 (Significant)**
Risk Owner/Lead:	Michael Watson, Executive Director of Corporate Services	Directorate: Board Committee:	Corporate Services Executive Committee / Audit, Risk and Compliance Committee
PHIP Deliverables and RAG Status:	Develop approaches to wellbeing, engagement and flexible working **HC** Implement the NHS Equality, Diversity, and Inclusion strategy **MC** Development and delivery of Culture & Leadership Programme **HC** Ensure clear and robust governance arrangements are in place **HC** Standardised approach to prioritisation and evaluation **MC** Views and needs of Essex residents are at the heart of the ICBs work **MC**	Overall Assurance Level: Trend: Risk Appetite Position:	**Assessment:** **MC / HC** **N** Outside Appetite

Alert	Advise	Assure	Celebrate
Strategic issues requiring intervention / key threats to delivery. • Need to ensure that organisation is sufficiently focused on priorities to deliver with limited capacity post change process. • Workforce retention and capability remain critical risks. • Targeted development required to increase strategic commissioning capabilities	Emerging concerns and developing risks. • Future operating model in some areas- digital, workforce etc still evolving. • Governance arrangements should continue to evolve alongside organisational maturity. • External stakeholder expectations of the new ICB continue to increase.	Areas where assurance has strengthened. Positive assurance. • New governance framework and committee structure established. • Programme governance for PHIP delivery embedded. • Comms and Engagement strategy developed.	Notable achievements. • Launch of ICB Culture and Leadership Programme • Governance arrangements- substantive assurance • Key partnership arrangements developed- convenor, Healthwatch.

Leading Indicators	Target	RAG
Organisational Capability	XX%	**LC**
Governance and Accountability effectiveness measures	XX%	
Maturity of commissioning, programme and transformation capability	XX%	
Staff Survey / engagement score	XX%	
Vacancy and turnover rates	Xx%	
Public awareness and stakeholder confidence	XX%	

Assurance

Moderate to high assurance is provided through the successful establishment of the new organisation, strengthening governance arrangements and positive partnership working. Continued focus is required to build organisational capability, resilience and commissioning maturity to support delivery of PHIP.

NHS
Essex
Integrated Care Board

ICB Board Meeting of 16 July 2026

Agenda Number: 17

Audit, Risk and Compliance Committee Summary and Escalation Report

Summary Report

1. Purpose of Report

1.1. To present the Board with the Audit, Risk and Compliance Committee Summary and Escalation Report, providing assurance on key audit, risk and compliance matters and drawing attention to any issues requiring Board consideration.

2. Executive Lead

2.1. Michael Watson, Executive Director of Corporate Services.

3. Report Author

3.1. Jane King, Assistant Governance Manager.

4. Responsible Committees

4.1. The Audit, Risk and Compliance Committee provides oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB, driven by organisational objectives and associated risks.

5. Link to the ICB's Strategic Objectives

5.1. Reference the relevant ICB objectives / This paper supports all ICB objectives as follows:

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

6. Impact Assessments / Financial Implications / Patient or Public Engagement or Consultation

6.1. Not applicable to this report.

7. Conflicts of Interest

7.1. None identified.

8. Recommendation/s

8.1. The Board is asked to receive the Audit, Risk and Compliance Committee Summary and Escalations Report for assurance.

Chair's Key Issues
Committee Summary / Escalation Report

Reporting route:	Audit, Risk and Compliance Committee (ARCC) on 9 July 2026, reporting to the Board.
Executive and Committee/Group Sponsor:	Executive Sponsor – Michael Watson, Executive Director of Corporate Services Chair – Rex Smith, Non-Executive Member
Report Author:	Jane King, Assistant Governance Manager
Confidentiality and Conflicts of Interest:	No conflicts of interest or confidentiality concerns to be noted.
PHIP Delivery / Risk:	The ARCC has oversight responsibility for the governance and control frameworks to enable PHIP delivery.

Agenda items covered:	**Assurance, Risk, Governance & Compliance** Health Inequalities Annual Report; Risk Management Framework, Risk Appetite and BAF; Governance Framework and CORE Group establishment; policy updates; Company Seal; Health and Safety, Information Governance and EPRR updates; Quality Statutory Compliance Reports; Internal Audit Progress Report; and Counter Fraud and Security annual reports, including the 2026/27 Security Workplan. **Finance** Mid and South Essex ICB Annual Report and Accounts 2025/26 and External Audit Opinion; Losses and Special Payments; Contract Governance and Procurement; Provider Selection Regime Year End Report; and Waiver Report.
	Key discussion points and matters to be escalated from the meeting:
Alert: Matters that need the Boards attention or action	Concerns identified regarding GP withdrawal from data sharing agreements linked to the Federal Data Platform, due to the potential impact on direct care, population health management, and health inequalities analysis. Additional risks requiring ongoing oversight included evidencing health and safety compliance and SEND pressures, particularly within neurodevelopmental services, where demand for ASD and ADHD assessments continued to exceed capacity. Further

Chair's Key Issues
Committee Summary / Escalation Report

	risks related to health involvement in EHCPs, compliance with the duty to cooperate, ongoing SEND inspections, and the potential impact of local government reform on service delivery
Advise: Matters the Board should be aware of	The Committee noted progress in establishing the governance, risk and assurance arrangements of the new Essex ICB, the continued development of quality and compliance reporting arrangements, and emerging national developments in information governance and SEND reform.
Assure: Positive assurance	Strong assurance was received from the external audit of the final Mid and South Essex ICB Annual Report and Accounts, with no material findings identified and all statutory financial duties achieved. Additional assurance was received in relation to emergency preparedness, information governance, counter fraud, security management, and progress in addressing health inequalities.
Celebrate Success:	The Committee acknowledged the successful closure of Mid and South Essex ICB, including a positive external audit outcome and successful implementation of the ISFE2 ledger system. It also noted substantial assurance on counter fraud compliance and fraud risk management, strengthened emergency preparedness arrangements and continued progress in addressing health inequalities.

Actions required:	**The following actions were noted within the ARCC minutes and action log:** • **Health & Safety**: Further work is required to strengthen the evidence for health and safety compliance, documentation, and assurance processes, with actions being progressed through the Health and Safety Group. **Responsible - Associate Director of Governance / Health & Safety lead.** • **Information Governance**: An Executive Committee paper will be developed to update on potential GP withdrawal from data sharing agreements, recognising the potential implications for direct care, population health management, and health inequalities analysis. **Responsible – Associate Director of Governance / Information Governance lead.**
Date of next meeting:	8 September 2026

NHS
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ICB Board Meeting of 16 July 2026

Agenda Number: 18

Communications, Engagement and Involvement Strategy 2026-2029

Summary Report

1. Purpose of Report

1.1. To present the NHS Essex Communications, Engagement and Involvement Strategy 2026–2029 for Board approval. The Strategy and accompanying delivery plans set out a recommended approach to communications, engagement and involvement that will support delivery of organisational priorities, statutory responsibilities and improved health outcomes.

2. Executive Lead

2.1. Michael Watson: Executive Director of Corporate Services.

3. Report Author

3.1. Claire Routh, Associate Director of Communications and Engagement.

4. Responsible Committees

4.1. N/A.

5. Link to the ICB's Strategic Objectives

5.1. This paper supports the delivery of all ICB objectives as follows but is particularly aligned to being an organisation that is up to the job, good to work for and good to partner with:

- 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

6.1. The Strategy is expected to have a positive impact on equality, accessibility and health inequalities by embedding inclusive communications, improving accessibility, strengthening engagement with underserved communities and ensuring that the voices of diverse communities inform decision-making across NHS Essex.

7. Financial Implications

7.1. There are no direct financial implications arising from approval of this Strategy. Delivery will primarily be supported through existing communications and engagement resources; however, implementation of specific workstreams and major programmes may require additional investment in communications, engagement and insight activity. Any such funding requirements will be identified and considered through the ICB's normal business planning and approval processes.

8. Details of patient or public engagement or consultation

8.1. The Strategy has been informed by a range of existing insight, engagement activity and stakeholder feedback. This includes learning from previous communications and engagement evaluations, public, stakeholder and staff surveys and national policy and best practice.

9. Conflicts of Interest

9.1. None identified.

10. Recommendation/s

10.1. The Board is asked to approve the draft Communications, Engagement and Involvement Strategy.

Communications, Engagement and Involvement Strategy 2026-2029

1. Introduction

The establishment of NHS Essex and the transition to a more strategic commissioning model provides an opportunity to strengthen how communications, engagement and involvement support the delivery of better health services across the county.

This Strategy establishes a strategic framework for communications, engagement and involvement across NHS Essex for 2026–2029, supporting delivery of the organisation's priorities, the Population Health Improvement Plan and statutory duties to involve patients and the public. It has been informed by organisational learning and recognised best practice. The Strategy sets out a clear approach to improving understanding, building trust, strengthening relationships and embedding meaningful involvement in decision-making, supported by three delivery plans and a framework for measuring impact and providing assurance to the Executive Team and Board.

2. Main content of Report

The NHS Essex Communications, Engagement and Involvement Strategy 2026–2029 provides the strategic framework for how NHS Essex will communicate, engage and involve people over the next three years. It will support the work of NHS Essex with its key partners - our almost two million residents, staff, provider organisations, primary care, local authorities, the voluntary, community and social enterprise sector, and other stakeholders.

The Strategy has been developed to support NHS Essex's transition to a more strategic commissioning organisation, ensuring communications and engagement are embedded within commissioning, service improvement and decision-making. It will directly support the delivery of the Population Health Improvement Plan, organisational priorities and statutory duties to involve patients and the public.

The Strategy establishes a consistent approach centred on four strategic priorities: Explain, Listen, Involve and Build Trust and is underpinned by three supporting delivery plans covering Internal Communications, External Communications and Working with People and Communities.

Together these set out how NHS Essex will build understanding, strengthen trust, improve participation, reduce health inequalities and demonstrate how insight from local people influences decisions. Progress will be monitored

through an agreed performance framework, with regular reporting to the Executive Team and Board.

3. Recommendation(s)

The Board is asked to approve the draft Communications, Engagement and Involvement Strategy.

4. Appendices

Appendix 1 – Internal Communications Delivery Plan

Appendix 2 – External Communications Delivery Plan

Appendix 3 – Working with People and Communities Delivery Plan

NHS Essex Integrated Care Board

NHS Essex Communications, Engagement and Involvement Strategy 2026-2029

Document Control:

Date: July 2026
Version: 2

Document set-up

1. Foreword

NHS Essex was established to bring together NHS planning and decision-making across the county, helping us work more consistently with partners and improve health services for almost two million people.

Delivering better health outcomes for local people will require trust, understanding and meaningful involvement.

The decisions we make affect people's lives, communities and experiences of health and care. We therefore have a responsibility to communicate openly, involve people in decisions that affect them and ensure that the voices of our staff, partners and communities help shape the future of health services in Essex.

This Strategy sets out how we will do that.

It establishes a shared approach to communications, engagement and involvement for NHS Essex and provides a framework for supporting delivery of our Population Health Improvement Plan, organisational priorities and statutory responsibilities.

The Strategy is supported by three delivery plans covering:

- Internal Communications
- External Communications
- Working with People and Communities

Together these documents will help ensure our communications and engagement activity is focussed, evidence-based and aligned to what matters most to the people we serve.

2. Why this Strategy matters

Demand for services continues to increase. Health inequalities remain significant and unacceptable. People's experiences of health and care are not consistent across Essex and resources must be used as effectively as possible.

At the same time, expectations of public services continue to change. People expect faster access to information, transparency and more opportunities to influence decisions that affect them.

Communications and engagement are therefore not simply supporting activities. They are essential strategic tools for delivering better health outcomes, improving services and maintaining public confidence.

This Strategy recognises that effective communications and engagement can help:

- Build understanding of why change is needed
- Support people to access services appropriately
- Improve trust and confidence in NHS Essex
- Reduce health inequalities by reaching communities that are often less heard
- Strengthen relationships with partners and stakeholders
- Ensure people have genuine opportunities to influence decisions
- Support staff in delivering our corporate objectives, including being an organisation that is good to work for and with.

3. Our purpose

Our purpose is simple:

To help make health services better in Essex. We do this by building understanding, trust and meaningful involvement through clear, evidence-based communications that help people understand services, influence decisions and improve health and care. We work with partners to tell the story of improvement, celebrate the people delivering care, and communicate openly about both progress and challenges.

We will achieve this through three interconnected functions:

Communications

Providing clear, timely and accessible information that helps people understand services, decisions and priorities.

Engagement

Creating opportunities for meaningful dialogue with staff, partners and communities.

Consultation and involvement

Ensuring local people and communities influence decisions and service improvements in line with our statutory responsibilities.

4. Our vision

Our plan covers the period 2026-2029. It will support delivery of the ICB's objectives and through continuous innovation and improvement ensure that our communication and engagement approach is recognised as a national exemplar and a strategic driver of better health services in Essex by the end of that period. We will:

- Build trust through open, honest and transparent communication
- Demonstrate how people's experiences shape decisions
- Celebrate the people and partnerships improving health and care across Essex
- Help communities access the right services and support healthier lives
- Equip staff and leaders with clear, consistent communications
- Use insight, best practice and evidence to guide our efforts and continually improve our impact

5. Strategic outcomes

Everything we do will contribute to five outcomes.

Outcome 1: Better understanding

People understand NHS Essex's role, priorities and the reasons behind decisions.

Outcome 2: Stronger trust

People have confidence that NHS Essex communicates honestly and acts in the best interests of local communities.

Outcome 3: Meaningful involvement

People and communities have genuine opportunities to influence decisions and can see how their views have shaped outcomes. By using a variety of engagement methods, we will make sure we hear from a broad and diverse range of people, ensuring that different perspectives inform our decisions.

Outcome 4: Confident staff and partners

Staff and stakeholders feel informed, involved and able to act as advocates for improvements in health and care.

Outcome 5: Better outcomes

Communications and engagement activity is informed by local insight and demonstrably supports delivery of organisational priorities and improved health outcomes.

6. Strategic principles

The way we work is as important as what we do. We will:

Start with insight

We will use evidence, data and community insight to focus engagement and understand what matters to people before deciding how we communicate or engage.

Communicate with honesty

We will be open about successes, challenges and difficult decisions.

Involve people early

We will seek views before decisions are made wherever possible, rather than simply explaining decisions after they have been taken.

Focus on people, not organisations

We will communicate in ways that make sense to local people and focus on what matters to them.

Tell authentic stories

We will use real experiences from patients, staff and communities alongside evidence and data to explain why change matters, celebrate improvement and build trust in health and care.

Prioritise inclusion

We will not rely on a single route for participation. Instead, we will use a range of accessible and targeted engagement methods to hear from a wider diversity of people and communities, especially those whose voices are often underrepresented in decision-making or those most impacted by our decisions.

Work collaboratively

We will work with our health and care partners, locally, regionally and nationally.

Evaluate impact, learn and improve continuously

We will continually evaluate our communications and engagement, learn from evidence, research and best practice across the NHS and beyond, and adopt approaches that have been shown to improve participation, inclusion and impact.

7. Our strategic approach

To support delivery of NHS Essex plans we will focus on four areas.

7.1. Explain

Helping people understand:

- Why change is needed
- What improvements are being made
- How services can be accessed
- How decisions are reached

7.2. Listen

Creating continuous opportunities to hear from:

- Local people
- Communities
- Staff

- Partners
- Stakeholders

7.3. Involve

Embedding involvement throughout commissioning, planning and service improvement activity.

7.4. Build Trust

Strengthening confidence through transparency, consistency and visible action in response to feedback. We will bring improvement to life by sharing authentic stories from patients, staff and partners that demonstrate how health services are changing, the challenges we face and the difference collaborative working makes to communities.

8. Working with People and Communities

We believe people should be involved in decisions that affect them.

Our approach will move beyond traditional consultation and place greater emphasis on continuous involvement and relationship building.

We will:

- Meet our statutory duties to involve people and communities
- Strengthen relationships with community organisations and Healthwatch
- Improve opportunities for participation through a range of methods
- Ensure engagement reflects the diversity of Essex communities
- Demonstrate how feedback has influenced decisions

A detailed Working with People and Communities Delivery Plan accompanies this Strategy.

9. Responsibilities

Communications and engagement are everyone's responsibility.

Leaders, managers and staff who work at NHS Essex all play a role in communicating effectively and building relationships with communities and stakeholders.

The Communications and Engagement Team will provide strategic leadership, professional advice, assurance and specialist support to help the organisation deliver this Strategy.

While NHS Essex is responsible for commissioning, strategy, governance and stewardship of NHS resources across Essex, the delivery of health services, and the operational communications and engagement associated with those services, is primarily the responsibility of provider organisations, including GP practices, community services, pharmacies, mental health services, ambulance services and hospitals.

As NHS Essex moves towards a more strategic commissioning model, communications and engagement will focus on providing strategic leadership, insight, assurance and influence across the health and care system.

The ICB's Communications and Engagement function is responsible for:

- Developing a shared narrative that supports delivery of NHS Essex priorities and the Population Health Improvement Plan.
- Identifying and amplifying authentic stories from patients, staff and partners that demonstrate improvements in health and care across Essex.
- Supporting consistent communications across NHS organisations so local, regional and national messaging works together to build trust and understanding.
- Providing strategic communications, engagement and reputation management advice to leaders and programmes.
- Helping to facilitate insight, engagement and intelligence that is used to inform decision-making, campaigns and strategic commissioning.
- Building relationships with partners, stakeholders, communities and system leaders.
- Supporting understanding of NHS Essex's role, priorities and decisions among staff, partners and the public.
- Providing strategic oversight of media relations, issues management and digital communications.
- Delivering internal communications that support organisational culture, leadership visibility and staff engagement.
- Providing assurance that NHS Essex meets its statutory responsibilities to involve people and communities in decisions about health and care services.
- Leading communications during major incidents and periods of system pressure.
- Establishing communications, engagement activity that meets accessibility and digital standards, policies and governance frameworks across NHS Essex.

Communication and engagement are shared responsibilities. Leaders, managers and programme teams are responsible for engaging their audiences effectively, supported by professional advice, guidance and assurance from the Communications and Engagement Team.

10. Measuring Success

Success will be measured through:

- Public awareness and understanding
- Stakeholder confidence
- Staff engagement
- Reach into under-represented communities
- Evidence of community influence on decisions
- Campaign effectiveness
- Reputation and trust measures
- Delivery of statutory responsibilities

Progress will be reported regularly to Executive Team and Board.

11. Risks and mitigations

Risk	Potential impact	Key controls and mitigations
Loss of public trust and Confidence	Reduced confidence in NHS Essex, increased challenge to decisions, lower participation in engagement activity and greater reputational risk.	• Open and transparent communications approach • Clear explanation of challenges and difficult decisions • Publish evidence and rationale for change • Demonstrate how

		feedback influences decisions
Failure to meet statutory engagement duties	Judicial review, programme delays, regulatory challenge and reputational damage.	• Working with People and Communities Framework • Early engagement embedded within commissioning processes • Equality and Health Inequalities Impact Assessments • Governance and assurance arrangements
Inability to build support for future service transformation	Increased opposition to change, political challenge, consultation fatigue and delays to programme delivery.	• Consistent county-wide narrative • Continuous engagement approach • Early discussion of challenges and opportunities • Use of trusted clinical and community voices
Failure to reach and involve underserved communities	Decisions informed by incomplete insight, widening inequalities and reduced confidence in engagement findings.	• Targeted engagement approaches • Community and VCSE partnerships • Accessible communications and engagement materials

		• Neighbourhood-based engagement activity
Communications and engagement capacity unable to meet organisational demand	Reduced quality and responsiveness of support, delayed programme delivery and workforce resilience risks.	• Prioritisation framework • Defined service offer • Early communications involvement in programmes • Workforce planning, succession planning and development opportunities

All risks will be monitored in line with NHS Essex's risk policy.

12. Conclusion

Communications, engagement and involvement are fundamental to making health services better in Essex.

By communicating clearly, listening actively and involving people meaningfully, NHS Essex will build stronger relationships, make better decisions and improve health outcomes for the communities we serve.

NHS Essex Communications and Engagement Strategy

Appendix 1: Internal Communications Delivery Plan

1. Purpose

This delivery plan sets out how NHS Essex will use internal communications and engagement to support organisational effectiveness, culture, leadership visibility and staff involvement.

It supports delivery of:

- NHS Essex Communications, Engagement and Involvement Strategy
- Organisational Development (OD) Plan
- NHS Essex operating model
- Workforce priorities
- Corporate objectives
- Population Health Improvement Plan

2. Strategic Context

2.1. 2026/27 will be a significant year for NHS Essex as we:

- Establish a new organisational identity following the creation of NHS Essex
- Embed new governance arrangements
- Launch the Organisational Development Strategy
- Develop new ways of working
- Build a single organisational culture
- Support staff through organisational change
- Strengthen leadership visibility and engagement
- Deliver organisational priorities and improve outcomes for residents

Internal communications will play a key role in helping staff understand organisational priorities, connect to the organisation's purpose, influence decision-making and contribute to building a positive organisational culture. Internal communications are everyone's business. While the Communications and Engagement Team provides strategic leadership and professional support, effective communication is the responsibility of all leaders and managers across NHS Essex.

2.2 Strategic principles

Internal communications will be:

- **Staff-centred** - focused on what staff need to know, feel and do.

- **Leadership-led** - visible, authentic leadership communications.
- **Two-way** - creating opportunities for dialogue, listening and involvement.
- **Insight-led** - shaped by staff feedback, engagement data and organisational insight.
- **Inclusive** - accessible, equitable and reflective of our diverse workforce.
- **Prioritised** - focused on organisational priorities and meaningful communication.

2.3 Strategic priorities

Priority 1: Building a shared NHS Essex culture

Supporting the development of a shared identity, values, behaviours and organisational culture.

Priority 2: Leadership communication and visibility

Ensuring leaders communicate consistently, visibly and authentically with staff.

Priority 3: Staff voice and involvement

Creating opportunities for staff to influence decisions, shape organisational development and contribute ideas.

Priority 4: Modern and effective communication channels

Providing accessible, engaging and effective channels that support communication, collaboration and engagement.

2.4 Strategic Outcomes

Outcome 1: Staff understand NHS Essex's vision, priorities and objectives.

Measures:

- Staff pulse survey results
- Staff briefing feedback
- Staff survey results
- Understanding of organisational priorities

Outcome 2: Staff feel informed about decisions that affect them and their work.

Measures:

- Communication effectiveness scores
- Staff feedback
- Staff survey results
- Pulse survey results

Outcome 3: Leaders communicate consistently, visibly and effectively.

Measures:

- Leadership visibility measures
- Staff confidence in leadership
- Staff briefing attendance
- Leadership communication activity

Outcome 4: Staff feel able to influence, shape and contribute to the development of NHS Essex.

Measures:

- Participation rates
- Staff network engagement
- Staff Partnership Forum activity
- Staff feedback themes
- "You said, we listened" actions

Outcome 5: A positive organisational culture is established and embedded.

Measures:

- Staff survey results
- Values and behaviours programme milestones
- Staff retention indicators
- Organisational culture feedback

2.5 Strategic content framework

Content will align to: **Making Health Services Better in Essex**

Supporting themes:

- Organisational vision
- PHIP priorities
- OD strategy
- New operating model
- Governance changes
- Workforce wellbeing
- Leadership communications
- Staff recognition
- Equality, diversity and inclusion
- Learning and development

3. Key audiences

Primary audiences:

- NHS Essex staff
- Senior leaders
- Line managers

Secondary audiences:

- Board members
- Staff network leaders
- Communications champions

4. Key channels

Channel	Purpose
Intranet	Primary information hub
Viva Engage	Discussion, collaboration and dialogue
Staff briefings	Leadership visibility and organisational updates
Team briefings	Local engagement and communication
Staff bulletin	Organisational news and updates
Leadership blogs	Context, narrative and leadership visibility
Staff events	Engagement and involvement
Pulse surveys	Listening and organisational insight
Staff networks	Inclusion, engagement and staff voice

5. Success Measures

Staff understanding

- 80% of staff attending staff briefings report they understand the organisational priorities.
- 80% of staff attending staff briefings report they understand key organisational changes.

Leadership visibility

- At least 75% of staff report they have seen or heard from a senior leader in the previous three months.
- Monthly leadership communication activity delivered as planned.

Staff engagement

- Staff briefing attendance maintained or increased year on year.
- Pulse survey participation exceeds 60%.
- Participation in engagement activities increases year on year.

Communication effectiveness

- Staff bulletin open rates maintained above 60%.
- Intranet engagement increases year on year.
- Staff rate internal communications as effective through survey feedback.

Staff voice

- Quarterly "You said, we listened" updates published.
- Staff networks active and represented across the organisation.
- Staff feedback themes reviewed quarterly.

Culture and organisational development

- Values and behaviours framework developed and launched by September 2026.
- Values embedded through organisational development activity by March 2027.
- Staff survey indicators relating to communication, involvement and culture improve over time.

6. Governance

The delivery plan will be monitored through:

- Quarterly reporting to Executive Team
- Communications and Engagement Team performance reporting
- Organisational Development governance arrangements
- Staff survey and pulse survey reporting

7. Risks and mitigations

Risk	Mitigation
Staff information overload	Prioritised communications and channel governance.
Lack of leadership engagement	Leadership communication expectations and support.
Low staff participation	Increased opportunities for engagement and feedback.
Inconsistent communication across teams	Manager communication support and guidance.
Change fatigue	Clear communication, listening and staff involvement.

Internal communications implementation plan 2026/27

Priority 1: Building a shared NHS Essex culture

Objective	Activity	Timeline	Lead	Success measure
Develop NHS Essex values and behaviours	Review legacy ICB values and behaviours to identify common themes	July-August 2026	OD / Comms	Review completed
Develop NHS Essex values and behaviours	Staff engagement programme including workshops, drop-ins, online survey and staff briefing discussions	July-September 2026	OD / Comms	Minimum 40% staff participation
Develop NHS Essex values	Develop final values and	September 2026	OD	Framework approved

Objective	Activity	Timeline	Lead	Success measure
and behaviours	behaviours framework			
Launch organisational values	Organisation-wide launch campaign	October 2026	Comms	80% awareness among staff
Embed values into organisational culture	Integrate values into induction, appraisal, recruitment and recognition processes	October 2026-March 2027	OD / HR	Implementation milestones achieved
Build organisational identity	Develop "Making Health Services Better in Essex" internal narrative and messaging framework	Q3 2026	Comms	Narrative adopted across communications
Celebrate staff contribution	Introduce regular staff recognition stories and case studies	Monthly	Comms	Minimum one story per month

Priority 2: Leadership communication and visibility

Objective	Activity	Timeline	Lead	Success measure
Increase leadership visibility	Monthly staff briefings with CEO and Executive Team	Monthly	Comms/ Executive Team	Attendance maintained or increased
Increase leadership visibility	Executive blogs and leadership updates	Monthly	Executive Team	One leadership communication per month
Improve communication cascade	Develop manager briefing framework	September 2026	Comms	Framework implemented

Objective	Activity	Timeline	Lead	Success measure
Support leaders to communicate effectively	Comms toolkit for managers and senior leaders	October 2026	Comms / OD	Toolkit launched
Increase access to leaders	Leadership Q&A sessions	Quarterly	Executive Team	Minimum 75% positive feedback
Strengthen executive visibility	Video updates from executive directors	Bi-monthly	Comms	Engagement monitored
Build leadership trust	Publish "You asked, we listened" responses following staff feedback	Quarterly	Comms	Four updates published

Priority 3: Staff voice and involvement

Objective	Activity	Timeline	Lead	Success measure
Strengthen staff voice	Launch quarterly pulse surveys	Quarterly	Comms / OD	Response rate above 60%
Support Staff Partnership Forum	Establish communication channels and reporting arrangements	July 2026	Comms	Forum updates published
Support staff networks	Promote network activity and opportunities for involvement	Monthly	Comms	Increased network participation
Improve feedback loops	Publish "You said, we listened" updates	Quarterly	Comms	Four updates published
Increase staff involvement	Staff consultation and engagement activity on major organisational changes	Ongoing	Comms / OD	Participation targets achieved

Objective	Activity	Timeline	Lead	Success measure
Gather organisational insight	Analyse staff feedback themes and report findings	Quarterly	Comms / OD	Quarterly insight reports produced

Priority 4: Modern and effective communication channels

Objective	Activity	Timeline	Lead	Success measure
Develop intranet as primary staff hub	Deliver Phase 2 intranet improvements	2026/27	Comms	Improvement programme completed
Improve intranet content governance	Introduce content standards and ownership model	September 2026	Comms	Governance framework agreed
Strengthen staff bulletin	Review content structure and effectiveness	August 2026	Comms	Open rate maintained above 60%
Deliver regular organisational updates	Publish staff bulletin	Fortnightly	Comms	Delivery maintained
Improve channel performance	Develop communication dashboard and reporting framework	October 2026	Comms	Dashboard implemented
Improve accessibility	Ensure all internal communication channels meet accessibility standards	Ongoing	Comms	Compliance maintained
Strengthen digital engagement	Increase use of Viva Engage and interactive content	Ongoing	Comms	Engagement increases year-on-year

NHS Essex Communications and Engagement Strategy

Appendix 2: External Communications Delivery Plan

1. Purpose

This delivery plan sets out how NHS Essex will use external communications, media relations, digital communications and campaigns to:

- Support delivery of the Population Health Improvement Plan (PHIP)
- Build trust and confidence in NHS Essex and the wider health and care system.
- Explain priorities, decisions and changes to services.
- Support prevention and behaviour change.
- Improve understanding of health and care services.
- Support delivery of wider organisational objectives.
- Strengthen relationships with stakeholders and partners.
- Ensure communities can influence decisions that affect them.

2. Strategic Context

NHS Essex is operating at a time when priorities and services are shifting against a backdrop of:

- Rising demand for health and care services.
- Significant health inequalities.
- Financial pressures across the public sector.
- NHS and local authority reform.
- Increasing public expectations.
- A rapidly changing digital and media landscape.

As a strategic commissioner, NHS Essex has a key role in improving health outcomes, reducing inequalities and ensuring services are sustainable for the future.

Effective external communication is essential to maintaining confidence and supporting improvement, while demonstrating NHS Essex is listening to people and acting on feedback to improve services for all. Communications also plays a critical role in supporting the three shifts set out in national policy:

- Hospital to community.
- Treatment to prevention.
- Analogue to digital.

This delivery plan supports:

- The Population Health Improvement Plan (PHIP).

- The NHS Essex five-year plan.
- Organisational objectives.
- Neighbourhood health development.
- Strategic commissioning priorities.

3. Strategic Principles

3.1. **External communications will be:**

- **Audience and data-led** - driven by insight and community understanding.
- **Honest** - open about challenges as well as successes.
- **Outcome-focused** - supporting organisational priorities and measurable change.
- **Consistent** - using a shared narrative across programmes and channels.
- **Inclusive –** accessible, representative and designed for all communities.
- **Evidence-based** - grounded in research, evaluation and insight.
- **Human-centred** - focused on real people, lived experience and community voices
- **Proactive** - Identifying risks, addressing misinformation and building trust before issues escalate.

3.2 Strategic Outcomes

Strategic outcome	What success looks like	How communications will contribute
Outcome 1: Greater understanding of NHS Essex and its priorities	Residents, patients and stakeholders understand the role of NHS Essex, its priorities and the decisions it makes.	Develop a clear NHS Essex narrative, explain commissioning decisions, use storytelling and case studies, and provide accessible information across channels.
Outcome 2: Increased public trust and confidence in NHS Essex	Residents and stakeholders view NHS Essex as a trusted and transparent organisation.	Deliver honest communications, demonstrate impact through real stories, media engagement and show how

Strategic outcome	What success looks like	How communications will contribute
		public feedback influences decisions.
Outcome 3: Improved understanding of prevention and healthy behaviours	More people understand how to stay well and are aware of services that support prevention and early intervention.	Deliver clear and relevant messages to inform prevention campaigns, promote screening and vaccination programmes, provide evidence-based health information and support behaviour change activity.
Outcome 4: Improved understanding of transformation and service change	Residents and stakeholders understand why changes are taking place and how they will benefit local communities.	Deliver proactive communications, engagement and consultation activity, explain decisions clearly and communicate the benefits of transformation programmes.
Outcome 5: Stronger stakeholder confidence and relationships	Stakeholders feel informed, engaged and involved in NHS Essex priorities and programmes, and feel empowered to work alongside the ICB in times of success and challenge.	Provide regular stakeholder communications, strengthen relationships with partners and support shared narratives across the system.
Outcome 6: Increased public participation in shaping health and care services	More residents take part in consultations, engagement and co-production activities.	Promote engagement opportunities, support consultation activity and demonstrate how feedback influences decisions through "you said, we did" reporting.
Outcome 7: Improved reach and engagement with underserved communities	Communications are more representative and reach communities who traditionally engage less with health services.	Use targeted communications, community partnerships, accessible content and audience insight to improve reach and representation.
Outcome 8: Improved confidence in trusted health information and reduced impact of misinformation	Residents are better able to identify trustworthy health information and make informed decisions.	Deliver the Think, Check, Trust pre-bunking campaign, promote trusted NHS information sources

Strategic outcome	What success looks like	How communications will contribute
		and support digital and health literacy.
Outcome 9: Communications contribute to a resilient and sustainable health and care system	Communications demonstrably support delivery of organisational priorities and improved outcomes for residents.	Ensure consistent, accurate and relevant messaging is shared through appropriate external channels that informs, educates and reassures the population. Align communications activity to the Population Health Improvement Plan, organisational objectives and strategic commissioning priorities, supported by robust evaluation and reporting.

3.3 Strategic Narrative Framework

All activity will align to: **Making Health Services Better in Essex**

Supporting themes:

- Population health improvement.
- Prevention.
- Health inequalities.
- Neighbourhood health.
- Care closer to home.
- Access to services.
- Strategic commissioning.
- Partnership working.
- Community involvement.

3.4 Our storytelling approach

Emphasis will be placed on lived experience and the real-world impact of strategic commissioning and population health improvement.

Storytelling should help residents understand:

- how prevention improves lives
- how inequalities are being addressed
- how neighbourhood health supports communities
- how public insight influences decisions

- how commissioning decisions affect people and families.

Storytelling formats will include:

- Case studies
- Short-form video
- Documentary-style storytelling
- Photography
- Community voices
- Vox pops
- Staff stories
- Clinician explainers
- Interactive digital content.

Storytelling should support:

- How prevention improves lives
- How inequalities are being addressed
- How communities influence decisions
- How commissioning decisions affect people
- How NHS Essex is improving outcomes for residents.

4. Key Audiences

Primary Audiences

- Residents
- Patients
- Carers
- Communities experiencing poorer health outcomes
- Communities facing barriers to accessing services

Secondary Audiences

- Local authorities
- NHS providers
- Primary care
- Voluntary, community, faith and social enterprise organisations
- Healthwatch
- MPs
- Councillors
- Professional bodies
- NHS England
- Department of Health and Social Care
- Media (local print, online, broadcast and national where appropriate).

5. Communications framework (PESO)

Paid*	Earned	Shared	Owned
Social media advertising. Search advertising. Digital display advertising. Community media opportunities.	Media relations. Press releases. Broadcast opportunities. Thought leadership. Opinion pieces. Stakeholder publications.	Social media channels. Partner channels. Community networks. Influencers and advocates. Healthwatch. VCFSE networks.	NHS Essex website. Virtual Views. Social media channels. YouTube. Email communications. Digital resources. Publications.

*Paid for activity is only possible subject to budget being available.

6. Key Channels

Channel	Strategic role
NHS Essex website	Trusted source of information and strategic narrative platform.
Virtual Views	Engagement, consultation and co-production.
LinkedIn	Strategic leadership, stakeholder engagement and thought leadership.
Facebook	Community engagement, prevention and campaign delivery.
Instagram	Human stories, visual storytelling and health promotion.
Nextdoor	Neighbourhood-level communications.

Channel	Strategic role
TikTok	Myth-busting, prevention messaging and younger audiences.
YouTube	Explainer content, case studies and longer-form storytelling.
Media relations (print, online, broadcast, local and national where appropriate)	Building trust and providing reassurance, explaining decisions and promoting opportunities for involvement, showcasing progress and supporting transparency.
Stakeholder Bulletin	Personal engagement from the CEO, providing insight, opportunities for involvement and showcasing progress.
News update	Community engagement, providing reassurance and information, providing opportunities for involvement and showcasing progress.

7. Campaign Framework

All major campaigns will follow the OASIS model.

OASIS is a series iterative process that can help bring order and clarity to planning campaigns. The aim is to help make the planning process rigorous and consistent.

The five steps you need to create a campaign using OASIS are:

- Objectives/Outcomes
- Audience/Insight
- Strategy/Ideas
- Implementation
- Scoring/Evaluation

Campaigns will align with:

- Population Health Improvement Plan
- Organisational objectives
- Neighbourhood health priorities
- National priority campaigns, as needed

8. Priorities 2026/27

1. Establish NHS Essex public identity.
2. Launch both public/strategic narrative to support understanding and consistency around the Population Health Improvement Plan.
3. Strengthen public trust by responding openly to issues and regularly sharing progress and results.
4. Support delivery of 26/27 priority programmes within the Population Health Improvement Plan.
5. Support key prevention campaigns, including vaccination, Learning Disability Health Check and cancer screening uptake.
6. Support transformation and change programmes.
7. Strengthen stakeholder relationships.

9. Success Measures

Strategic outcome	Measure	Indicative target
Greater understanding of NHS Essex and its priorities	Minimum of one good news story each week showcasing ICB progress against PHIP Public awareness surveys and engagement activity, specifically, timely circulation of fortnightly public newsletter, monthly stakeholder bulletin and via Virtual Views.	Year-on-year improvement in awareness and understanding. Increase stakeholder understanding of the role of NHS Essex through pulse survey from baseline starting point.
Increased trust and confidence	Media sentiment based on ICB progress against priorities Stakeholder feedback and reputation monitoring	Maintain 75% positive to neutral sentiment. Circulate one positive news item each week.
Improved understanding of prevention and healthy behaviours	Campaign evaluation and public and stakeholder engagement	Campaign objectives achieved and positive audience feedback.
Improved understanding of transformation and service change	Stakeholder and public feedback. Pulse survey responses via newsletters.	Increased understanding and reduced misinformation
Stronger stakeholder confidence and relationships	Stakeholder surveys and engagement metrics	Year-on-year improvement in stakeholder confidence from an initial baseline and survey response rate.
Increased public participation in shaping services	Consultation and engagement participation	Increased participation and broader representation
Improved reach into underserved communities	Audience profiling and demographic analysis	Improved representation from priority groups and areas.
Increased resilience to misinformation	Evaluation of pre-bunking campaign activity	Increased awareness of trusted information sources

Strategic outcome	Measure	Indicative target
Communications support delivery of organisational objectives	Delivery against annual implementation plan	90%+ of planned activity delivered

10. Governance

Quarterly reporting to:

- Executive Team.
- Senior Leadership Team.

Annual review through:

- Corporate planning process.
- Population Health Improvement Plan governance.

Delivery of this strategy will be supported by corporate policies that establish clear standards, responsibilities for communications activities across NHS Essex.

11. Risks and mitigations

Risk	Potential impact	Mitigation
Misinformation and disinformation undermine public confidence in health information and services.	Reduced trust in NHS Essex, confusion among residents and increased reputational risk.	Deliver the Think, Check, Trust pre-bunking campaign, monitor emerging issues, provide rapid responses and work with partners to amplify trusted information.
Low public trust in organisations and institutions.	Reduced engagement with communications, consultations and behaviour change campaigns.	Use transparent and honest communications, demonstrate impact through real stories, publish clear evidence and show how public feedback influences decisions.
Failure to reach underserved communities.	Existing health inequalities could widen, and key audiences may not	Use targeted communications, community partnerships, audience insight, accessible formats and

Risk	Potential impact	Mitigation
	receive important information.	translated materials where appropriate.
Significant service changes generate negative public or media attention.	Reputational damage and reduced confidence in decision-making.	Implement proactive communications and engagement plans, provide clear rationale for decisions and ensure early stakeholder engagement. Engage media contacts at an early stage to support understanding, limit negative news and misleading information and provide a trusted ICB contact for updates.
Service changes are perceived to negatively impact the most vulnerable communities, going against the ICB's drive to reduce health inequalities.	Reputational damage, key communities become disengaged, loss of trust and confidence in decision-making.	Ensure engagement activity reaches the most vulnerable communities early, provide clear rationale and feedback on insight gathered.
Limited communications resource and capacity.	Reduced ability to deliver planned activity and respond to emerging issues.	Workforce planning. Prioritise activity against organisational objectives, use annual implementation plans and maximise partner and shared channels.
Changes to social media algorithms or platform performance.	Reduced reach and effectiveness of digital communications.	Maintain a balanced PESO approach, strengthen owned channels and regularly review channel performance.
Failure to demonstrate communications impact.	Reduced organisational confidence in communications investment and activity.	Implement robust evaluation, establish baseline measures and provide regular performance reporting.

Risk	Potential impact	Mitigation
Accessibility or health literacy standards are not maintained.	Some communities may be excluded from information and engagement opportunities.	Continue accessibility monitoring, apply health literacy principles and maintain compliance with accessibility legislation.
Major incidents, emergency planning incidents or unplanned events divert resources.	Planned campaigns and proactive communications activity may be delayed.	Maintain flexible workplans, prioritise statutory and urgent communications and ensure business continuity arrangements are in place.
Partner organisations communicate inconsistent messages.	Public confusion and reduced confidence in system communications.	Maintain productive and trusted relationships with partners. Develop shared narratives, provide partner toolkits and maintain regular stakeholder engagement.
Public consultation fatigue reduces participation.	Lower levels of engagement and reduced representativeness of feedback.	Coordinate engagement activity, demonstrate "you said, we did" outcomes and use a variety of engagement methods.
Increased use of artificial intelligence and synthetic media makes it harder for residents to identify trusted information.	Increased vulnerability to misinformation and fraud.	Deliver public awareness campaigns, promote trusted NHS information sources and incorporate AI literacy within pre-bunking activity.
Communities in west and north-east Essex feel disconnected with the ICB following reorganisation, leading to public frustration.	Low levels of engagement, increased risk of misinformation, negative publicity.	Increased ICB communications activity in west and north-east Essex, showcase proportionate number of lived experience stories and initiatives in these areas, build productive relationships with local media in these areas.

Content and channel framework

This framework sets out the primary role of each communication channel and supports a channel-first approach to content planning. Content should be tailored to audience needs and channel behaviours rather than duplicated across all platforms.

All content should support one or more of the following strategic themes:

- Population Health Improvement Plan (PHIP)
- Prevention and behaviour change
- Health inequalities
- Neighbourhood health
- Strategic commissioning
- Service transformation
- Access to services
- Trust and transparency
- Partnership working

Channel	Primary audience	Strategic purpose	PHIP-aligned content themes	Best content formats	Content to limit
Website	All audiences	Trusted information hub and strategic narrative platform	Service information, PHIP, prevention, service change, public engagement	Articles, case studies, explainer pages, consultation content, videos	Duplicate content from social channels
Media relations	Residents, stakeholders, opinion formers	Build trust, explain decisions, manage reputation, open opportunities	Strategic priorities, prevention, transformation, partnership working	Press releases, interviews, media briefings, feature articles, case studies	Reactive-only communications
Broadcast media	Residents and communities	Reach large audiences with trusted messages	Prevention, service change, public information	Television and radio interviews, case studies, expert commentary	Corporate announcements without public relevance
Stakeholder briefings	MPs, councillors, partners, NHS orgs	Build understanding and confidence among key stakeholders	Strategic commissioning, transformation, PHIP	Briefings, newsletters, presentations	Excessive operational detail

Channel	Primary audience	Strategic purpose	PHIP-aligned content themes	Best content formats	Content to limit
Community and partner networks	VCFSE, community leaders, Healthwatch	Reach underserved communities through trusted partners	Prevention, inequalities, neighbourhood health	Toolkits, newsletters, posters, community resources	Corporate news with little community relevance
Virtual Views	Residents, patients, stakeholders	Formal engagement, consultation and co-production	Public participation, transformation, service change	Consultations, surveys, engagement reports	General news content
LinkedIn	Professionals, partners, stakeholders	Leadership, strategic positioning and partnership engagement	Strategic commissioning, partnerships, innovation, workforce	Articles, newsletters, thought leadership, leadership videos	General public health advice
Facebook	Adults aged 30+	Community engagement and prevention campaigns	Prevention, patient stories, service improvements, community initiatives	Videos, photo stories, graphics, links	Generic awareness days without local relevance
Instagram	Adults aged 18–40	Human-centred storytelling and prevention	Staff stories, patient stories, prevention, wellbeing	Reels, carousels, photography, graphics	Long text-heavy posts
TikTok	Adults aged 16–35	Engage younger audiences and tackle misinformation	Prevention, myth-busting, health literacy, patient experiences	Short-form video, trends, clinician explainers	Corporate announcements
Nextdoor	Local residents	Hyper-local health communications	Community services, prevention, local clinics and events	Short updates, event notices, local links	National policy announcements
WhatsApp Community	Opt-in residents and community groups	Deliver timely, trusted information	Service updates, reminders, local health campaigns	Short text updates, links, simple graphics	Frequent or lengthy messaging
YouTube Shorts	Public seeking quick information	Deliver bite-sized health content	Prevention, myth-busting, awareness campaigns	Vertical videos under 60 seconds	Long-form content
YouTube Long-form	Residents, patients, stakeholders	Provide deeper storytelling and education	Patient journeys, service impact, transformation,	Documentary-style videos, interviews, explainers	Content better suited to short-form channels

Channel	Primary audience	Strategic purpose	PHIP-aligned content themes	Best content formats	Content to limit
			neighbourhood health		
Community events and outreach	Residents, community groups, underserved communities	Face-to-face engagement and trust building	Prevention, inequalities, public participation	Roadshows, community events, listening activities	One-way information sharing
Printed materials	Residents with limited digital access	Support inclusion and accessibility	Prevention, access to services, public information	Posters, leaflets, community resources	Large volumes of general information

Content planning principles

Content should prioritise:

- Real people and lived experience.
- Prevention and population health improvement.
- Neighbourhood health and community impact.
- Explaining strategic commissioning and service change.
- Building trust through transparency.
- Tackling misinformation through the Think, Check, Trust approach.
- Demonstrating how NHS Essex is making health services better in Essex.

As a guide, content planning should broadly follow:

- 50% patient, resident and community stories based on strategic commissioning, transformation and neighbourhood health
- 25% prevention and population health improvement.
- 15% access to services and service information.
- 5% partnership and stakeholder content
- 5% trust, transparency and misinformation content.

NHS Essex Communications and Engagement Strategy

Appendix 3: Working with People and Communities Delivery Plan

1. Purpose

This delivery plan sets out how NHS Essex will work in partnership with people and communities to:

- Improve decision-making through lived experience and community insight
- Reduce health inequalities
- Build trust and confidence in the NHS
- Support delivery of the Population Health Improvement Plan
- Meet statutory duties to involve people in decisions about health services

2. Strategic Context

NHS Essex serves almost two million residents across diverse communities with significant variation in health outcomes and experiences.

People experience services, not organisations. To improve health and care outcomes, NHS Essex must work alongside residents, patients, carers, communities and partners to understand what matters most and involve them in shaping decisions.

This approach supports:

- NHS Act 2006 Section 14Z45 duty to involve
- Equality Act 2010 Public Sector Equality Duty
- NHS England Working in Partnership with People and Communities Guidance
- Core20PLUS5 and health inequalities objectives
- Population Health Improvement Plan ambitions
- Neighbourhood Health Service development

NHS Essex is operating in a period of significant transformation. The NHS 10-Year Plan and Model ICB Blueprint reinforce the need for Integrated Care Boards to move beyond organisation-led approaches to planning and service redesign. Instead, ICBs are expected to work in partnership with people, communities, local authorities, providers and the voluntary sector, ensuring that lived experience, community insight and neighbourhood relationships help shape commissioning decisions, improve outcomes and reduce inequalities.

As services increasingly develop through neighbourhood health models, engagement must also become more local, relational and continuous. Working with people and communities is fundamental to improving population health, reducing inequalities and ensuring services reflect the realities of people's lives.

This delivery plan builds on strong foundations established across Mid and South Essex, West Essex and North East Essex and provides a consistent Essex-wide approach to involvement, co-production and community partnership.

2.1. Strategic Principles

Working with people and communities will be:

- **Continuous**
  Engagement is ongoing and not limited to consultations.
- **Inclusive**
  Actively reaching people whose voices are least often heard.
- **Influential**
  Demonstrating how insight informs decisions.
- **Proportionate**
  Matching engagement activity to the scale and impact of decisions.
- **Community-centred**
  Working through trusted community networks and organisations.
- **Transparent**
  Providing feedback and demonstrating impact.
- **Evidence-based**
  Combining lived experience with data and intelligence.
- **Collaborative**
  Supporting co-production wherever appropriate.

In addition to the principles outlined above, NHS Essex will be guided by six core commitments:

1. Start with people, design services around lived experience.
2. Co-produce as standard, involve communities from the earliest stages of planning and design.
3. Neighbourhood first, ensure engagement is local, continuous and connected to communities.
4. Focus on inequalities, prioritise communities facing the greatest barriers to health and care.

5. From insight to action, demonstrate how involvement influences decisions.
6. Be open and accountable, clearly communicate what we heard and what we did.

2.2. Strategic Outcomes

Outcome 1
People and communities influence decisions about health and care services.

Outcome 2
NHS Essex demonstrably meets statutory duties to involve.

Outcome 3
Greater participation from underserved and seldom-heard communities.

Outcome 4
Lived experience is routinely used in commissioning and service improvement.

Outcome 5
Improved trust, confidence and transparency.

Outcome 6
Reduced inequalities in participation and engagement.

Outcome 7
Working with people and communities is embedded within organisational culture and governance.

Collectively, these seven outcomes align with all ten NHS England principles for working with people and communities, ensuring that NHS Essex moves beyond transactional consultation towards a culture of continuous partnership with people and communities. The outcomes support statutory compliance, reduce inequalities, strengthen public trust, embed lived experience in decision-making and provide assurance that engagement is integral to governance, commissioning and service improvement.

2.3. Strategic Framework

All activity will support delivery of the Population Health Improvement Plan that sets out six system ambitions:

- **Start Well**
  Giving every child the best start in life by strengthening maternity, early years support, SEND pathways and early intervention.

- **Live Well**
  Supporting people to stay healthy for longer through prevention, screening, vaccination and better long-term condition management.

- **Feel Well**
  Improving mental health and emotional wellbeing through earlier support, community-based care and reduced reliance on inpatient services.

- **Age Well**
  Helping people to live independently for longer by improving frailty care, falls prevention and coordinated community support.

- **Die Well**
  Ensuring high-quality, compassionate end-of-life care that respects personal preferences and improves advance care planning.

- **Respond Well**
  Delivering timely access to urgent and emergency care, improving system flow and ensuring people receive the right care in the right place.

Public involvement activity will be prioritised towards the organisation's most significant transformation programmes and commissioning decisions, ensuring lived experience helps shape prevention, neighbourhood health services and improvements in access, experience and outcomes.

Ultimately, working towards making health services better in Essex by:

- Understanding community priorities
- Building relationships with communities
- Co-producing solutions
- Feeding back outcomes
- Measuring impact

3. Key Audiences

Primary Audiences:

- Residents
- Patients
- Carers
- Communities experiencing poorer health outcomes informed by the Core20PLUS5 approach
- People with protected characteristics
- Seldom-heard groups

Secondary Audiences:

- Community leaders
- Healthwatch

- VCSE organisations
- Local authorities
- Primary Care Networks
- NHS providers
- Faith organisations
- NHS staff
- Health and Wellbeing Boards
- Scrutiny Committees

4. Delivery model

Working with people and communities will operate across three levels:

Neighbourhood

Primary Care Networks and Integrated Neighbourhood Teams will lead local engagement.

Neighbourhood-level involvement will:

- Strengthen Patient Participation Groups within primary care
- Build relationships with community leaders and VCSE partners
- Support social prescribing and asset-based approaches
- Embed codesign in local service redesign

This reflects the central role of neighbourhoods within the 10-Year Plan.

Place (Alliances)

In each 'Place' engagement will be coordinated across boroughs and districts, aligning with Joint Strategic Needs Assessments and local authority strategies.

Place-level engagement will:

- Support transformation programmes
- Ensure EHIAs are completed and acted upon
- Coordinate targeted engagement with priority populations

System (Essex-wide)

System functions will:

- Maintain and develop online engagement through Virtual Views and strategic Voluntary and Community sector involvement.
- Collate insight into a shared Essex Insight Bank

- Provide support and advice to build organisational capability for working with people and communities shaping a culture where working with people and communities is recognised as everyone's responsibility
- Provide assurance to the ICB Board
- Ensure statutory consultation requirements are met

5. Key mechanisms

Mechanism	Role
Essex Virtual Views	Public participation and consultation
Insight Bank	Community intelligence and evidence
Healthwatch Essex	Independent patient voice
VCSE Networks	Community engagement and trusted relationships
Readers' Panels	Testing materials and communications
Community Champions	Local advocacy and feedback
Neighbourhood Engagement Networks	Place-based insight and co-design
Public Surveys	Understanding priorities and experiences
Focus groups and deliberative events	In-depth engagement
Co-production Groups	Service design and improvement

6. Engagement Assurance Framework

All significant programmes are expected to demonstrate:

- Early engagement planning
- Stakeholder mapping
- Use of existing insight
- Equality and Health Inequalities Impact Assessment
- Proportionate engagement activity
- Feedback and "you said, we did" reporting
- Evidence of influence on decision-making

6.1. Programme Assurance Requirements

Programme Boards are expected to:

- Identify a Communications and Engagement Champion.
- Include engagement as a standing agenda item, demonstrating proportionate engagement plans.

- Use existing insight before commissioning new engagement.
- Complete Equality and Health Inequalities Impact Assessments, where appropriate.
- Demonstrate how public insight has informed recommendations.
- Provide evidence of co-production where appropriate.
- Escalate risks an requirements relating to statutory consultation requirements.

7. Priorities 2026/27

1. Establish a system-wide approach to working with people and communities.
2. Re-launch and embed the NHS Essex Insight Bank.
3. Develop neighbourhood-level engagement infrastructure.
4. Strengthen partnerships with VCSE organisations and Healthwatch.
5. Increase participation from underserved communities.
6. Embed engagement requirements within commissioning and transformation programmes.
7. Develop co-production capability across NHS Essex.
8. Establish process to ensure assurance and reporting.
9. Support delivery of the Population Health Improvement Plan.
10. Demonstrate compliance with NHS England statutory guidance.

8. Success Measures

8.1. Assurance Measures

- Percentage of major programmes with approved engagement plans
- Percentage of major programmes with a completed Equality and Health Inequalities Assessment

8.2. Impact Assessments

- Number of programmes evidencing public influence on decisions
- Compliance with statutory involvement requirements
- Assurance against NHS England Working with People and Communities principles

8.3. Participation Measures

- Number of residents engaged
- Representation from priority communities
- VCSE partner participation
- Readers' Panel membership and diversity
- Neighbourhood engagement activity levels

8.4. Impact Measures

- Examples of decisions influenced by engagement
- Stakeholder confidence measures
- Public trust indicators
- Reduction in participation inequalities
- Community feedback on engagement quality

9. Governance

Quarterly reporting to:
• Executive Team

Annual reporting through Integrated Care Board Annual Report.

10. Risks and Mitigations

Risk	Mitigation
Engagement undertaken too late to influence decisions.	Mandatory engagement planning at programme inception.
Under-representation of underserved communities.	VCSE partnerships, targeted outreach and community-led engagement.
Failure to meet statutory duties.	Assurance framework, engagement checkpoints and executive oversight.
Consultation fatigue and declining participation.	Continuous engagement model and better use of existing insight
Lack of evidence that engagement influences decisions.	Formal "You said, We did" reporting and Board assurance requirements.
Insufficient capacity to deliver statutory engagement and involvement duties across Essex.	Continue strategic partnership with Healthwatch organisations to provide engagement capacity, independent community insight and lived experience intelligence. This provides resilience should national reforms transfer additional patient voice responsibilities to ICBs.

ICB Board Meeting of 16 July 2026

Agenda Number: 19.1

Essex ICB Risk Appetite Statement

Summary Report

1. Purpose of Report

1.1. This paper presents the Essex ICB Risk Appetite Statement for consideration and approval by the Board.

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 has responsibility for setting the risk appetite for the ICB. The Executive Committee has provided views and guidance and contributed to the development of the statement and endorsed the statement for approval by the Board.

5. Link to the ICB's Strategic Objectives

5.1. The document supports each organisational objective setting the risk appetite that will frame the management of risks across all 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

6.1. Not Applicable.

7. Financial Implications

7.1. None.

8. Details of patient or public engagement or consultation

8.1. The risk appetite is set by the Board but will be published on the ICB website.

9. Conflicts of Interest

9.1. None identified.

10. Recommendation/s

10.1. The Board is asked to consider and approve the risk appetite statement.

Essex ICB Risk Appetite Statement

1. Introduction

As part of the organisations approach to establishing mature governance and risk management arrangements, the organisation has developed a formal Risk Appetite Statement aligned to best practice and the Good Governance Institute framework. This framework will support assurance and the delivery of the organisation's corporate objectives.

The need for a clear articulation of risk appetite is driven by:

- The ICB's role as a strategic commissioner
- An increasingly complex, resource-constrained and dynamic operating environment
- The requirement to make difficult decisions, including prioritisation, transformation and disinvestment
- A need for greater consistency and clarity in risk-based decision-making and oversight

The development of risk appetite forms a key component of the wider approach to enhancing the Board Assurance Framework and supporting more proactive, risk-informed governance.

The purpose of this paper is therefore to:

- Present the Essex ICB Risk Appetite Statement
- Describe the approach undertaken to develop the statement
- Explain the strategic importance of risk appetite in decision-making and assurance

The statement represents a key step in strengthening the ICB's risk management framework, providing clarity on the level of risk the organisation aims to operate within (appetite) and what it is willing to tolerate in pursuit of its strategic objectives.

The development of the Risk Appetite Statement has been informed through engagement with the Executive Committee and Board, including structured discussion and consensus-building using the Good Governance Institute (GGI) risk appetite framework.

The resulting position supports the ICB's role as a strategic commissioner, enabling informed, consistent and transparent decision-making across the organisation, whilst maintaining appropriate oversight and assurance.

It also acknowledges the wider context within which the ICB is operating, and in particular the current changes taking place to the regulatory regime.

The Board is asked to endorse the Risk Appetite Statement and support its embedding within decision-making, the Board Assurance Framework (BAF), and organisational governance processes.

2. Main content of Report

A clearly defined risk appetite is critical to ensuring that the organisation:

- Makes informed and consistent decisions aligned to strategy
- Understands the level of risk it is prepared to accept in delivering objectives
- Balances innovation and transformation with appropriate assurance
- Supports effective Board and Committee oversight
- Enables translation of risk appetite into target risk scores within the BAF

Ultimately, risk appetite enables the organisation to move from reactive risk management to proactive, risk-informed decision-making. The agreed approach will be widely shared with the organisation to support appropriate risk management.

Strategic Context: PHIP and Health Inequalities

The ICB's risk appetite is explicitly aligned to its Population Health Improvement Plan (PHIP) and corporate objectives.

The PHIP provides the primary framework through which the ICB delivers:

- Improved population outcomes
- A shift towards prevention and neighbourhood-based care
- Sustainable and equitable health and care services

As such, risk is not managed in isolation but is purposefully directed to support delivery of the PHIP.

Central to this approach is the recognition that reducing health inequalities is a cross-cutting priority, underpinning all decision-making. Risk appetite has therefore been shaped to enable:

- Innovation in service design and delivery
- Targeted interventions for underserved or higher-risk populations
- System-wide approaches that address variation in outcomes

Risk appetite is therefore not solely about managing downside risk, but about enabling the ICB to take considered risks necessary to improve health outcomes and reduce inequalities across Essex.

Development of the Risk Appetite Statement

The Risk Appetite Statement (stated in appendix A) has been developed through a structured process, including:

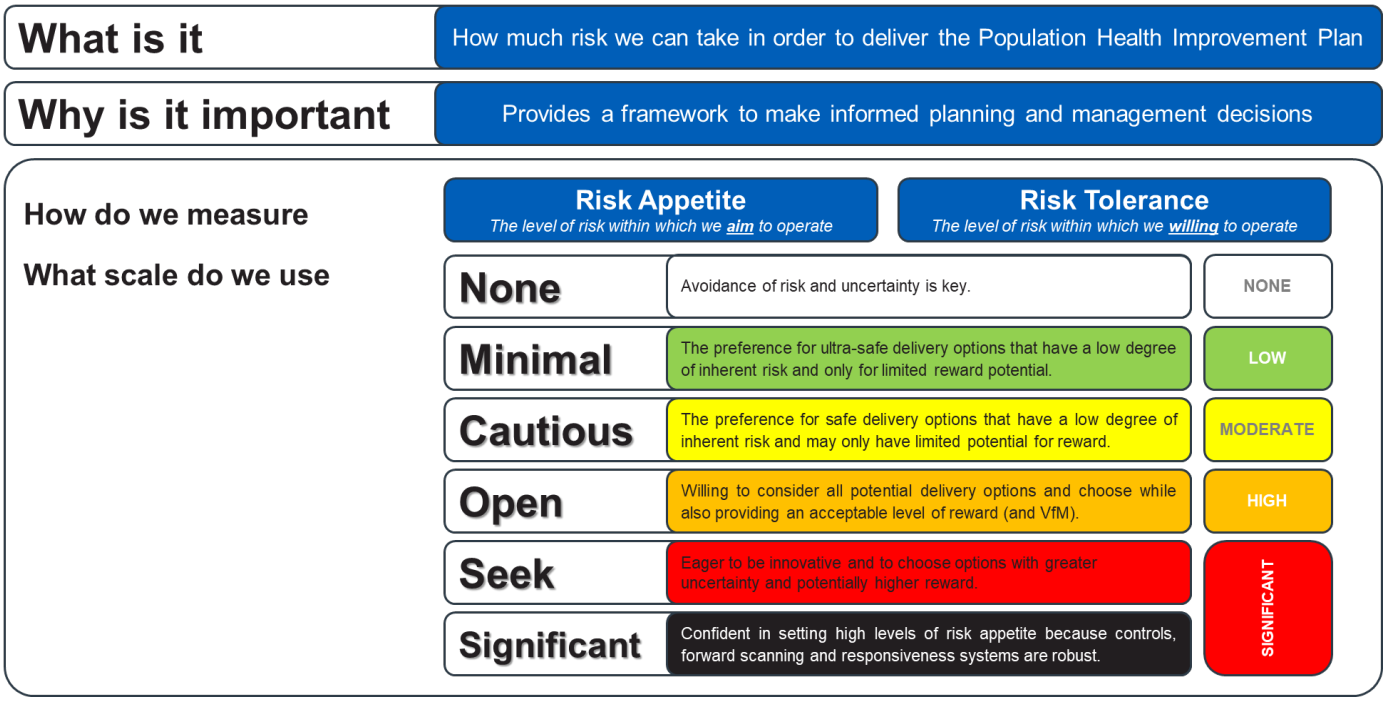
- Application of the Good Governance Institute Risk Appetite Matrix
- Consideration by the Executive Committee (May 2026)
- A dedicated ICB Board seminar (21 May), enabling discussion and calibration of appetite levels
- Capture of Board and Executive views through facilitated discussion and feedback
- Endorsement of the formal statement by the Executive Committee on 16 June 2026

This process reinforced three key principles:

- Risk appetite must be aligned to organisational objectives
- The organisation must define clear thresholds for acceptable risk
- Risk appetite must be communicated and consistently applied across the organisation

Through this process, agreed appetite levels were established across the five domains (within the GGI matrix, show in appendix B) Financial; Regulatory; Quality; Reputational; and People.

The following diagram outlines the categories of risk appetite and describes the scoring mechanism used in assigning risk appetite levels.



Essex ICB Risk Appetite Statement

The Essex ICB risk appetite reflects its role as a strategic commissioner operating within a complex and evolving system.

The ICB will take balanced and purposeful risk to deliver its strategic objectives, with a higher appetite for innovation, transformation and system leadership; a moderate and controlled approach to regulatory risk; and a focus on long-term population outcomes and service sustainability.

Risk-taking will be aligned to the PHIP and corporate objectives, underpinned by robust governance and assurance arrangements, applied consistently across the organisation, and communicated transparently to stakeholders and partners.

Embedding the Risk Appetite

On approving the risk appetite statement, the next phase will focus on embedding risk appetite into organisational processes, including:

- Integration into the Board Assurance Framework (BAF)
- Alignment with target risk scores and tolerance levels recorded within Datix
- Incorporation into committee reporting and decision-making frameworks

- Utilising internal communication channels to share the appetite and approach with staff
- Training and communication across the organisation
- Strengthening consistency of risk reporting across Directorates and Committees

The work programme to support achievement of this is being drafted and will be included within the ICB Risk Management Strategy.

3. Findings/Conclusion

The Essex ICB Risk Appetite Statement has been designed to support the organisation to deliver the requirements of the PHIP make risk informed decisions in a complex and resource constrained environment. The statement sets out the Board direction for managing risk.

4. Recommendation(s)

The Board is asked to consider and approve the risk appetite statement.

5. Appendices

Appendix A – Essex ICB Risk Appetite Statement.

Appendix B – GGI Risk Appetite Maturity Matrix

Appendix A – Essex ICB Risk Appetite Statement

The Essex ICB risk appetite reflects its role as a strategic commissioner operating within a complex, resource-constrained and evolving system. The ICB will take balanced and purposeful risk to deliver its Population Health Improvement Plan, with a higher appetite for innovation, transformation and system leadership, while maintaining appropriate caution in relation to regulatory compliance. Risk-taking will be aligned to corporate objectives, underpinned by robust governance, and transparently communicated to support informed decision-making across the organisation.

Financial Risk Appetite – Seek (4)

The ICB has a **high but controlled appetite for financial risk** in order to deliver system transformation and maximise value from finite resources. As a strategic commissioner, the ICB will take **deliberate and informed financial risks**, including pursuing innovative investment and **disinvestment decisions**, where this supports the Population Health Improvement Plan and system sustainability.

While operating in a **financially constrained and nationally regulated environment**, the ICB will prioritise **best value and long-term outcomes over short-term stability**, recognising that difficult choices may attract external scrutiny. Robust governance, financial controls and system-wide planning will underpin decision-making to ensure that risks are understood, managed and aligned to system priorities.

Regulatory Risk Appetite – Open (3)

The ICB has a **moderate and balanced appetite for regulatory risk**, recognising both the importance of compliance and the need to enable transformation. The ICB will **work within regulatory frameworks**, but is prepared to **exercise judgement and challenge constructively** where this supports improved outcomes for the Essex population.

As a newly formed organisation operating within an evolving regulatory landscape, the ICB will remain **mindful of its statutory responsibilities and external oversight**, particularly the consequences of non-compliance. However, it will seek to act with **confidence and pragmatism**, ensuring that regulatory considerations do not unnecessarily constrain innovation and system improvement.

Quality Risk Appetite – Seek (4)

The ICB has a **high appetite for risk in relation to quality improvement through commissioning**, recognising its role is to **secure safe, effective services rather than directly deliver them**. The ICB will be **proactive and ambitious in commissioning differently**, including working with a broader range of providers and adopting new models of care.

The ICB is prepared to accept **short-term uncertainty or variation** where there is a clear case for **long-term improvement in outcomes, access or equity**, including the use of emerging approaches such as digital and AI-enabled services. This will be underpinned by **robust assurance arrangements, clear accountability, and system oversight**, ensuring that patient safety and quality standards are not compromised.

Reputational Risk Appetite – Significant (5)

The ICB has a **significant appetite for reputational risk** in order to deliver meaningful system change and improved outcomes. It recognises that acting as a system leader and making **difficult, high-impact decisions**—including service reconfiguration and disinvestment—will inherently attract **scrutiny and challenge**.

The ICB will take a **transparent, proactive and mature approach to stakeholder engagement**, favouring **open and honest communication**, including where decisions are complex or contentious. It will prioritise **clear, timely engagement with partners, elected members and the public**, and is prepared to accept reputational impacts where this supports the **long-term interests of the population and the sustainability of services**.

People Risk Appetite – Significant (5)

The ICB has a **significant appetite for workforce-related risk** in order to create a more agile, innovative and effective organisation. It is committed to enabling **new ways of working**, embracing innovation (including digital and AI), and supporting **staff-led change** to improve organisational capability.

The ICB acknowledges that transformation may be **disruptive in the short term but** is prepared to accept this where it enables **long-term improvements in workforce sustainability, capacity and capability**. This will be supported by a strong organisational framework, **meaningful engagement with staff**, and a continued focus on making the ICB **a positive place to work and a strong system partner**.

NHS Essex

Appendix B – Good Governance Institute Risk Appetite Maturity Matrix

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

ICB Board Meeting of 16 July 2026

Agenda Number: 19.2

Governance Update

Summary Report

1. Purpose of Report

1.1. The purpose of the report is to provide the Board with an update on the establishment of sub-groups to the ICB Board sub-committees; and consequently, seek approval of revised Board sub-committees' terms of reference and an updated Functions and Decisions Map.

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. Each relevant committee is responsible for approving the terms of reference of their associated sub-groups and keeping their terms of reference up to date, with any changes to be approved by the ICB Board.

4.2. The Audit, Risk and Compliance Committee has oversight of ICB governance generally and has endorsed the proposed changes to the governance framework, recommending to the Board 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

6.1. Not applicable.

7. Financial Implications

7.1. Not applicable.

8. Details of patient or public engagement or consultation

8.1. None required. Governance documents, once finalised and approved by the Board, will be published on the ICB website.

9. Conflicts of Interest

9.1. None identified.

10. Recommendation/s

10.1. The Board is asked to:

- Approve the revised terms of reference for the Audit, Risk and Compliance Committee, Executive Committee, Neighbourhood Health Committee and Commissioning, Quality and Resource Committee.
- Approve the updated Functions and Decisions Map.
- Note the changes to the governance framework and thus the establishment of committee sub-groups.

Governance Update

1. Introduction

During establishment of the Essex Integrated Care Board (ICB), a Functions and Decisions Map was developed as part of the required governance framework, mapping the decision-making responsibilities, escalation routes and assurance flows of the ICB committees. This formed part of the Governance Handbook that included key governance documents such as committee terms of reference.

Following establishment, the Board sub-committees have had their first meetings, at which they discussed their terms of reference, expectations of the committee to discharge its responsibilities over the coming year, as well as agreeing the establishment of committee sub-groups.

This paper sets out those changes and the resulting updates required of the governance handbook.

2. Main content of Report

The updated governance model (and committee sub-groups) is shown in appendix A (Functions and Decisions Map) and introduces a consistent structure of sub-groups across all principal Board committees, strengthening assurance and enabling clear escalation of risks and performance issues.

A review of Board sub-committee terms of reference has been completed to align with the updated governance model and reflect the establishment of sub-groups. Changes to committee ToR are set out below, alongside a note of the sub-groups they have established.

Audit, Risk and Compliance Committee (ARCC). The revised ToR:

- Formally incorporates additional sub-groups within the Committee's structure, including the CORE Group and Individual Funding Request Panel.
- Strengthens the Committee's oversight of statutory compliance through expanded coverage (including infection prevention and control and wider statutory responsibilities); and
- Enhances clarity of reporting requirements and assurance flows.

The committee has established the following sub-groups:

- Information Governance Steering Group
- Health and Safety Group
- Individual Funding Request Panel

- Corporate Oversight of Resilience and Emergency Preparedness (CORE) Group (newly established)

Executive Committee. The revised ToR:

- Includes the Staff Partnership Forum as part of the Executive Committee governance framework, strengthens arrangements for staff engagement, consultation and co-production.
- Clearly links delivery oversight to the Population Health Improvement Plan.

The Committee has established the following sub-groups:

- Senior Leadership Team
- Strategic Delivery Group
- ICB People, Inclusion and Belonging Group (being established)
- Staff Partnership Forum (being established)

Neighbourhood Health Committee. The revised ToR:

- An increase in the Non-Executive Member representation from one to two members, strengthening independent oversight.
- A change in status for provider representatives, moving from members to attendees, to support a clearer distinction between commissioner oversight and provider contribution while maintaining appropriate engagement with partners; and
- Continued alignment with the committee's role in overseeing neighbourhood delivery and integration.

The Committee has established the following sub-groups:

- Primary Care Commissioning Group
- Health Inequalities and Prevention Group (being established)
- Place-based Alliances (Basildon and Brentwood, Mid Essex, North East Essex, South East Essex and Thurrock, including West Essex arrangements via the Princess Alexandra Hospital NHS Trust) (evolving to reflect proposed changes in local government from September 2026)
- Better Care Fund governance arrangements (being established)

Commissioning, Quality and Resource (CQR) Committee. The revised ToR:

- More clearly defines the reporting between the CQR and ARCC on quality issues v's statutory compliance.

The Committee has established the following sub-groups:

- Provider Selection Regime Review Group
- Quality, Contracting and Performance Review Meetings (QCPRM)
- Medicines Commissioning Group

- System Quality Group (awaiting National Quality Board guidance to be established)
- Estates and Capital Group.

Revised ToRs are available upon request and will be published on the ICB website once approved by the Board.

The establishment of key sub-group structures provide greater transparency of how operational delivery groups support committees and how assurance is aggregated and escalated to the Board.

3. Findings/Conclusion

Collectively, these changes strengthen governance by reinforcing clear lines of accountability between operational groups, committees and the Board; by enhancing the depth and breadth of assurance available to the Audit, Risk and Compliance Committee, and ultimately the Board; and ensuring terms of reference are aligned to the ICB's statutory duties and emerging operating model.

Further work will continue to embed these arrangements, including refining reporting flows and ensuring consistent assurance outputs from sub-committees.

These changes and arrangements have been presented to and supported by the Audit, Risk and Compliance Committee.

4. Recommendation(s)

4.1. The Board is asked to:

- Approve the revised terms of reference for the Audit, Risk and Compliance Committee, Executive Committee, Neighbourhood Health Committee and Commissioning, Quality and Resource Committee.
- Approve the updated Functions and Decisions Map.
- Note the changes to the governance framework and thus the establishment of committee sub-groups.

5. Appendices

Appendix A – Updated Functions and Decisions Map

Formal Committee ToRs are available upon request.

Essex Integrated Care Board

The Board is responsible for planning and commissioning health services for its local population. As strategic commissioner, the focus is on delivering three strategic shifts: sickness to prevention, hospital to community, analogue to digital thereby improving population health, reducing health inequalities, and ensuring access to high-quality care. The ICB leads system-wide planning by developing long-term, evidence-based strategies, allocating resources effectively, and overseeing performance, functioning as healthcare "payer," ensuring value for money and accountability, supported by strong partnerships with local authorities and data-driven decision-making.

Membership: Chair, CEO, EDFC, ECNO, EMD, 4 NEMs, 3 LA Partner Members, 1 General Practice Member, 3 Provider Partner Members
Quoracy: 8 Members including a NEM, Clinical, Partner Member and CEO/CFO **Frequency:** Quarterly in public, + monthly seminars

Essex Integrated Care Partnership

Accountable to the ICB and Essex, Thurrock, Southend Health and Wellbeing Boards

The ICP brings together NHS, Local Authorities and other partners to develop a shared strategy for improving health and wellbeing across the local population. Focussing on tackling health inequalities, promoting prevention, and aligning services to deliver better outcomes through collaboration.

Membership: Chair, CEO, EDNH, 3x Healthwatch, 3x LA Partners, 3x Provider Members
Quoracy: 6 including Chair, 1 Provider, 1 LA Partner **Frequency:** Twice per annum

Audit, Risk and Compliance Committee

Provide oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB, driven by organisational objectives and associated risks.

Sub Groups: Health and Safety Group, IG Steering Group, IFR Panel and CORE.
Frequency: Quarterly (+ Annual Report and Accounts meeting)

Remuneration Committee

Agrees ICB policy on pay/pay framework and recommends Pay, terms and conditions for board members. Provides assurance to the Board on the discharge of this ICB statutory duty.

Sub Groups: Non-Executive Member Remuneration Panel
Frequency: Twice per annum, plus ad hoc meetings as required.

Executive Committee

Development and oversight of strategy and operational decisions. Considers approval of business case / investment / disinvestment decisions up to £5m. Responsible for organisational and staff developing and the equality agenda.

Sub Groups: Senior Leadership Team, Strategic Delivery Group, Inclusion and Belonging Steering Group, ICB People Group, Staff Partnership Forum
Frequency: Weekly

Commissioning, Quality and Resource Committee

Agrees the commissioning, contracting and financial framework, makes investment decisions /recommendations, receives assurance on delivery of financial performance, contract management and quality outcomes in accordance with the Quality Strategy set by the National Quality Board.

Sub Groups: PSR Review Group, QCPRM, Medicines Commissioning Group, System Quality Group, Estates and Capital Group
Frequency: Quarterly

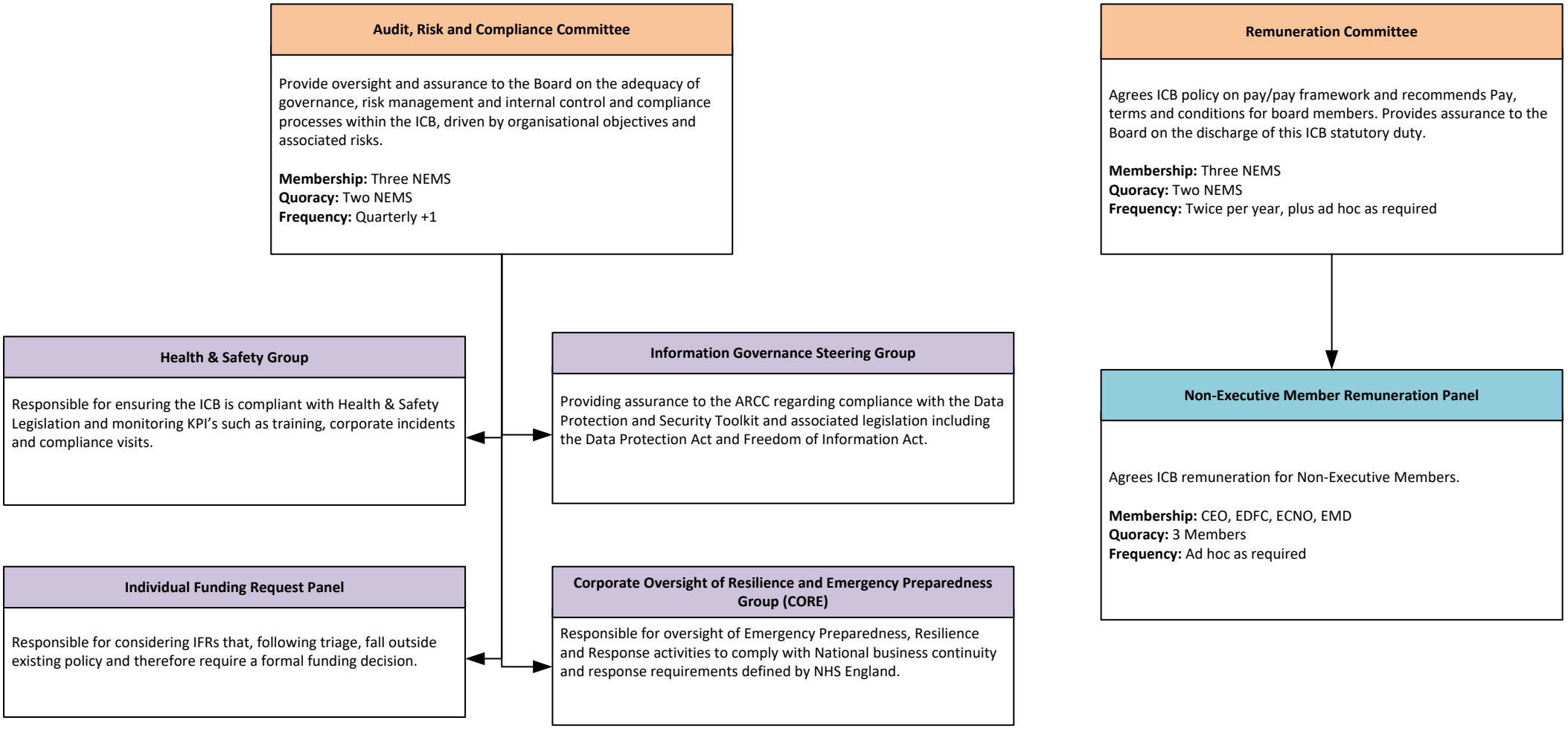
Neighbourhood Health Committee

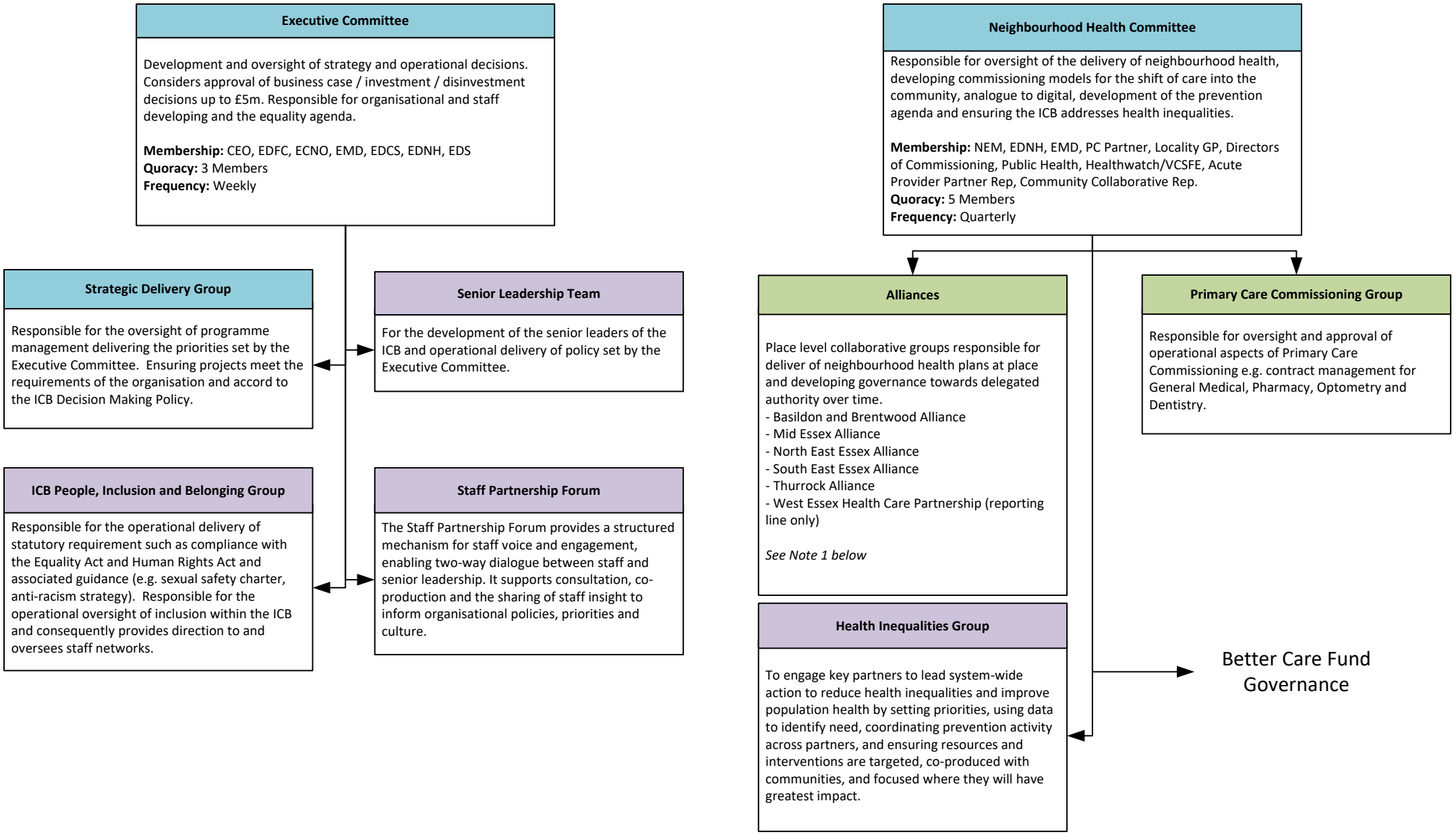
Responsible for oversight of the delivery of neighbourhood health, developing commissioning models for the shift of care into the community, analogue to digital, development of the prevention agenda and ensuring the ICB addresses health inequalities.

Sub Groups: Primary Care Commissioning Group, Alliances x 5, Health Inequalities and Prevention Group
Frequency: Quarterly

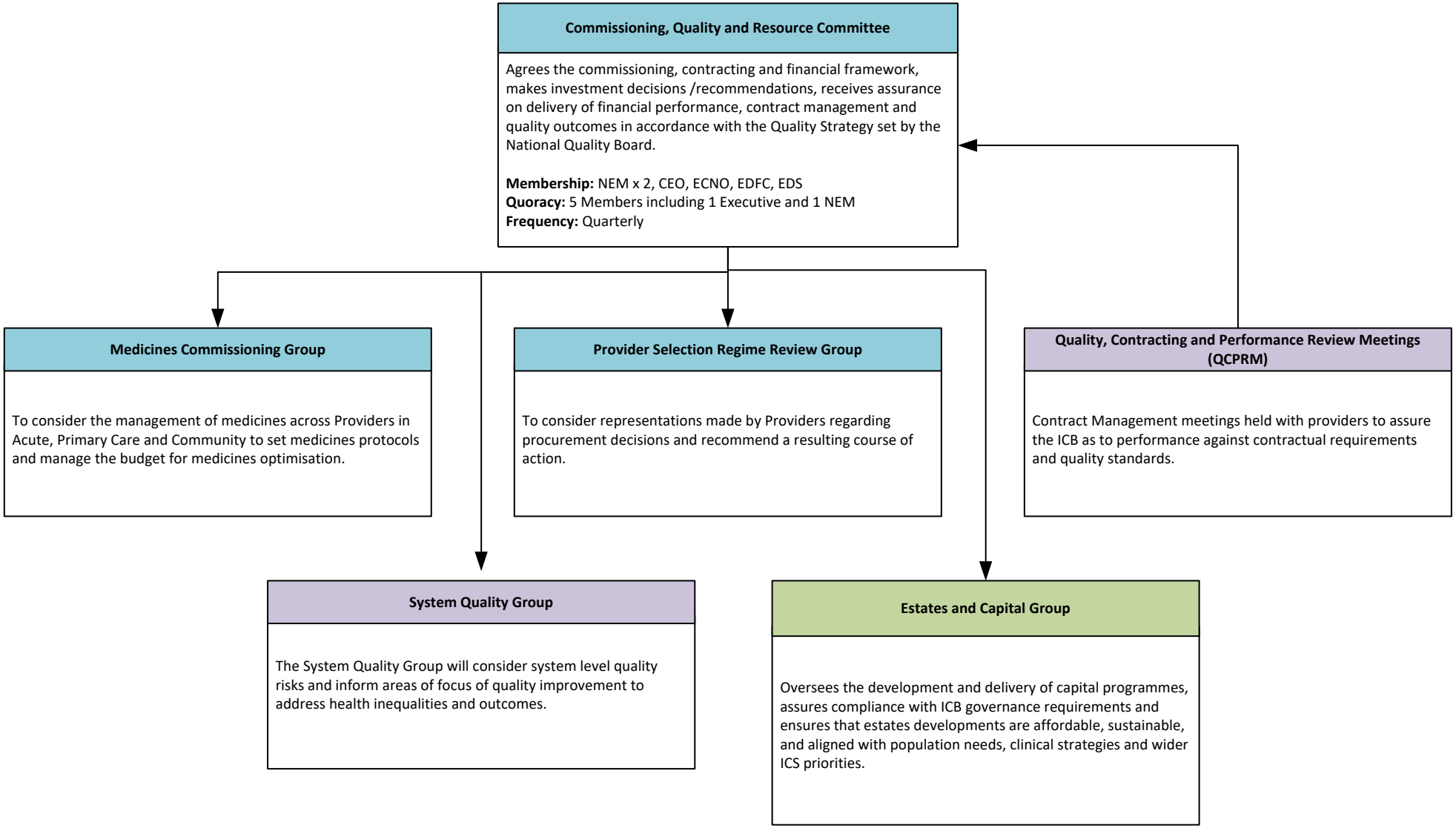
Key:
- Statutory & Assurance
- Decision Making
- Assurance
- Developing Decision Making & Assurance

Key:
CEO: Chief Executive Officer
ECNO: Executive Chief Nursing Officer
EMD: Executive Medical Director
EDFC: Executive Director of Finance and Commercial
EDCS: Executive Director of Corporate Services
EDNH: Executive Director of Neighbourhood Health
EDS: Executive Director of Strategy
NEM: Non-Executive Member
AD: Associate Director
HO: Head of
Bi-Monthly: Every two months


Audit, Risk and Compliance Committee
Provide oversight and assurance to the Board on the adequacy of governance, risk management and internal control and compliance processes within the ICB, driven by organisational objectives and associated risks.
Membership: Three NEMS
Quoracy: Two NEMS
Frequency: Quarterly +1
Remuneration Committee
Agrees ICB policy on pay/pay framework and recommends Pay, terms and conditions for board members. Provides assurance to the Board on the discharge of this ICB statutory duty.
Membership: Three NEMS
Quoracy: Two NEMS
Frequency: Twice per year, plus ad hoc as required
Health & Safety Group
Responsible for ensuring the ICB is compliant with Health & Safety Legislation and monitoring KPI's such as training, corporate incidents and compliance visits.
Information Governance Steering Group
Providing assurance to the ARCC regarding compliance with the Data Protection and Security Toolkit and associated legislation including the Data Protection Act and Freedom of Information Act.
Non-Executive Member Remuneration Panel
Agrees ICB remuneration for Non-Executive Members.
Membership: CEO, EDFC, ECNO, EMD
Quoracy: 3 Members
Frequency: Ad hoc as required
Individual Funding Request Panel
Responsible for considering IFRs that, following triage, fall outside existing policy and therefore require a formal funding decision.
Corporate Oversight of Resilience and Emergency Preparedness Group (CORE)
Responsible for oversight of Emergency Preparedness, Resilience and Response activities to comply with National business continuity and response requirements defined by NHS England.



Note 1: The existing Alliance structures inherited from the former Mid and South Essex, Suffolk and North East Essex, and Hertfordshire and West Essex ICBs will be retained within the Essex ICB for a transition period of up to six months. Maintaining the current arrangements during this period is intentional and ensures that the subsequent restructure is fully informed and appropriately aligned with emerging Neighbourhood Health guidance (pending at the time of publication) and the implications of Local Government Reform. This approach will support a cohesive and well-sequenced transition to the future operating model.


Commissioning, Quality and Resource Committee
Agrees the commissioning, contracting and financial framework, makes investment decisions /recommendations, receives assurance on delivery of financial performance, contract management and quality outcomes in accordance with the Quality Strategy set by the National Quality Board.
Membership: NEM x 2, CEO, ECNO, EDFC, EDS
Quoracy: 5 Members including 1 Executive and 1 NEM
Frequency: Quarterly
Medicines Commissioning Group
To consider the management of medicines across Providers in Acute, Primary Care and Community to set medicines protocols and manage the budget for medicines optimisation.
Provider Selection Regime Review Group
To consider representations made by Providers regarding procurement decisions and recommend a resulting course of action.
Quality, Contracting and Performance Review Meetings (QCPRM)
Contract Management meetings held with providers to assure the ICB as to performance against contractual requirements and quality standards.
System Quality Group
The System Quality Group will consider system level quality risks and inform areas of focus of quality improvement to address health inequalities and outcomes.
Estates and Capital Group
Oversees the development and delivery of capital programmes, assures compliance with ICB governance requirements and ensures that estates developments are affordable, sustainable, and aligned with population needs, clinical strategies and wider ICS priorities.

NHS
Essex
Integrated Care Board

ICB Board Meeting of 16 July 2026

Agenda Number: 19.3

Revised Policies

Summary Report

1. Purpose of Report

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

2. Executive Lead

- Michael Watson, Executive Director of Corporate Services
- Jennifer Kearton, Executive Director of Finance and Commercial
- Giles Thorpe, Executive Chief Nursing Officer

3. Report Author

Helen Chasney, Governance and Risk Manager

4. Responsible Committees

- Audit, Risk and Compliance Committee (Chaired by Rex Smith, Non-Executive Member)
- Commissioning, Quality and Resource Committee (Chaired by Jo Churchill, Non-Executive Member)

5. Link to the ICB's Strategic Objectives

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

Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.

7. Financial Implications / Patient or public engagement or consultation

Not Applicable.

8. Conflicts of Interest

None identified.

9. Recommendation/s

The Board is asked to note the revised policies set out within this report.

NHS
Essex
Integrated Care Board

Revised ICB Polices

1. Introduction

The ICB has a policy framework to ensure that it has properly documented the controls in place to achieve its objectives, manage its risk and guide the work it does in accordance with legislation, statutory guidance and best practice. Each policy must be periodically reviewed or updated following any changes in legislation/best practice and has a designated 'sponsoring committee' responsible for overseeing its implementation and approving any updates to the policy.

2. Policies approved by relevant Committees

Since the last Part I Board meeting, the following policies were approved by relevant committees, as per the authority set out in their terms of reference.

Committee / date of approval	Policy Ref No and Name
Audit, Risk and Compliance Committee 9 June 2026	The committee approved the following revised policies, which had been updated to reflect the organisational change and responsibilities of the ICB: • C008 Lone Worker Policy • C011 Security and Lockdown Policy
Commissioning, Quality and Resource Committee 21 April 2026	The committee approved the following revised policies: • F007 Provider Accreditation Policy

3. Findings/Conclusion

The above policies ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities. The approved policies will be published on the ICB's website or the ICB intranet.

4. Recommendation(s)

The Board is asked to note the revised policies set out in this report.

NHS
Essex
Integrated Care Board

ICB Board Meeting of 16 July 2026

Agenda Number: 19.4

Changes to the Scheme of Reservation and Delegation

Summary Report

1. Purpose of Report

1.1. To seek the Board approval of an amendment to the Scheme of Reservation and Delegation (SoRD) to increase the authorisation limits for staff responsible for complex care. The current annualised authorisation limits set out in section 9 result in a significant number of approvals being escalated to senior staff, creating delays in arrangement of short-term care packages. Increasing these limits would streamline decision-making, improve operational efficiency, and support the timely provision of care for patients.

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 approving changes to the SoRD, as recommended by appropriate sub-committees.

5. Link to the ICB's Strategic Objectives / Impact Assessments / Financial Implications / Engagement

5.1. N/A.

6. Conflicts of Interest

6.1. None identified.

7. Recommendation/s

7.1. The Committee are asked to consider and endorse, thereby recommending the Board approve the change to section 9 of the SoRD.

8. Appendices

Appendix A – Section 9 of the SoRD.

NHS Essex

Appendix A – Section 9 of the Scheme of Reservation and Delegation

Provision	Who can authorise	Notes
9. **Complex Care: Continuing Healthcare, Individual Placements Team (S117), Neurorehabilitation**		
a. Approval limits for committing expenditure and service contracts, including variation of contracts, but excluding staff pay costs:		
i. Up to contractually agreed standard rate per week	CHC Operational Manager IPT Manager Neurorehabilitation Assistant Manager	Authorising officers only to authorise within their own budget area
ii. Up to annual equivalent £200,000 (£3,846 weekly rate)	CHC Operational Manager	
iii. Up to annual equivalent £250,000 (£4,808 weekly rate)	Senior CHC CYPCC Operational Lead IPT Manager	
iv. Up to annual equivalent £500,000 (£9,615 weekly rate)	Head of AACC Head of IPT Neurorehabilitation Manager	
v. Up to annual equivalent £1,000,000 (£19,231 weekly rate)	Director of Operations – Complex Care	
vi. Over annual equivalent £1,000,000	Executive Chief Nursing Officer	
b. Patient Transport (journeys outside of contract)	Any posts identified in 9a.	

NHS
Essex
Integrated Care Board

ICB Board Meeting of 16 July 2026

Agenda Number: 20

Mid and South Essex ICB Annual Report and Accounts

Summary Report

1. Purpose of Report

1.1. To provide the Board (as the successor body) with the final approved Mid and South Essex ICB Annual Report and Accounts following approval by the Audit, Risk and Compliance Committee (ARCC) and submission to NHS England, alongside the associated Health Inequalities Information Statement – Annual Report.

2. Executive Lead

2.1. Michael Watson – Executive Director of Corporate Services.
2.2. Jennifer Kearton – Executive Director of Finance and Commercial.

3. Report Author

3.1. Nicola Adams – Associate Director of Governance.

4. Responsible Committees

4.1. The Essex ICB Board delegated responsibility to the ARCC to approve the Annual Report and Accounts on their behalf to meet the national submission deadline.

5. Link to the ICB's Strategic Objectives

5.1. N/A as this paper relates to the predecessor ICB.

6. Impact Assessments

6.1. Not Applicable.

7. Financial Implications

7.1. None.

8. Details of patient or public engagement or consultation

8.1. None required. The final NHS England / Auditor approved version is presented to the Board meeting in public and will then be published on the Essex ICB website.

9. Conflicts of Interest

9.1. None identified.

10. Recommendation/s

10.1. The Board is asked to receive and note the Mid and South Essex ICB Annual Report and Accounts, associated audit opinion and the Health Inequalities Annual Report.

NHS Mid and South Essex ICB Annual Report and Accounts

1. Introduction

As the successor body to Mid and South Essex Integrated Care Board, the Essex ICB is responsible for finalisation and publication of its predecessor ICB's Annual Report and Accounts and Health Inequalities Annual Report.

At its meeting on 23 April 2026, the Essex ICB Board delegated responsibility for approval of the Mid and South Essex Integrated Care Board Annual Report and Accounts for 2025/26 to the Audit, Risk and Compliance Committee (ARCC) to enable the ICB to meet the required statutory submission deadline of 18 June 2026.

2. Main content of Report

Development of the Annual Report and Accounts was undertaken in line with statutory requirements and national guidance, including the Department of Health and Social Care Group Accounting Manual and NHS England reporting expectations. The report was produced using the national template and reflects a comprehensive and iterative process of drafting, review and assurance involving corporate, finance and clinical teams, supported by alignment with national returns and engagement with external auditors.

A draft version of the Annual Report and Accounts was submitted to NHS England in April in accordance with national requirements after review by the ARCC. Since that stage, a structured process of review and refinement was undertaken, including detailed consideration of feedback from NHS England. All NHS England comments were addressed through a tracked response log.

At its meeting on 9 June, the ARCC considered and approved the Annual Report and Accounts on behalf of the ICB Board. This follows the Committee's previous consideration of the draft version and reflects the completion of all internal review, external feedback and audit processes required prior to formal submission.

The report highlights the key achievements and challenges faced by the Mid and South Essex ICB during 2025/26 and confirms that no material weaknesses in systems of internal control have been identified.

The report includes the outcomes of Service Auditor Reports (SARs), relating to third-party assurances, again confirming that while some weakness in control was noted, they weren't significant and did not affect the operation of the ICB.

The external auditors KPMG provided an unqualified audit opinion relating to the accounts and the report aligns fully with the final audit position.

The Annual Report and Accounts relating to North East Essex and West Essex are reported in their respective predecessor ICBs, Suffolk and North East Essex and Hertfordshire and West Essex respectively. The reports for each area will be published with their successor ICBs (Norfolk and Suffolk ICB and Central East ICB, respectively).

Health Inequalities – Annual Report

NHS organisations have a legal duty to collect, analyse and publish information on health inequalities every year. NHS England's Statement on Information on Health Inequalities sets out how organisations should exercise this duty and what information should be published. This includes a list of indicators which organisations should report against. The indicators are aligned to key health inequalities priorities for the NHS, which includes the five priority areas for addressing healthcare inequalities and the Core20PLUS5 approach to reducing inequalities for adults and children and young people.

This is now the third year in which NHS bodies have been required to publish this information, and we are beginning to build a clearer picture of trend patterns across key indicators. The availability of three years of data enables us to identify where health inequalities are persistent and sustained, and where further targeted action is required.

This report for 2025/26 brings together (for mid and south Essex) both new analyses and ongoing monitoring across all areas included in the statutory statement, supported by strengthened local data quality and improved analytical capability.

3. Findings/Conclusion

The Annual Report and Accounts and Health Inequalities Annual Report have been progressed and submitted in accordance with the required statutory timetable, including submission of draft versions in April and final audited submission by the statutory deadline of 19 June 2026, for all areas across Essex.

The Board is asked to note that this Annual Report and Accounts represent the final statutory reports prior to the dissolution of the ICBs on 31 March 2026 and the establishment of the Essex Integrated Care Board. As such, it provides formal closure of the organisation's statutory reporting responsibilities and reflects a significant body of work delivered over the reporting period.

As reflected within the reports themselves, they capture the scale of achievement delivered by the ICBs and their staff during a period of both operational delivery and organisational transition. The approval of these reports

therefore marks not only the completion of statutory duties but also the close of an important chapter for the organisations.

The reports for Mid and South Essex ICB will be published on the Essex ICB website, with a link to the two other Essex bodies reports to provide a complete picture for Essex during that period.

4. Recommendation(s)

4.1. The Board is asked to receive and note the Mid and South Essex ICB Annual Report and Accounts, associated audit opinion and the Health Inequalities Annual Report.

5. Appendices

Appendix A – MSE ICB Annual Report and Accounts

Appendix B – MSE Health Inequalities Annual Report

NHS
Essex
Integrated Care Board

ICB Board Meeting of 16 July 2026

Agenda Number: 21

Approved Committee Minutes

Summary Report

1. Purpose of Report

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

- Audit, Risk and Compliance Committee (ARCC) – 1 April 2026 and 22 April 2026
- Commissioning, Quality and Resource Committee (CQRC) – 21 April 2026

2. Chair of each Committee

- Rex Smith, Chair of ARCC
- Mark Bailham, Chair of CQRC

3. Report Author

- Helen Chasney, Governance and Risk Manager

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

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 / Financial Implications / Patient or public engagement or consultation

Not Applicable.

7. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

8. Recommendation/s

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

Committee Minutes

1. Introduction

1.1. Committees of the Board are established to deliver specific functions on behalf of the Board as set out within their terms of reference. Minutes of meetings held (once approved by the committee) are presented to the Board to provide assurance and feedback on functions and decisions delivered on its behalf.

2. Main content of Report

2.1. The following summarises key items discussed, and decisions made by committees as recorded in the minutes approved since the last Board meeting.

Audit, Risk and Compliance Committee, 1 April 2026

This was the inaugural meeting following the launch of the Essex ICB and the following items were considered:

- The appointment of the internal auditors, TIAA, and the external auditors, KPMG, from 1 April 2026 was confirmed.
- The internal audit strategic plan for 2026/27 was approved.
- The Head of Internal Audit Opinion for Mid and South Essex ICB (MSE ICB) was noted.

Audit, Risk and Compliance Committee, 22 April 2026

The following items were considered:

- The establishment of the following ARCC sub-groups were approved and the relevant Terms of Reference:
  - Information Steering Group
  - Health and Safety Working Group
  - Individual Funding Request Panel
- The draft MSE ICB Annual Report and Accounts were noted, with suggested amendments, and the final draft would be brought back to the meeting on 9 June 2026.
- An update on the conflicts of interest process.
- An update on the Risk Management Framework.
- Information Governance Update
- Emergency Preparedness, Resilience and Response and received assurance on preparedness arrangements.
- Losses and Special Payments
- A verbal update on Statutory Compliance.
- The Local Counter Fraud Specialist Plan for 2026/27 was noted.

- The committee workplan for 2026/27 was noted.

Commissioning, Quality and Resource Committee, 21 April 2026

The following items were considered:

- The establishment of the following CQRC sub-groups were approved and the relevant Terms of Reference:
  - Medicines Commissioning Group
  - Provider Selection Regime Review Group
  - Estates and Capital Group
- The Provider Accreditation Policy was approved, subject to amendments discussed.
- The Essex ICB Patient Group Direction (PGD) Policy was approved as the formal governance framework for the development, review, authorisation and management of PGDs across all Essex ICB-commissioned services.
- An update on the Population Health Improvement Plan (PHIP).
- Approved the ICB Operating Plan – Capital Resource and Allocation.

3. Recommendation

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

NHS
Essex
Integrated Care Board

Minutes of the Audit Risk and Compliance Committee Meeting

Held on 1 April 2026 at 11.00am

via MS Teams

Attendees

Members

- Mark Bailham (MB), Non-Executive Member, Essex Integrated Care Board (EICB) - Deputy Audit Committee Chair.
- Dr Neha Issar-Brown (NIB), Non-Executive Member, EICB
- Jo Churchill (JC), Non-Executive Member, EICB.

Other attendees

- Jennifer Kearton (JKe), Executive Director of Finance and Commercial, EICB.
  Michael Watson (MW), Executive Director of Corporate Services, EICB.
- Helen Chasney (HC), Governance Senior Officer, EICB (Minutes).

Apologies

- None

1. Welcome and Apologies

MB welcomed everyone to the meeting. No apologies were noted.

2. Declarations of Interest

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

There were no further declarations raised.

3. Appointment of Auditors

MW advised that NHS England guidance set out clear principles for managing mergers and boundary changes, including arrangements for internal and external audit. In line with this guidance, the existing Mid and South Essex (MSE) contracts for internal audit (TIAA) and external audit (KPMG) were identified as transferring to the Essex ICB from 1 April 2026 and confirmation of those appointments were sought by the committee.

No further comments were raised.

Outcome: The committee confirmed the appointment of TIAA Limited as the internal

auditors, and KPMG LLP as the external auditors of Essex ICB from 1 April 2026.

4. Internal Audit Strategic Plan 2026/27

JK presented the Internal Audit Strategic Plan for 2026/27, outlining the proposed internal audit activity for 2026/27 and beyond. The plan had previously been considered by MSE Audit Committee and Executive Committee.

Assurance was provided that the plan offered sufficient coverage to support the Head of Internal Audit Opinion and allowed flexibility to adjust the programme in response to the future evolution of the ICB and if the Board suggested other areas for review.

No further comments were made.

Outcome: The committee Approved the Internal Audit Strategic Plan 2026/27.

5. Head of Internal Audit Opinion for Mid and South Essex ICB

MW presented the Head of Internal Audit Opinion for the MSE ICB, noting that the key findings were summarised in the executive summary and that the report was previously considered by the MSE ICB Audit Committee.

MB observed that the level of assurance (across the audits over the year) had somewhat reduced compared to the previous year, although it was noted positively that there were no 'no assurance' ratings and the overall level of assurance remained 'reasonable'. JK advised that the opinion was presented in draft form for feedback and would form part of the final MSE ICB annual report. The opinion would be finalised following further work with the auditors.

Outcome: The committee noted the Interim Internal Audit Annual Report / Head of Internal Audit Opinion 2025/26 for Mid and South Essex ICB.

6. Any other Business

There were no items of any other business discussed.

7. Date of Next Meeting

Wednesday 22 April 2026 at 2.00-4.30pm, in the Nightingale Room, Seax House, Chelmsford or via Microsoft Teams.

Minutes of the Essex ICB Extraordinary Audit, Risk and Compliance Committee meeting

Held on 22 April 2026 at 2.00pm

Microsoft Teams meeting and in person at Seax House, Chelmsford.

Attendees

Members

- Rex Smith (RSm), Non-Executive Member, Essex Integrated Care Board (EICB) – Audit, Risk and Compliance Committee (ARCC) Chair.
- Mark Bailham (MB), Non-Executive Member, EICB - Deputy ARCC Chair.
- Jo Churchill (JCh), Non-Executive Member, EICB.

Other attendees

- Jennifer Kearton (JKe), Executive Director of Finance and Commercial, EICB.
- Michael Watson (MW), Executive Director of Corporate Services, EICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, EICB.
- Nicola Adams (NAd), Associate Director of Governance, EICB.
- Helen Chasney (HC), Governance Senior Officer, EICB
- Jane King (JK), Assistant Governance Manager, EICB (minutes via recording).
- Natalie Brodie (NB), Associate Director of Financial Management Accounts and Financial Services, EICB.
- Iain Gear (IGe), Information Governance Manager, EICB.
- Jim Cook (JCo), Head of Emergency Preparedness, Resilience and Response, EICB.
- Rachel Stinson (RSt), People Business Partner.
- Emma Larcombe (EL), Partner, KPMG.
- Dakshita Takodra (DT), Senior Audit Manager, TIAA.
- Hannah Wenlock (HW), Anti-Crime Specialist, Counter Fraud, TIAA.
- Bob Street (BS), Security Specialist, TIAA.

1. Welcome and Apologies

RSm welcomed everyone to the meeting. No apologies were noted and the meeting was confirmed as quorate.

2. Declarations of Interest

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

There were no further declarations raised. A minor amendment to MB's role was highlighted on the Register of Interests. It was noted that, although not included on the current Register of Interests, a declaration of interest had been received from RSm. No conflicts of interest were identified in relation to items on the agenda. The declaration would be included in the next iteration of the Register of Interests.

3. Minutes of the Previous Meeting

The minutes of the meeting held on 1 April 2026 were received.

Outcome: The minutes of the meeting held on 1 April 2026 were approved as an accurate record.

4. Matters arising

The Committee confirmed that there were no matters arising from the previous meeting.

5. Action Log

The action log was reviewed, and it was noted that there were no outstanding actions.

6. Establishment of ARCC Sub-Committees

NA shared a presentation outlining the Essex ICB governance framework and the role of ARCC. The Committee noted the revised committee structure, including expansion of the Committee's remit to formally include compliance reporting. The importance of aligning audit, risk and compliance functions to provide coherent and robust assurance to the Board was acknowledged.

The Committee discussed expectations of good governance, including the need for constructive challenge, clarity of reporting, and a risk-based approach to agenda planning. Members emphasised the importance of developing increasingly data-driven reporting as the organisation matured.

The Committee discussed the distinction between sub-committees and working groups within the revised governance framework and noted the streamlined Terms of Reference format. Minor drafting inconsistencies within the Terms of Reference, including references to "workstream" and "working group", were identified and it was agreed these would be corrected.

Approval was given for the establishment of the Health and Safety Group, the Information Governance Steering Group (IGSG) and the Individual Funding Request (IFR) Panel as sub-groups of the Committee.

The Committee noted that the IFR Panel would be responsible for clinical decision-making, while the Committee's role would be limited to providing assurance on the effectiveness of governance, policy and process arrangements.

It was agreed by the Committee that measures of success would include strong internal audit assurance, high-quality evidence-based reporting, regular deep dives into high-risk

areas, a clear audit trail of challenge and assurance, and a review of Committee effectiveness at six months.

ACTION: To schedule a mid-point review of ARCC effectiveness.

Outcome: The Committee APPROVED the establishment of the ARCC sub-committees, and thereby APPROVED the Terms of Reference for the following sub-groups:

- Information Governance Steering Group
- Health and Safety Working Group
- Individual Funding Request Panel

7. Mid and South Essex ICB Draft Annual Report and Accounts 2025/26

NA presented the draft Mid and South Essex (MSE) ICB Annual Report to the Committee, noting that MSE formed part of the wider Essex ICB footprint. The Committee was advised that the 2025/26 annual reports covering West Essex and North East Essex would be approved by Central East ICB and Norfolk and Suffolk ICB respectively and presented to the Committee to note at a future date.

The Committee noted that the Annual Report followed a prescribed national format, comprising the Performance Report, the Accountability Report and Parliamentary Accountability Audit Report. The report had undergone internal review, with only minor issues identified, and some sections remained subject to completion following the external audit process.

It was agreed that Committee feedback would be incorporated into the draft Annual Report prior to its submission to the Board.

NA agreed with the recommendation from JCo that MSE ICB compliance with the Emergency Preparedness Resilience and Response (EPRR) Core Standards be reported within the Annual Report to strengthen assurance and transparency.

The Committee noted the key annual reporting timelines and that the team was on track to meet the draft Annual Report submission deadline.

JKe advised that a briefing session would be arranged for Non-Executive Board Members to provide a walkthrough of the year-end accounts in advance of Committee sign-off. Due to the timescales involved, it was noted that the Board would be asked to delegate authority to the Committee to approve the final Annual Report and review the Accounts.

ACTION: The Committee to receive West Essex and North East Essex 2025/26 Annual Reports when available, for noting.

8. Managing Conflicts of Interest

HC advised that the Standards of Business Conduct Policy had been reviewed and refreshed, supported by the former Mid and South Essex Audit Committee in March, and was formally adopted by the Essex ICB Board on 1 April 2026.

The updated policy consolidated best practice from the three legacy ICBs and included provisions on declarations of interest, gifts and hospitality, and commercial sponsorship.

The process for submitting declarations of interest had been updated and was nearing completion. Declarations would be submitted via an online SharePoint form, with declared interests routed to line managers for approval before Governance Team oversight; nil returns would be submitted directly to the Governance Team. An annual automated reminder would be issued to staff to review and resubmit declarations, with Business Managers supporting and monitoring completion across directorates.

A full register of interests would be presented to the Committee at a future meeting, and the Board Register of Interests had been appended to the papers.

In response to RSm, NA confirmed that the Gifts and Hospitality Register was included on the Committee's cycle of business.

Outcome: The Committee NOTED the Conflicts of Interest Management update.

9. Risk Management

The Committee received an update on the Risk Management Policy and Strategy from NA and MW.

The Committee noted the introduction of a new risk management framework and the planned development of a Board Assurance Framework for July 2026. It was noted that a Board seminar was scheduled in May 2026 to agree the organisational risk appetite.

The Committee discussed the need for clearer articulation of how risks related to organisational objectives and population health outcomes. Members emphasised the importance of consistent risk terminology and scoring, and of ensuring that Committee papers clearly described the risk context and implications.

The Committee agreed that future reports should strengthen the risk-focused narrative and explicitly link decisions to risk exposure and mitigation.

Outcome: The Committee NOTED the Risk Management update.

10. Information Governance

The Committee received the Information Governance report presented by IGe.

The Committee noted that the Data Security and Protection Toolkit submission had achieved "Standards Met" and that the independent audit had assessed overall information governance risk as very low, with a high level of confidence.

The Committee discussed improvements in compliance and maturity of the information governance framework and noted that the volume and severity of information governance incidents remained low. The Committee received assurance that appropriate arrangements were in place.

Outcome: The Committee NOTED the Information Governance update.

11. Emergency Preparedness, Resilience and Response

JCo provided the Committee with an update on Emergency Preparedness, Resilience and Response (EPRR). The Committee noted the focus on managing major incident risks, including cyber incidents, pandemics and terrorism, and acknowledged challenges arising from organisational transition and capacity pressures.

The Committee discussed ongoing work to strengthen business continuity arrangements, the importance of training and exercising plans, and the need to manage resource pressures. The Committee received assurance on preparedness arrangements.

Outcome: The Committee NOTED the EPRR update.

12. Losses and Special Payments

There were no losses or special payments to note.

Outcome: The Committee NOTED there were no losses or special payments reported.

13. Statutory Compliance Report

The Committee received a verbal statutory compliance update from GT.

The Committee noted the range of statutory responsibilities, including safeguarding and SEND reforms, and discussed the increasing complexity of compliance requirements across the system. The Committee emphasised the importance of embedding compliance within governance processes and receiving regular assurance.

Outcome: The Committee NOTED the Statutory Compliance update.

14. Local Counter Fraud Specialist Plan 2026/27

The Committee received the Local Counter Fraud Specialist Plan for 2026/27, presented by HW.

The Committee approved the plan and noted that it provided the required coverage for compliance purposes. The Committee discussed the importance of maintaining visibility of fraud risks and noted the requirement to complete the annual return by 31 May 2026, with Audit Chair oversight.

Outcome: The Committee NOTED the Local Counter Fraud Specialist Plan 2026/27.

15. Committee Workplan

The Committee reviewed the Committee workplan presented by NA.

The Committee noted that the workplan covered governance, risk, audit and financial assurance requirements throughout the year and included key deliverables such as the annual accounts and audit reporting. Members discussed the importance of ensuring continued alignment with evolving risk priorities.

Outcome: The Committee NOTED the Committee Workplan for 2026/27.

16. Any other Business

There were no items of any other business discussed.

17. Items for Escalation

The Committee confirmed that no formal items were identified for escalation. The Committee noted potential themes for future escalation, including system assurance relating to provider performance and the development of risk and governance frameworks.

18. Effectiveness of the Meeting

The Committee reviewed the effectiveness of the meeting.

The Committee discussed the significant volume of papers and the impact this had on effective scrutiny. Members emphasised the need for more concise reporting, clearer executive summaries, reduced duplication and earlier circulation of papers.

The Committee agreed that improvements would be made to the quality, structure and timeliness of future papers.

19. Date of Next Meeting

Tuesday, 9 June 2026 at 2.00pm, Seax House, Chelmsford or via Microsoft Teams.

Minutes of the Essex ICB Commissioning Quality and Resource Committee

Held on 21 April 2026 at 2.00pm

Microsoft Teams meeting and in person at Seax House, Chelmsford

Attendees

Members

- Mark Bailham (MB) Non-Executive Member, Chair
- Neha Issar-Brown (NI-B) Non-Executive Member
- Tom Abell (TA) Chief Executive Officer
- Sam Goldberg (SG) Executive Director of Commissioning – Acute & Adult Mental Health Services
- Jennifer Kearton (JK) Executive Director of Finance and Commercial
- Giles Thorpe (GT) Executive Chief Nurse
- Michael Watson (MW) Executive Director of Corporate Services (part)

Other attendees

- Nicola Adams (NA) Associate Director of Governance
- Viv Barker (VB) Director of Quality (part)
- Natalie Brodie (NB) Associate Director of Financial Management, Accounts & Financial Services
- Kate Butcher (KB) Associate Director of Strategy (for agenda item 7)
- Keith Ellis (KE) Associate Director Value, Planning and Productivity
- Emily Hughes (EH) Associate Director of Planned Care Commissioning (Elective Care) (for agenda item 5)
- Janette Joshi (JJ) Associate Director of Contracting – Strategy (for agenda item 9)
- Ashley King (AK) Director of Capital and Estates
- Paula Wilkinson (PW) Director of Pharmacy, Medicines and Clinical Policies (for agenda items 4-6)
- Emma Seabrook (ES) Business Manager (Minutes)

1. Welcome and apologies

MB welcomed attendees to the first meeting of the Commissioning, Quality and Resource Committee. Introductions were conducted and the meeting was confirmed quorate.

There were no apologies.

2. Declarations of interest

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

There were no declarations of interest raised in relation to the agenda items.

Outcome: The Committee Register of Interests was noted.

3. Setting the Standard: Committee Role and Expectations

NA set out the expectations for good governance across ICB Committees to support the effective operation of the Commissioning, Quality and Resource Committee.

It was emphasised that the Committee should focus on strategic issues, risk, and assurance rather than operational detail, providing constructive challenge to Executives. Members were reminded that they sit as a collective body, rather than representatives of individual areas.

Noting the basis of decision-making should be data driven and evidence based, NA added that agendas would be prioritised to ensure areas of risk were discussed earlier in the meeting to allow good discussion.

Success would be measured by the Committee fulfilling its Terms of Reference and receiving assurance from reporting groups. It was noted that whilst minutes provide useful insight, summary reports of outcomes, escalations, and areas of concern would be more beneficial. Given the quarterly meeting cycle, assurance from sub-groups was highlighted as essential.

MW noted the need for the Committee to remain flexible during its first year within Essex ICB, recognising its evolving role and adapting to future requirements within the wider operational framework. It was agreed that the Committee's approach would be reviewed over the year and amended as necessary.

Outcome: The Committee noted the update on Setting the Standard: Committee Role and Expectations.

4. Establishing sub-committees and approving their terms of reference

The Commissioning, Quality and Resource Committee (CQRC) was responsible for providing oversight and assurance to the ICB Board across commissioning, quality and finance. As part of discharging its responsibilities, the Committee would establish sub-groups to support delivery, oversight and assurance across key domains.

NA explained that the Committee Standard Operating Protocol established the standard procedures for managing ICB Committees, this enabled a greater focus on the Committee's objectives within each Terms of Reference.

NA presented the Terms of Reference for CQRC approved at the ICB Board on 1 April 2026.

GT highlighted that, in line with National Quality Board recommendations, three areas through which the ICB discharges its statutory quality functions fall within the remit of the Audit, Risk and Compliance Committee and should be removed from the CQRC Terms of Reference.

The Committee agreed that Safeguarding Children and Adults, Special Educational Needs and Disabilities (SEND), and Infection Prevention and Control was removed from the CQRC Terms of Reference.

NI-B was confirmed as Vice Chair of the CQRC.

<u>Medicines Commissioning Group</u>

PW presented the Terms of Reference for the Medicines Commissioning Group, which would oversee the safe and effective use of medicines to improve population health.

The Formulary and Prescribing Pathway Sub-Group would report to the Medicines Commissioning Group and undertake the detailed clinical work, supporting the strategic direction for greater clinician involvement in medicines optimisation and utilisation.

Provider Selection Regime Review Group

The Terms of Reference mirrored those in place for neighbouring ICBs to provide mutual aid and support across the region. The group would provide independent review of any representations made in relation to procurements.

NA informed the Committee that if and when required, the group would be 'stood up' from members listed in the terms of reference to meet quoracy but also to manage any conflicts of interest thereby maintaining its independence. Consequently, the group would not meet with the full membership listed in the terms of reference.

Estates and Capital Group

The Estates and Capital Group would oversee the development and delivery of capital programmes to ensure estates developments were affordable, sustainable, and aligned with ICB priorities.

In line with the Scheme of Reservation and Delegation (SORD) the Group could approve ICB capital investment between the values of £500k and £2.5m.

System Quality Group

The Terms of Reference for the System Quality Group would be shared with the Committee following receipt of final guidance from the National Quality Board.

Quality, Contracting and Performance Review Meetings (QCPRM's)

The Quality, Contract and Performance Meetings (QCPMs) were the main review meetings in place with providers for the ICB's main NHS contracts. The Terms of Reference were under development and would be presented at a future meeting.

MB referred to the Committee Standard Operating Protocol and queried if the role of the Vice Chair was missing from the document under 4. Membership and Attendance. NA agreed to review the document.

Following a query from MB on whether each of the groups reporting to CQRC would have a Vice Chair, NA advised the protocol allowed for a Vice Chair but this was the responsibility of the group to decide whether determine that role at the outset was necessary.

Outcome: The Commissioning, Quality and Resource Committee:

- **noted its terms of reference as approved by the ICB Board on 1 April 2026 and agreed to the amendment above.**
- **established the sub-committees of CQRC and thus approve their Terms of Reference for the:**
    - **Medicines Commissioning Group**
    - **Provider Selection Regime Review Group**
    - **Estates and Capital Group**
- **noted the progress in developing the Terms of Reference for the System Quality Group and the Quality, Contracting and Performance Review Meetings**

ACTION: The Committee agreed that Safeguarding Children and Adults, Special Educational Needs and Disabilities (SEND), and Infection Prevention and Control was removed from the CQRC Terms of Reference and included within the Terms of Reference for the Audit, Risk and Compliance Committee.

ACTION: NA to review the Committee Standard Operating Protocol, section 4 (Membership and Attendance) following a query if the role of the Vice Chair was missing from the document.

5. Provider Accreditation Policy

The Provider Accreditation Policy was presented for approval, the policy brings together relevant policies across Essex to create the policy for Essex ICB.

Noting that there were minimal differences across the three ICB policies, the policy supported providers through the accreditation process to become a provider of choice for patients and enabled the ICB to gain assurance that providers were suitable to deliver services.

MB raised that the policy stated there were no definitions however definitions were used throughout the policy. It was noted the contents page would be updated as part of the final review before the policy was published.

It was clarified 7.2 should read 'Commissioning, Quality and Resource Committee' as the responsible Committee to receive Annual Reports to provide an update on accredited providers and providing assurance the policy was operating effectively.

Outcome: The Commissioning, Quality and Resource Committee approved the Provider Accreditation Policy subject to the amendments required above.

Action: Policy to be updated to address inconsistencies identified by MB by ensuring definitions are accurately reflected throughout the document, updating the contents page during final review prior to publication, and amending section 7.2 to correctly state that the "Commissioning, Quality and Resource Committee" is responsible for receiving Annual Reports, including updates on accredited providers and assurance on the policy's effectiveness.

6. Patient Group Directions Policy

The Patient Group Directions (PGD) was a legal framework to support the delivery of commissioned services where insufficient independent prescribers were available to prescribe for patients being seen. This was required for providers who did not have authorisation for their own independent prescribers.

The ICB encouraged providers to have independent prescribers and were aiming to move away from the framework in time.

The policy brings together relevant policies to create a new Essex ICB policy. It was noted there were no material differences across policies.

The Committee were asked to approve the formal adoption of PGDs previously authorised by the legacy Mid and South Essex (MSE) ICB, in line with the policy's provisions for the transfer and adoption following changes in commissioning responsibility. It was noted there were no PGDs in place for north east Essex or west Essex.

Following a request from NHS England regarding the requirement for Board approval of PGDs, NA confirmed that approval had been provided by the ICB Chair, but that there was no formal governance established for the approval of PGDs.

To ensure appropriate governance arrangements were in place, NA clarified that a summary paper would be submitted to the ICB Board outlining the governance framework, sponsoring committee, and delegated authority relating to PGDs.

Outcome: The Commissioning, Quality and Resource Committee

- **approved the Essex ICB Patient Group Direction (PGD) Policy as the formal governance framework for the development, review, authorisation and management of PGDs across all Essex ICB-commissioned services.**

- **approved the formal adoption of PGDs previously authorised by the legacy Mid and South Essex (MSE) ICB, as listed in the accompanying schedule, in line with the policy's provisions for transfer and adoption following changes in commissioning responsibility.**

VB present from this point in the meeting.

7. Population Health Improvement Plan (PHIP)

KB presented an overview of Essex ICB's Population Health Improvement Plan (PHIP) that set out the 5-year strategic ambition for improving health outcomes, reducing inequalities and delivering sustainable, high-quality services for residents.

MW left at 15.00

In response to a question from MB on the intention to publish the document. KB advised the PHIP would be published on Virtual Views, a public engagement platform and an accessible version shared on the ICB's website.

MB queried the confidence and accuracy of the data. KB advised the data reflected a point-in-time position and acknowledged that further work was needed to strengthen the organisation's Business Intelligence (BI), analytics and population health management capabilities. As these capabilities developed, the ICB would undertake deeper analysis and improve the use of data to inform future decision-making, strategies and planning.

MB asked how the ICB would measure outcomes to determine success and, where improvements were not being achieved take alternative action. KB explained programme Boards provided the forum to discuss metrics at a project level to ensure actions were having the desired impact.

Outcome: The Commissioning, Quality and Resource Committee noted the Population Health Improvement Plan.

8. Executive Director Report

JK presented the draft report, noting this was a working document and welcomed feedback to shape future reporting.

The Essex Joint Committee (as part of the governance created by the predecessor ICBs) agreed the Essex Plan for submission in March 2026; the plan included the high-level budget envelopes for spend areas. This paper provided a detailed level of budgetary allocation. Next steps were for Executives to sign off their individual budget areas.

The Essex ICB allocation was £5.282bn for 2026/27. MB welcomed sight of how the planned spend profile would change over years as resource shifted to support prevention.

As Suffolk and North East Essex ICB achieved financial balance in 2025/26, Essex ICB would receive a proportionate revenue bonus allocation, this would be directed to the acute setting.

JK presented the ICB Operating Plan – Capital Resource and Allocation for approval. The ICB capital allocation of £11.4m was made up of three allocations: Operational (business as usual (BAU)) Capital, ICB Strategic Capital and the Utilisation and Modernisation Fund (UMF).

Schemes under the UMF allocation to improve and expand practices totalled £1.8m for 2026/27, approval of schemes would be sought from NHS England.

A pipeline of schemes was developed and would allow the ICB to progress quickly should future funding be identified.

The Committee approved the overall Capital Resource and Allocation.

JK discussed the layout and future population of content for the report including key financials against the planned position (actual and underlying), issues, risks and mitigation.

There was an aim to report at a programme budget level to show spend at a more granular level against services.

GT referred to slide: Acute Services, Mental Health and Specialist Commissioning and requested NELFT service expenditure was captured in future reporting.

It was agreed a report from each of the Quality, Contracts and Performance Meeting (QCPM) would provide more context compared to a joint report.

MB requested that any contractual disputes or unsigned contracts were reported within the Contracting and Procurement section of the report.

SG highlighted the Essex ICB metrics and National Oversight Framework metrics that the ICB was responsible for delivering and reporting on. These would be supported by narrative to provide further detail.

MB raised the current layout of reporting did not provide a sense of how far performance was from target. GT suggested that future reporting includes forecasted performance at year end.

AK presented an update on Capital, Estates, Primary Care Capital and Section 106. It was reported work was underway to ensure estate the ICB was responsible for was fully utilised.

GT advised that the Committee would be kept informed of regulatory compliance relating to quality and standard contractual requirements. The Committee would also receive updates on any breaches of the National Oversight Framework (NOF), including Level 5 concerns at MSEFT, and any provider responses to national quality issues.

The Committee would receive updates on core service responsibilities, including All Age Continuing Care (AACC), and any warning notices issued. A set of national quality metrics was being developed alongside the quality strategy, which would align with the wider system model. The Quality Team would work with data analysts to ensure relevant data was reported to the Committee.

Outcome: The Commissioning, Quality and Resource Committee noted the working document and approved the Capital Resource and Allocation.

ACTION: Slide: Acute Services, Mental Health and Specialist Commissioning to include North East London NHS Foundation Trust (NELFT) service expenditure in future reporting.

9. Urgent Treatment Service

Minute redacted to maintain confidentiality.

10. Any other Business

It was agreed that a standing agenda item was added towards the end of future agendas to reflect on the effectiveness of the meeting.

MB encouraged members to feedback any areas that required greater consideration or areas of deep dives.

ACTION: Review of Committee Discussions and Effectiveness to be added as a standing agenda item.

11. Items for Escalation

There were no items raised for escalation.

12. Date of next meeting

Tuesday 7 July 2026 at 2.00pm

To maximise attendance from members, it was agreed the 6 October 2026 meeting would move from the afternoon to the morning.

ACTION: 6 October 2026 meeting to be moved to take place in the morning.