

Making health services better in Essex – a partnership with communities, local government, and providers

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How NHS Essex is responding to ICB and local government reform – a community focus



Essex pre reform

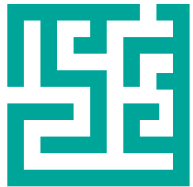


3 ICBs

15 councils

What has Essex been?

Despite some examples of great practice in Essex, the system in which we have had to work has been a...



Fragmented system → difficult for the public to navigate - current system also sees cost shunting between health and local govt, etc



Postcode lottery → inconsistent services across geographies

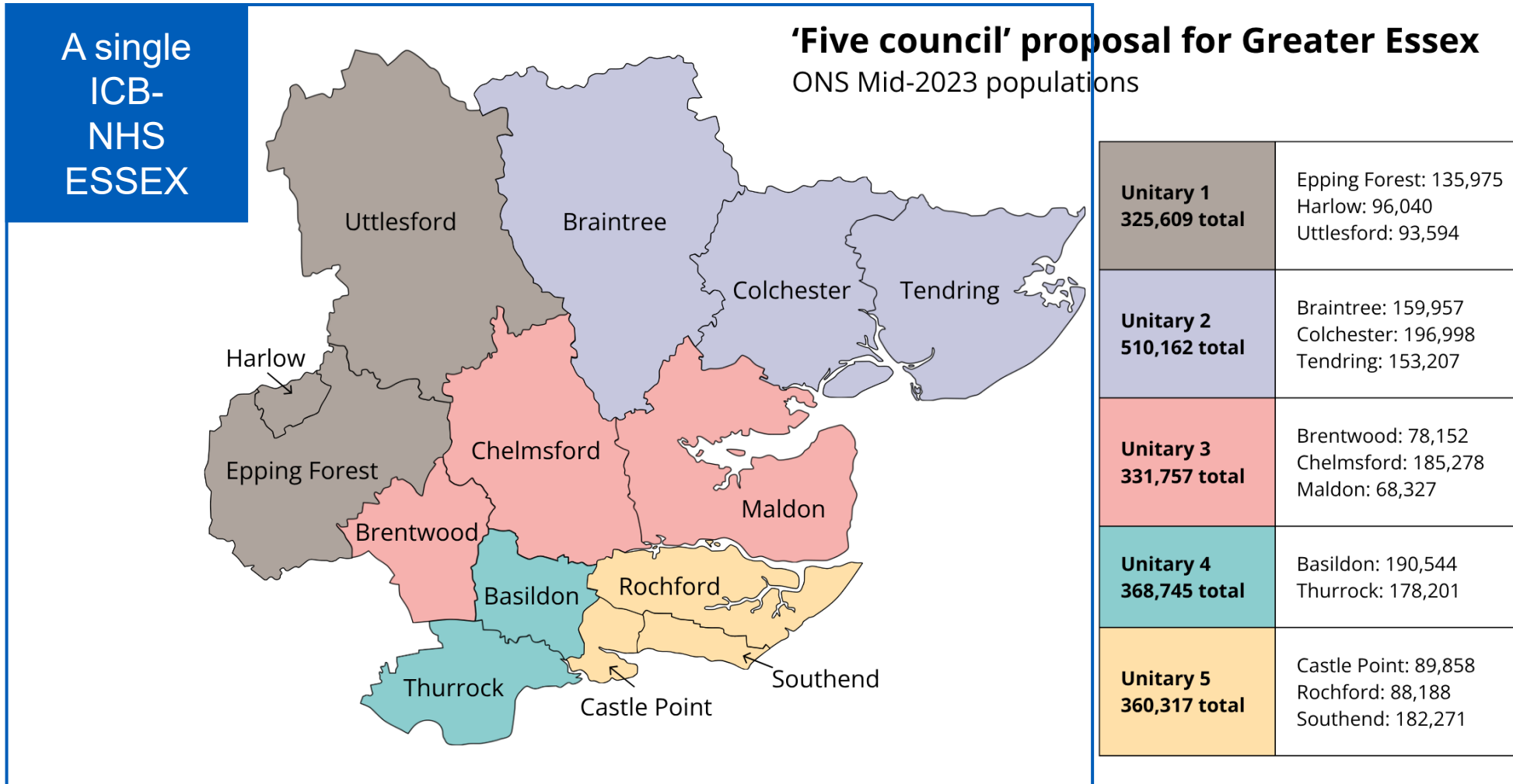


Skills & capacity spread thin → siloed and inefficient

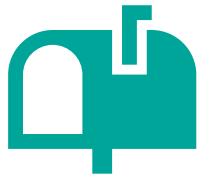


Rising costs → prevention too fragmented and not delivered at scale

Proposed Configuration



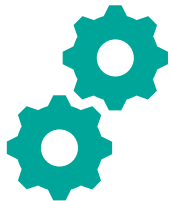
What is the Essex we can now build?



System where **local partner assets** are best nurtured and deployed to “**treat early and treat fast**”



Management and governance understanding how we all share the burden to **build stronger and healthier communities**



A reduction of staffing costs via joint posts where it makes sense for us all, fewer complicated systems and **genuine collaboration**



A system where partners are integrated at community level so that **patients are no longer seen as separate clients in different buildings. Seeing people – not patients**

A simple way of organising the system

We propose a clear three-level model:

Essex wide (doing things once where it makes sense)

- Set overall priorities and outcomes
- Allocate NHS resources across Essex
- Commission services where scale is required
- Provide shared infrastructure (e.g. data)
- Deliver core statutory functions (e.g. safeguarding)

Multi-neighbourhood (MN) (five unitary council areas – where most change happens)

- Joint service planning and commissioning
- Align budgets where possible
- Commission integrated services for local populations
- Accountability for improving outcomes
- Primary level for future commissioning (multi-neighbourhood contracts)

Single neighbourhoods (SN) (38 across Essex – focus on delivery)

- Multi-disciplinary teams supporting local populations
- Coordinate services and improve access
- Focus on prevention and early intervention
- Service delivery level (not governance)
- Delivered through contracts commissioned at neighbourhood level

Examples of how this works in practice

Essex-wide

- Example: Learning Disability services
- Jointly commissioned services with councils
- Includes specialist acute, mental health and community services

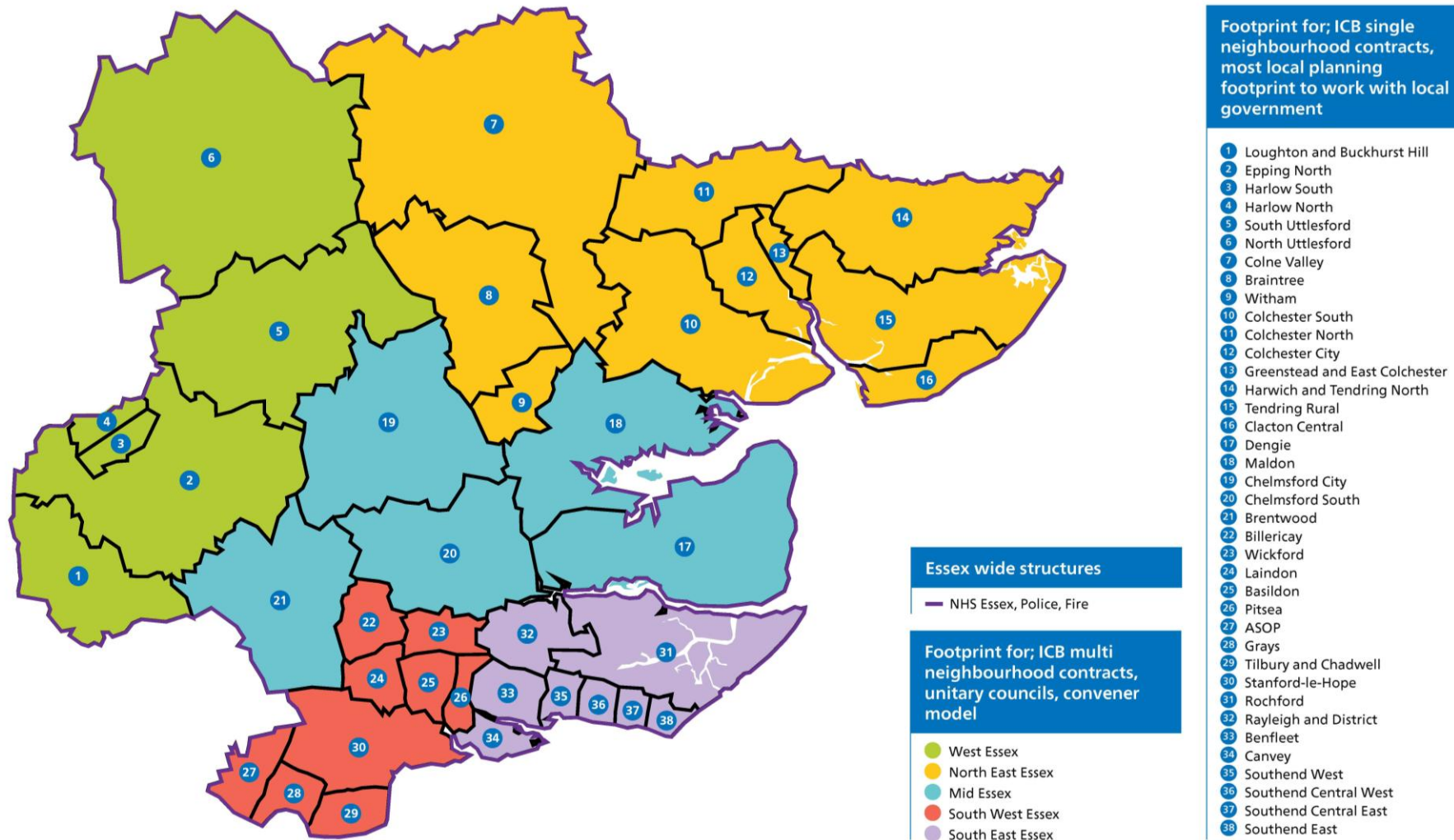
Multi-neighbourhood (MN)

- Commission services at place level to bring together currently separate services
- Align around shared outcomes for local populations
- Example: Voluntary, Community, Faith and Social Enterprise (VCFSE) Convener Model on unitary footprint
- Enables alignment with wider determinants (e.g. housing)
- Supports future public health integration and Better Care Fund (BCF) pooling
- Healthwatch used to maintain a strong patient voice at this level

Single neighbourhoods (SN)

- Strengthen local coordination and social prescribing
- Potential alignment with Local Authority Neighbourhood Delivery Committees (NDCs)
- Shared footprints to support wider determinants (e.g. housing)
- PCNs not required to change but future contracting to align wherever possible with neighbourhood footprints
- Ongoing engagement with Local Medical Committee (LMC) GPs and other primary care partners

Common areas we all understand



Notes

- **County wide** – Essex NHS, Essex Fire and Rescue Service, Essex Police
- **Place** – Unitary council / multi-neighbourhood contract area / Convener footprint
- **Most local** – Single neighbourhood – seeking to work with NDC's

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

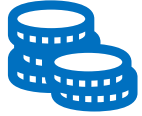
What is neighbourhood health



What is neighbourhood health?

| | | |
|---|---|--|
| <p>Risk Based Population Health Management</p> | <p>Modern General Practice</p> | <p>Integrated Neighbourhood Teams</p> |
| <ul style="list-style-type: none"> • Using data to understand population need • Targeting proven interventions to support people to stay healthy | <ul style="list-style-type: none"> • Continuing to improve access, including through digital services • Improving patient experience, including reducing the '8am rush' | <ul style="list-style-type: none"> • Groups of professionals working together to support patients to stay health and well • Supporting people with complex needs, in health and beyond |
| <p>Universal Community Services Offer</p> | <p>Integrated Intermediate Care</p> | <p>Urgent out of Hospital Services</p> |
| <ul style="list-style-type: none"> • Reducing unwarranted variation in community services • Strengthening community services role in local care provision in neighbourhoods | <ul style="list-style-type: none"> • Helping people recover as close to home as possible – ideally 'home first' • Reducing unnecessary time in hospital | <ul style="list-style-type: none"> • Providing access to urgent clinical advice and treatment when it is needed • Maximising alternatives to A&E, e.g. primary care, community, pharmacists and ambulances |

PHIP objectives



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



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



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



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



Being a good organisation to work with and for



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

Neighbourhood priorities

Health inequalities narrowing year on year

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

A decisive shift towards neighbourhood care delivery and prevention

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

Timely access and excellent outcomes across services

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

Financially and clinically sustainable services across Essex

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

Engaging the VCFSE sector - the convener model



What is the convener model?

- Essex NHS sees the voluntary, community, charitable, faith and enterprise sector as vital and as equal partners in wellbeing.
- The end goal is a VCSFE led body, working with NHS and local government, with devolved budgets, nurturing the third sector to issue community grants aligned to high level “problem statements” on wellbeing.
- A convener will be a roughly a 10-member board on the footprint of the new unitary councils.
- It will be supported by the ICB but not owned or controlled by the ICB.
- The benefit of this approach will be the insight from the VCSE sector to ensure money spent is wise, enhances the hidden strength in local groups, and brings diverse talent together to enable the neighbourhood health agenda outside of the larger NHS contracts.

Why we need to do this

Trust

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

A- annual funding which robs groups of long-term planning

B- overly prescriptive tenders which stifle innovation

C- An overly centralised process which is often slow and forces groups to compete and not collaborate

D- Constant restructures which prevent the sector and the public from maintaining working relationships.

Stability

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

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

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

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

The following slides outline the draft thinking for the body.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emerging thinking on governance – VCSFE members



Essex

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

Emerging thinking on governance – Non-VCSFE members



Essex

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

County wide governance – convener star chamber

Purpose –

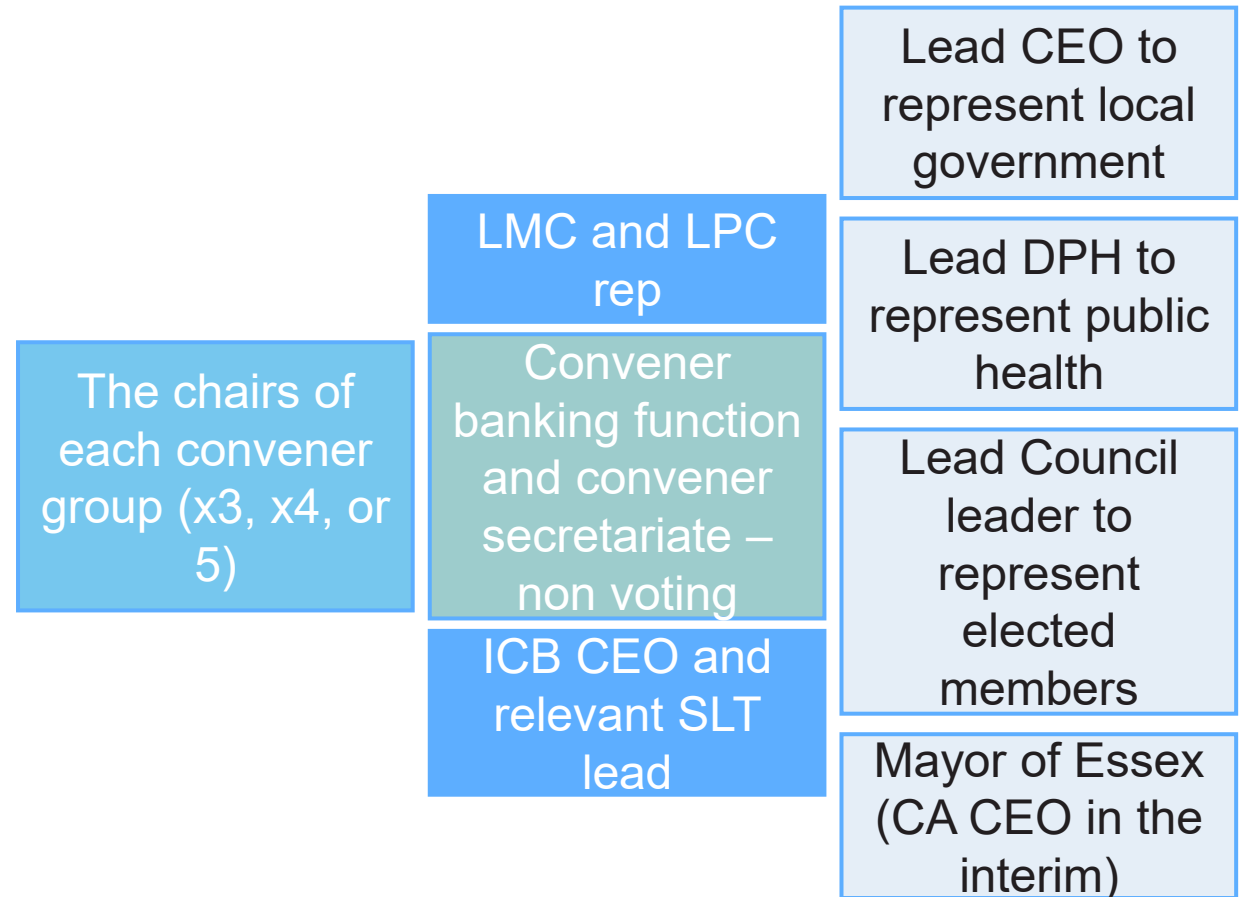
To act as a county-wide convener for issues which can only be sensibly commissioned at county wide level

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

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

To hear any appeal or support in the resolution of conflict

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



Initial thinking on timing and targets

Sept 2026 – formal consultation on this model. Jan
– Feb -2027; tender for model to give live in May
2027

2027/2028 – Frailty, and local determination

2028/2029 – Frailty, low level mental health
(inc schools), and local determination

2029/2030 – Frailty, low level mental health
(inc schools), support for hospices & end of
life, and local determination

2030/2031 – May 31 retender

Some questions we still are working through



Remuneration – how do we reflect the time commitment of a VCS group?

Banking function and secretariat – is a centralised ICB function the ideal way to avoid admin burden?

Who can and who can't act as a host / chair

Conflicts of interest vs inclusivity of membership

Financing – what does the first 3 years look like in terms of devolved funds and a staggered rollout, and a non capitated budget?

What needs to sit at county wide level

We want to make services better – here are a few examples of how we have started



NHS Essex wants to hold itself to a high standard – so what are we focused on in terms of self improvement?



Patient voice – we are taking steps to ensure the voice of our communities is at the heart of everything we do. We believe constructive challenge leads to better decision-making. People need to have their voices heard and to hold us to account, which is why we will continue to work with partners like Healthwatch to strengthen how we engage communities and involve them in shaping plans such as the Population Health Improvement Plan and its alignment with social care across Essex.

Estates - We are working with partners to robustly bid for every national pot of money possible for our communities, as well as scoping out the work and possible policy changes we need in partnership with local government to get a lot more out of the development / 106 process. We have expanded our estate team to reflect the fact that this is an area where we haven't delivered well enough with partners.

NHS Essex wants to tackle long standing issues in care – here are a few examples



Supporting the learning disabled community. Supporting the learning disability community, we are working to improve uptake of annual health checks for people aged 14 and over with a learning disability, alongside personalised health action plans to support better health outcomes. In many areas of Essex this ambition is not yet being met, so we are piloting a new approach working with the charity sector and with primary care to test more effective ways of increasing access and supporting people to improve their health.

Supporting the ADHD community. To help reduce waiting times and make sure children and adults are seen sooner, the NHS Mid and South Essex Integrated Care Board (MSEICB) has locally approved new specialist providers to carry out Autism and ADHD assessments. These new providers have confirmed they have capacity and can help people be assessed sooner. All providers have been fully checked to make sure they meet NHS standards for care, safety, governance, and quality. Being part of our local network of approved providers means care will be safe and coordinated with local NHS pathways. With an anticipated spend of just approximately £5m, we are currently working closely with our NHS providers to identify children and adults who have been waiting the longest to be seen for assessment to transfer those waits to the new providers. Patients don't need to do anything but will be contacted if they are eligible. We expect to test the effectiveness of this model to determine how we can further improve patient experiences in 26/27.

Thank you

