**MINUTES OF THE MEETING OF THE COMMUNITY LEADERSHIP OVERVIEW AND SCRUTINY COMMITTEE,
HELD ON TUESDAY, 10TH FEBRUARY, 2026 AT 7.30 PM
IN THE COMMITTEE ROOM, TOWN HALL, STATION ROAD, CLACTON-ON-SEA, CO15 1SE**

Present:	Councillors Steady (Chairman), Barrett (Vice-Chairman), Codling, Davidson, Doyle and Griffiths
Also Present:	Councilor Placey (Portfolio Holder for Partnerships)
In Attendance:	Lee Heley (Corporate Director (Place and Wellbeing) & Deputy Chief Executive), Ian Ford (Democratic Services Manager), Katie Koppenaal (Democratic Services Officer) and Bethany Jones (Democratic Services Officer)
Also in Attendance:	James Halden (Chief of Staff to the Chief Executive Designate – Essex ICB) (except items 39 and 40)

34. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Apologies for absence were received from Councillors Ferguson and Oxley with no substitutions appointed.

It was noted that the Assistant Director (Corporate Policy & Support), Keith Simmons, had sent his apologies for being unable to attend. Ian Ford, Democratic Services Manager, attended the meeting in his place.

35. MINUTES OF THE LAST MEETING

It was moved by Councillor Barrett, seconded by Councillor Davidson and unanimously **RESOLVED** that the minutes of the last meeting of the Committee held on Thursday, 15 January 2026, be approved as a correct record and be signed by the Chairman.

36. DECLARATIONS OF INTEREST

There were no declarations of interest made by Councillors in relation to any item on the agenda for this meeting.

37. QUESTIONS ON NOTICE PURSUANT TO COUNCIL PROCEDURE RULE 38

No Questions on Notice pursuant to Council Procedure Rule 38 had been submitted by Members for this meeting.

38. REPORT OF THE ASSISTANT DIRECTOR (CORPORATE POLICY AND SUPPORT) - A.1 - CHIEF EXECUTIVE OF NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD (ICB) ATTENDANCE AT COMMITTEE MEETING

Members of the Committee received a presentation from James Halden, Chief of Staff and representative of Tom Abell, Chief Executive Designate of the new Essex Integrated Care Board (ICB). It was confirmed that the Essex ICB was scheduled to be

formally established on 1 April 2026. The presentation outlined the ICB's emerging strategic direction as preparations for its formation progressed. Members were also updated on ongoing discussions regarding the definition of neighbourhoods within Essex and on the ICB's work to identify opportunities for strengthening collaboration with voluntary and community sector (VCS) organisations.

The Corporate Director (Place & Wellbeing) and Deputy Chief Executive, Lee Heley, acknowledged the ongoing work and commitment of the ICB. He highlighted the consideration given to the division of proposed neighbourhoods and noted that this Authority's feedback had been reflected in the proposed neighbourhood structure, which was welcomed. The positive implications of this approach in the context of Local Government Reorganisation (LGR) were also recognised.

The Corporate Director further noted the range of healthy lifestyles initiatives that Tendring District Council had delivered and continued to support, including Essex Pedal Power, leisure facilities, and rehabilitation programmes for individuals leaving hospital. Additional areas of work referenced included the Jaywick Sunspot, the role of Family Support Officers in providing social support, suicide prevention activity across Essex, and the establishment of Mental Health Hubs in 31 primary schools within the District. It was highlighted that the Health Index Score for Tendring had increased significantly, reflecting the impact of the Council's continued involvement in those programmes.

It was also noted that previous collaboration with the predecessor organisation, Suffolk and North East Essex (SNEE), had focused on the wider determinants of health. This had aligned with the Council's broader public sector responsibilities and its ongoing voluntary and community sector partnerships.

At an informal meeting of the Committee held on 4 February 2026, the Committee had assembled the following questions which had been shared with James Halden in the days leading up to this meeting:-

(1) *are you familiar with the District-specific health and inequalities issues we face, and how do these compare with those encountered in Colchester, Braintree, and other surrounding areas?;*
(2) *how is the new ICB intending to develop its working relationships with hospital trusts and Alliances, and what has this process entailed to date, as well as what is anticipated moving forward?*
(3) *is there scope for common working geographies among public services aligning with the new NHS neighbourhood health services, such as working in tandem with the new governance arrangements post LGR and emerging neighbourhood policing initiatives?*
(4) *given the forthcoming transition to a Unitary Authority and the introduction of a Mayoral model, how is the new ICB factoring these structural changes into its planning? For instance, is there an expectation of an interim governance or operational arrangement over the next two years, followed by further adjustments once the new system is fully in place?*

Those questions had been answered to a greater or lesser extent by Mr. Halden in his presentation.

At this meeting, Members asked further questions, as set out below, to which Mr. Halden responded as follows:-

Questions by Members:	Answers:
One concern I have regarding the proposal to merge the three ICBs is that, although the population requiring services and the range of partner organisations will remain unchanged, staffing levels are set to be reduced. What assessment has been undertaken of the potential impact on health provision in Essex as a result of this change, including the disproportionate effects on rural communities compared with major urban centres that typically benefit from large-scale centralisation, and can we be confident that this approach represents the most effective way forward?	(James Halden) We should remain mindful of the risks associated with increased centralisation. While we cannot directly influence decisions relating to staffing reductions, we can determine how we respond and adapt. It is therefore essential that our approach prioritises resilience and long-term sustainability. The Convener Model demonstrates clearly that greater trust in, and investment in, the community sector is not only beneficial but necessary. This must remain a core principle of our strategy, irrespective of structural changes elsewhere. Attempting to run a newly centralised ICB across three existing areas, serving a population of more than two million, with an approximate 30% reduction in staffing would be an unsustainable and ultimately damaging model. However, by pursuing the collaborative approach we are now consulting on and implementing, we avoid the pitfalls of over-centralised planning and instead give greater autonomy to community partners working on the ground. In my view, this significantly mitigates the risks associated with centralisation. Another important consideration is recognising where the NHS does not need to retain direct control. For example, some of the work taking place in leisure centres is exemplary and could open up opportunities to explore areas such as physiotherapy provision. This illustrates how the NHS can act as a supportive partner without needing to lead every element of delivery. We will continue to emphasise that being a centralised organisation does not require us to adopt a centralised planning mindset.

	It is also important to note that there are no reductions to the GMS contract for doctors; the cuts relate solely to the administrative running of the ICB. While this will inevitably create challenges for alliance working due to reduced capacity, we are committed to maintaining strong and effective relationships. I would be pleased to return to this Committee in a year's time to revisit the question of centralisation, with the aim of demonstrating that we have done everything possible to avoid unnecessary central planning despite becoming a larger organisation.
The Convener model is encouraging, and it is positive to see care being brought back into neighbourhoods where it rightly belongs. However, professionals across health, social care and local government can sometimes be protective of their roles and organisational boundaries, rather than focusing on the best outcomes for individuals and their families. What steps are you taking to address this cultural challenge and to ensure that colleagues from different sectors work together effectively?	(James Halden) There are two keyways in which the ICB can address the cultural changes required. First, the Population Health Management Plan provides a data-led foundation for understanding need. Second, the new neighbourhood contract is the primary mechanism through which funding can be directed into communities. Together, these tools offer a clear, data-driven view of the patient population and help to challenge traditional expectations, ensuring that individuals receive the right care regardless of which organisation delivers it. For example, this includes enabling greater use of pharmacies for certain minor health issues. We are developing a primary-care-led neighbourhood contract and, as part of this, are engaging with the Local Medical Committee (representing GPs), the Local Pharmacy Committee, the Optometry Committee and the Local Dental Committee. This collaborative approach is designed to ensure that each profession is supported to deliver its role effectively, while maintaining a strong focus on patient-centred care.
(Asked to John Fox at previous meeting) Could you provide details of	The Council has received: £900K all allocated for a Jaywick

the funding that Tendring District Council has received from health bodies?	healthy homes project; £600K for health inequalities (all spent or allocated); £245K for wellbeing hubs in primary schools (spent); £68K further for the wellbeing hubs project; and £165K for health and housing (still to be allocated).
Supplement – to the ICB representative – what is the prospect of similar funding streams going forward?	(James Halden) The funding will, of course, be subject to rigorous standards. In relation to the neighbourhood health hubs specifically, we do not yet have national guidance on the level of capital allocation we will receive. However, we are already exploring how best to use the resources currently available to us. For example, we have begun discussions regarding Harwich and what improvements can be made within our existing budget. Any additional resources we secure will be used in close collaboration with the Local Authority to ensure maximum value and impact.
Are the neighbourhood delivery committees going to be medical based or elected?	(James Halden) What the Government is proposing should form the basis of Local Government Reorganisation (LGR). Once we receive the “minded-to” decision, a statutory Transition Committee will be established. Neighbourhood delivery committees should remain focused on local communities to ensure that new unitary authorities do not become too distant from the people they serve. The plan I presented, which sets out the health neighbourhoods, is already informing our approach. We intend to work closely with all transition committees formed under LGR to ensure alignment. This is important because, for example, if a neighbourhood delivery committee in Local Government is supporting the homeless population, it is highly likely that the NHS will be commissioning

	services that overlap. Aligning the geography of local Government Delivery Committees with our neighbourhood health hubs will therefore be beneficial. The same principle applies to governance. Neighbourhood Delivery Committees in Local Government will inevitably include elected Members, so we need to consider how best to integrate both Officers and elected representatives into a coherent structure. Our commitment is to ensure these arrangements operate in sync. Once we receive the “minded-to” decision, we will be able to return with more detailed and concrete proposals.
Access to doctors and dentists is clearly falling short of what residents need. Could you outline what steps are being taken to improve this, how meaningful change can be delivered, and what is being done to encourage doctors and dentists to return to and remain in our local surgeries?	(James Halden) There are, of course, national contractual constraints, but within that framework the ICB can take three key approaches. First, we can work with you on capital issues by making a strong offer to clinicians—providing modern, fit-for-purpose facilities such as the Community Diagnostics Centre in Clacton. Second, we can reduce the number of people who need to see a practitioner in the first place by accelerating community-based diagnosis and addressing non-clinical needs that contribute to demand. A good example is in mental health, where only a proportion of need can be met through psychotherapy or medication; much of the lower-level wellbeing support can be delivered effectively through community and voluntary sector partners, reducing pressure on clinical services. Finally, neighbourhood teams will ensure that people with complex needs can access the care they require. By addressing other needs earlier and more effectively, we can free up appointments for those who will not benefit from redirection or prevention because of acute or ongoing health

	conditions and who genuinely need to see their practitioner.
If residents are unable to see a doctor to obtain the necessary referrals, how will we ensure that those who need primary care or community-based support are reached and treated?	(James Halden) There are several measures we can take to reduce the need for patients to see a GP simply to obtain a referral. In parts of the county, for example, we are implementing Pharmacy First Plus as part of the wider Pharmacy First scheme, which provides a quicker route into the system and we are exploring how this can be further strengthened. For certain conditions—such as those requiring specific antibiotics—we can ensure that patients are seen by an appropriate health professional who is authorised to prescribe, removing the need for a GP appointment. This approach frees up GP capacity, allowing them to focus on patients with more complex needs rather than spending time on conditions that can be safely managed elsewhere.
Many older residents lack confidence in approaching a pharmacy for support. How do we ensure that this group is not overlooked and continues to receive the care they need, particularly those in smaller villages?	(James Halden) While we are exploring digital solutions, we fully recognise the need to maintain accessible options for those who prefer to speak to someone by phone or see a professional in person.
While I appreciate the responses provided, we continue to face significant challenges with excessive waiting times simply to make contact with GP surgeries.	(James Halden) Our Primary Care Team works closely with GP practices across all 203 surgeries in Essex. Where specific surgeries are experiencing bottlenecks, there may be a range of underlying causes. If you are willing to contact me by email, I would be happy to ask the Primary Care Team to investigate the issues and identify opportunities to strengthen the triage process and improve patient access.
Given the backdrop of organisational restructuring and reduced staffing levels, do you appreciate why many people remain sceptical? In addition, can you provide more than reassurance and demonstrate how this new system will genuinely deliver better healthcare outcomes?	(James Halden) I appreciate the scepticism — it's understandable, particularly given how much the sector has changed during the time I've worked in it. The neighbourhood agenda I outlined reflects what I would prioritise regardless of any restructure, streamlining, or budget pressures. Community-focused healthcare is, in my

	view, the most logical and sustainable approach, and it creates the conditions for local government and the NHS to work together effectively. A primary-led model is also the most sensible direction. The largest proportion of NHS spending currently goes toward services such as urgent treatment centres, even though these areas do not see the highest patient volumes. In reality, most people in the community will interact far more frequently with their GP, dentist, or optometrist than with a trauma surgeon in A&E. Aligning resources with actual patterns of need is why I believe this approach is the most coherent and future-proof.
Would it be possible for James to return next year so that the committee can review progress against the commitments outlined, particularly given the current uncertainties surrounding LGR and the likelihood that many existing Council Officers may have moved into different roles or even left the sector by that time	(James Halden) You're right that LGR may result in significant and rapid organisational changes. What matters from our perspective, however, is that—using the convener model as an example—we are working with established community groups. If we implement this correctly, those groups should experience very little disruption as a result of any restructuring. Given the strength of the CVS in Tendring, they should in fact gain improved access to funding and support through the convener model. The internal adjustments required to deliver this should not materially affect them. I am happy to return in a year, as discussed. However, we will be going out to consultation on the model in September, so if the Committee would find it helpful for me to return sooner to talk through the proposals in more detail, I would be very willing to do so. This would also give the Committee an opportunity to engage with GPs and other partners to ensure the model is workable for them. (Lee Heley) I wanted to reassure the Committee that Tendring staff will

	transition into the new Authority with continuity, and that the Council remains committed to putting Tendring in the best possible position throughout this process. A key part of achieving this is maintaining our existing partnerships and the strong relationships we have built. While LGR will inevitably bring change, it will also involve a significant degree of continuity. Our aim is to ensure that, as the ICB continues to develop and as we navigate LGR in a calm and measured way, we preserve those external partnerships—even as relationships and geographies inevitably evolve. At the same time, we remain focused on delivering services effectively and improving population health, and we are confident that this will continue throughout the transition.
Following the recent announcement by Mid and South Essex NHS Trust regarding the addition of three new Right to Choose providers for autism and ADHD assessments, is the newly formed Essex ICB considering registering further providers to help reduce extensive waiting times across the county?	(James Halden) Yes, this is a significant national issue. The ability to access a private diagnosis has led to a rapid increase in the number of people seeking assessments, and understandably many assume that doing so entitles them to the full range of post-diagnostic support within the NHS. As a result, demand for services continues to rise even after diagnosis, placing sustained pressure on the system. It is also important to note that the Government is in the process of revising its national approach to SEND, which will have implications for how assessment pathways and support services are delivered. This is therefore an area that will require ongoing review as national policy, local demand, and provider capacity continue to evolve. The ICB will need to keep the position under regular consideration, including the potential registration of additional providers where this is appropriate and sustainable. I would be happy to

	arrange a dedicated session for the Committee to explore these issues in more depth, including the wider policy context and the implications for local services.

At their informal meeting, the Committee had also compiled the following question to the Partnerships Portfolio Holder to which a written response (as detailed below) had been received and circulated:-

Questions by Members:	Answers:
(Asked to Councillor Placey at previous meeting) Are you confident in your ability to maintain effective communication channels with the new ICB and to advocate for the district, and what strategies do you intend to employ to achieve this?	Yes. I have already met with the Chief Executive, Chief of Staff and Neighbourhood Director for the incoming Essex ICB and expect to hold future meetings. In addition, I attend the local health Alliance meetings which are attended by the ICB and I attend the Essex Health and Wellbeing Board which also has the ICB represented. These meetings allow me to advocate for our district and as part of this I have already shared the Council's Health and Wellbeing Strategy, co-chair the Council's Community Safety Partnership and Health and Wellbeing Board and attend a variety of Alliance meetings including co-chairing the Alliance Place Group which focuses on our place and provides opportunity to influence and communicate with wider partners including the ICB.

It was moved by Councillor Griffiths, seconded by Councillor Doyle and:-

RESOLVED that the Committee –

(a) formally records its thanks and appreciation to James Halden for his informative presentation and the answers he gave to the Committee's questions;
(b) is gratified to note the positive working relationships that exist between the Portfolio Holder for Partnerships and the Officers and the Integrated Care Board (ICB);

(c) welcomes the new Essex ICB's ongoing work, and is excited at the prospect of, health services being brought closer to the community, given the backdrop of continuing turbulence within the NHS;

(d) formally invites Tom Abell and James Halden to attend future meetings of the Committee to give an update on the implementation of the new Essex ICB cluster and further information on the Essex ICB's progress in reducing reduce extensive waiting times across the county for autism and ADHD assessments;

(e) requests Officers to investigate opportunities for joined up working on health scrutiny matters with its local authority partners once the configuration of the new Unitary Authority is known; and

(f) approves the matters referred to in resolutions (d) and (e) above being included within the Committee's work programme for 2026/2027.

39. REPORT OF THE ASSISTANT DIRECTOR (CORPORATE POLICY & SUPPORT) - A.2 - WORK PROGRAMME - INCLUDING MONITORING OF PREVIOUS RECOMMENDATIONS AND SUMMARY OF FORTHCOMING DECISIONS

The Committee was presented with the Report of the Assistant Director (Corporate Policy & Support) which provided it with its approved Work Programme for 2025/26, feedback to the Committee in respect of previous recommendations from the Committee in respect of enquiries undertaken and a list of forthcoming decisions for which public notice had been given.

In the absence of the Assistant Director, the report was introduced at the meeting by the Democratic Services Manager (Ian Ford).

The Democratic Services Officer, Katie Koppenaal, provided Members with an update on the proposal of a joint working with Colchester City Council and Braintree District Council in respect of scrutiny matters. It was reported that Colchester City Council had responded to the initial invitation and steps were being taken to secure a meeting date. A response from Braintree District Council had not yet been received in relation to any joint working opportunities.

The Democratic Services Officer further reported that in November 2025 she had held a meeting with Kirsty Hunt who was the Governance, Development and Consultancy Manager at South East Employers. The meeting had been to discuss her podcast, Governance Matters and within that discussion, the practice around evidence-based scrutiny had been referenced and it was intended that Officers examine practice at another Council. That Council had been contacted; however, a response had not yet been received.

The Chairman, Councillor Steady, formally recorded his thanks to the Officers in compiling the detailed contents of this report.

It was moved by Councillor Steady, seconded by Councillor Davidson and:-

RESOLVED that the Committee –

a) notes its Work Programme for 2025/26 (Appendix A) together with the feedback to the Committee on the decisions in respect of previous recommendations (Appendix B) and the list of forthcoming decisions (Appendix C);

b) notes the remaining contents of the report; and

c) notes that the Assistant Director (Corporate Policy & Support), in consultation with the Chairman of the Committee, will exercise, in due course, the authority delegated to him by the Committee at its meeting held on 17 November 2025 and will:-

(i) establish the Youth Mental Health Issues Task & Finish Working Group and make the necessary arrangements for that Working Group to meet; and

(ii) formally appoint Councillor Chapman BEM to the membership of the 'Joint Working with Parish and Town Councils' Task & Finish Working Group.

40. CARNARVON TERRACE REGENERATION PROJECT TASK AND FINISH GROUP

It was moved by Councillor Davidson, seconded by Councillor Griffiths and:-

RESOLVED that the Committee –

(a) notes and endorses the establishment of a Carnarvon Terrace Regeneration Project Task and Finish Working Group, and its appointed membership; and

(b) authorises, in view of the restricted timescales involved, the Assistant Director (Corporate Policy & Support), in consultation with the Chairman of the Committee, to directly report to the Cabinet meeting to be held on 20 March 2026 the outcome of the Task and Finish Working Group's enquiry together with its recommendations and/or comments et cetera.

The meeting was declared closed at 9.00 pm

Chairman