Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Mid and South Essex Integrated Care Board

Annual Report:

April 2023 – March 2024

Contents

Chair’s Foreword

As we draw the curtain on another year at NHS Mid and South Essex, it gives me pleasure to reflect upon our journey together.

The year that has unfolded was, without a doubt, punctuated by familiar and unprecedented challenges, yet it was also rich with moments of triumph, innovation, and unwavering dedication.

Over the past year, I have witnessed the evolution of our healthcare system, adapting to the needs of our community, and embracing advancements in medical science and technology.

Our staff, from clinicians to administrative teams, have demonstrated resilience and adaptability ensuring the delivery of healthcare services for our communities.

With immense pride, I acknowledge the hard work, empathy, and professionalism displayed by every member of our NHS family.

Innovation has been a cornerstone of our approach and not least our flagship Stewardship programme continues to put our clinical leaders at the heart of transforming how we meet the needs of our residents for the future.

This year, we embraced new technologies and methodologies that have not only enhanced our capacity to treat patients but have also improved their experience within our system. This includes our virtual hospital programme highlighted in this report.

The past year has not been without change. We have said goodbye to some key personnel during this time who were founding members of our Integrated Care System, not least with the retirement of outgoing CEO Anthony “Mac” McKeever.

Mac led us through the pandemic and the creation of our organisation, and we are indebted to his vision and leadership which set us on course from the outset.

We have also faced the task set nationally of making a 30 per cent cut to our running costs, a tough ask for any organisation but more so given our recent formation.

I am grateful for our teams who have led and sustained us through the difficult process of change. As we turn the page, let us carry forward the lessons learned and the sense of purpose that drives us. Together, we will continue to make a difference to the lives of those we serve, navigating challenges and embracing opportunities.

As we look to the future, our focus remains steadfast on improving health outcomes with and for our community, driven by evidence-based practices and a commitment to excellence.

Our Integrated Care Partnership continues to flourish, bringing together the energy of our wider colleagues in upper tier, district and borough councils, higher education, and the voluntary and community sector, who crucially support delivery on the ground in our communities. No NHS body is an island, and we must acknowledge the sterling support of our local authorities and in particular Essex County Council, Southend City Council and Thurrock Council.

Our three Healthwatch organisations have continued their constructive support and we thank them for their commitment to collaboration.

As a partnership, we are poised to embrace greater digital health solutions, focus efforts on key drivers of health inequity, and maintain our culture of continuous improvement. These efforts are crucial in our mission to provide more personalised care for everyone in our community.

In closing, I extend my heartfelt gratitude to all – our staff, our partners, and to the community we serve.

May we continue to advance, innovate, and inspire, united in our mission to support healthy lives together. We know we face even tougher financial and performance targets this coming year, but I am confident that if everyone in the mid and south Essex system pulls together, we have the skills to overcome our challenges.

Professor Michael Thorne CBE
Chair, NHS Mid and South Essex Integrated Care Board

24 June 2024

PERFORMANCE REPORT

Introduction with Tracy Dowling

As the interim Chief Executive Officer (CEO) of NHS Mid and South Essex ICB, it's with a blend of humility and pride that I pen this foreword to our annual report.

Reflecting on the financial year 2023/24, I am struck by both the enduring challenges we face and the remarkable strides we have made under immense pressure.

This past year, the lingering effects of the COVID-19 pandemic continued to exacerbate health inequalities within our community, highlighting vulnerabilities that require our urgent attention.

Our primary care services have responded to the significant demands made of them by increasing activity by over 8%. We continue to face significant demands on our mental health, urgent, and emergency services, and again have continued to improve performance significantly over 2023/24.

Notably, we have experienced long waits for planned treatments and are still working to recover performance levels in cancer services, and over 2023/24 we have made significant inroads into clearing treatment backlogs and reducing wait times and waiting lists.

Our system workforce challenges, characterised by high vacancies and a heavy reliance on bank and agency staff, can affect the quality of care we provide, and our focus remains relentlessly on achieving high quality care for all. Over this last year in the mid and south Essex system, we have seen vacancy rates reduce; staff turnover rates improve, and we have seen reductions in sickness absence. We are focussed this year on significantly reduced temporary staff use given the successes in recruitment and retention.

Financially, we face a significant deficit that has prevented us from meeting our planned financial positions. Recovering this will dominate our actions in 2024/25.

Despite these formidable challenges, our ambitions remain high, and our achievements this year are testament to the dedication of our staff and the resilience of our system.

The improvements we have delivered have not only impacted our community positively but have also gained national recognition. Innovations like our anchor programme, our virtual hospital initiatives, and advancements in teledermatology to reduce urgent suspected skin cancer wait times, highlight our commitment to technological integration and improved patient outcomes.

Our happy hubs and wellbeing cafes have been pivotal in creating accessible wellness centres within the community, directly addressing the holistic needs of our residents.

In December 2023 alone, primary care delivered over 7% more consultations than in the previous year, an achievement supported by the introduction of new roles, enhanced technology, and self-referral pathways that empower our residents to access the best possible care for their needs.

The introduction of integrated neighbourhood teams and transfer of care hubs are both helping our patients to receive the help and support they need in the most timely and appropriate locations.

Our focus continues to be on reducing health inequalities and improving the overall health and wellbeing of the population we serve. Looking forward, we remain steadfast on enhancing patient care and health outcomes.

This will require continued innovation, enhanced collaboration across all levels of our system, and a strengthened resolve to overcome the financial and operational challenges we face.

I extend my deepest gratitude to our dedicated staff, whose commitment has been nothing short of inspiring. To our partners and stakeholders, thank you for your unwavering support and collaboration. And to our community, thank you for entrusting us with your health and wellbeing.

The landscape of healthcare is ever evolving, marked by shifts in policy, emerging health needs, and the ongoing quest for sustainability. These challenges call for a continued commitment to excellence, innovation and, above all, compassion.

Tracy Dowling
Interim Chief Executive Officer of NHS Mid and South Essex Integrated Care Board

24 June 2024

Performance Overview

What we do

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services and to improve the lives of people who live and work in their area.

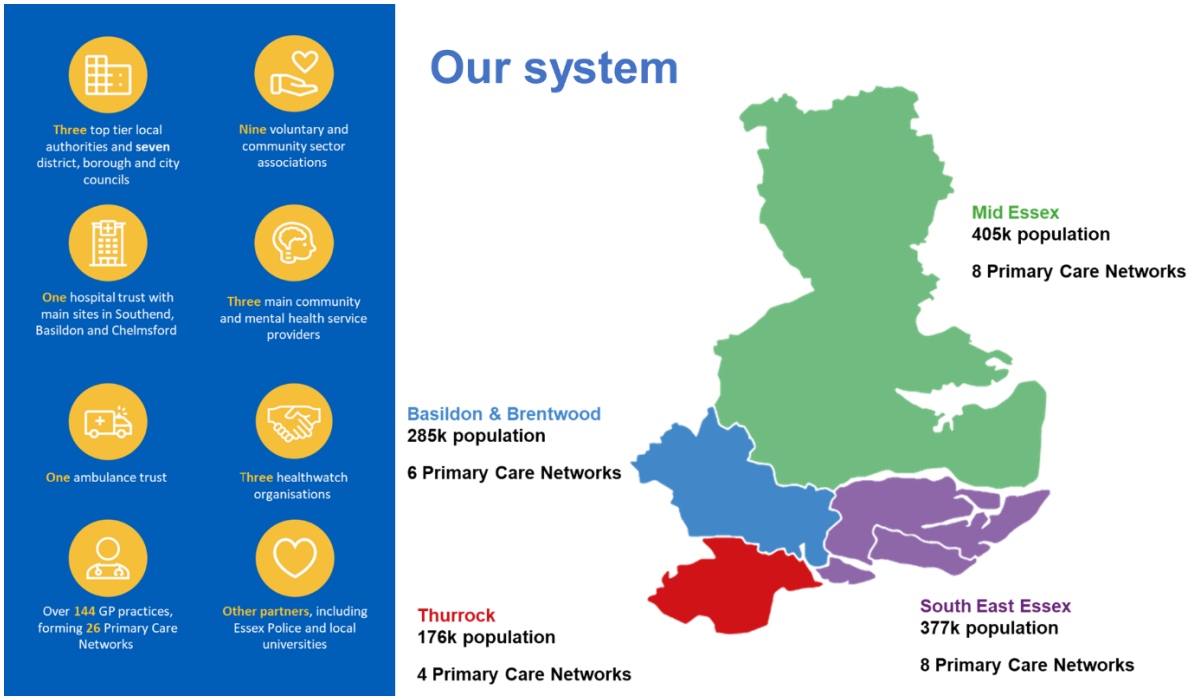
Following several years of locally led development, recommendations from NHS England (NHSE) and the passage of the Health and Care Act (2022), forty-two ICSs were established across England on a statutory basis on 1July 2022. The ICS is made up of two main Boards/committees:

Integrated Care Board (ICB*):* A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the ICS area.

Integrated Care Partnership (ICP): A statutory committee jointly formed between the NHS ICB and all upper-tier local authorities (councils with responsibility for children's and adult social care and public health) that fall within the ICS's area. The ICP brings together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an Integrated Care Strategy on how to meet the health and wellbeing needs of the population in the ICS area. The ICB is committed to delivering the vision and objectives set out within the strategy from a health perspective.

In mid and south Essex (MSE), our ICS is made up of a wide range of partners, supporting our population of 1.2 million people. We operate at several levels, ensuring we always organise our work and deliver services at the most local appropriate level and closest to the residents we serve.

The diagram below shows the shape of our partnership, explained further overleaf:



Neighbourhoods*:* The areas covered by our 26 Primary Care Networks (PCNs), and local neighbourhood teams (INTs).

Places: The areas covered by our four alliances, covering mid Essex, Basildon and Brentwood, Thurrock and south east Essex.

System: The whole of MSE.

Our partnership includes:

Three upper tier local authorities*:* Essex County Council, Southend-on-Sea City Council (unitary), and Thurrock Council (unitary).

Seven district councils: Basildon Borough Council, Braintree District Council, Brentwood Borough Council, Castle Point Borough Council, Chelmsford City Council, Maldon District Council, Rochford District Council.

One acute hospital provider: Mid and South Essex NHS Foundation Trust (MSEFT), with main sites in Southend, Basildon, and Chelmsford.

Three main community and mental health service providers: Essex Partnership University NHS Foundation Trust (EPUT) delivers community and mental health services; North East London NHS Foundation Trust (NELFT) delivers community and the Child and Adolescents Mental Health Service (CAMHS); Provide Community Interest Company (CIC) delivers community services.

These three providers work together in the delivery of community services (physical health) as the Mid and South Essex Community Collaborative.

One ambulance service provider: East of England Ambulance Service NHS Foundation Trust (EEAST).

Primary care: 26 Primary Care Networks (PCNs) covering 144 GP Practices.

Three local independent watchdog bodies: Healthwatch Essex, Healthwatch Southend and Healthwatch Thurrock.

Nine voluntary and community sector associations: Basildon, Billericay and Wickford Community and Voluntary Service (CVS), Brentwood CVS, Castle Point Association of Voluntary Services, Chelmsford CVS, Community 360 (covering the Braintree District), Maldon and District CVS, Rayleigh, Rochford, and District Association for Voluntary Service, Southend Association of Voluntary Services and Thurrock CVS.

Other partners: Essex Police, Essex County Fire and Rescue Service, parish and town councils, the Local Medical Committee, local universities and colleges, hospice providers, and community and faith organisations.

"We will know what success looks like with a clear set of outcome measures and adapt our plans in line with what matters to local people and partners"

Commitment from ICS partners made during the ICP strategy design process

Our Vision and Journey

In establishing the ICS, the ICB builds on long standing relationships with its partners in MSE who agreed our ambition to 'up our game'. We want people to live longer, healthy lives, to be able to access the best of care and to experience the best clinical outcomes, and for us to be exceptionally able to attract good people to work with us, recognising we offer meaningful careers.

The ICB is committed to the delivery of the Integrated Care Strategy, co-developed with partners through our ICP. The strategy draws heavily upon the joint health and wellbeing strategies of our upper tier local authorities, and our plans will contribute to the delivery of those strategies through our networks and neighbourhoods, the alliances and (where appropriate) across the MSE system.

The ICB published its first Joint Forward Plan (JFP) for 2023-2029 in June 2023. The JFP outlined a set of shared ambitions for the system, drawing on priorities from within the NHS as well as our local government partners as set out in joint local health and wellbeing strategies. The JFP provides a five-year framework for how we want to deliver and improve services for people living in MSE, which will be reviewed each year in line with NHSE guidance. The full JFP is published on the ICB website, alongside the updated 2024-2029 version. Joint Forward Plan - Mid and South Essex Integrated Care System (ics.nhs.uk)[hyperlinks]

Within the 2023-29 JFP, the ICB, including its partner NHS organisations, committed to a set of strategic ambitions that have guided the system's work. These ambitions are:

Let staff lead	Improve quality (access, experience and outcomes)	Supporting our workforce
Mobilising and supporting communities	Reduce health inequalities	Data, digital, technology
Further developing our system	Population health improvement	Financial sustainability
Improve oversight framework rating	Operational delivery	Research and Innovation

In support of these strategic ambitions, the ICB made several commitments that have directed its work in 2023/24:

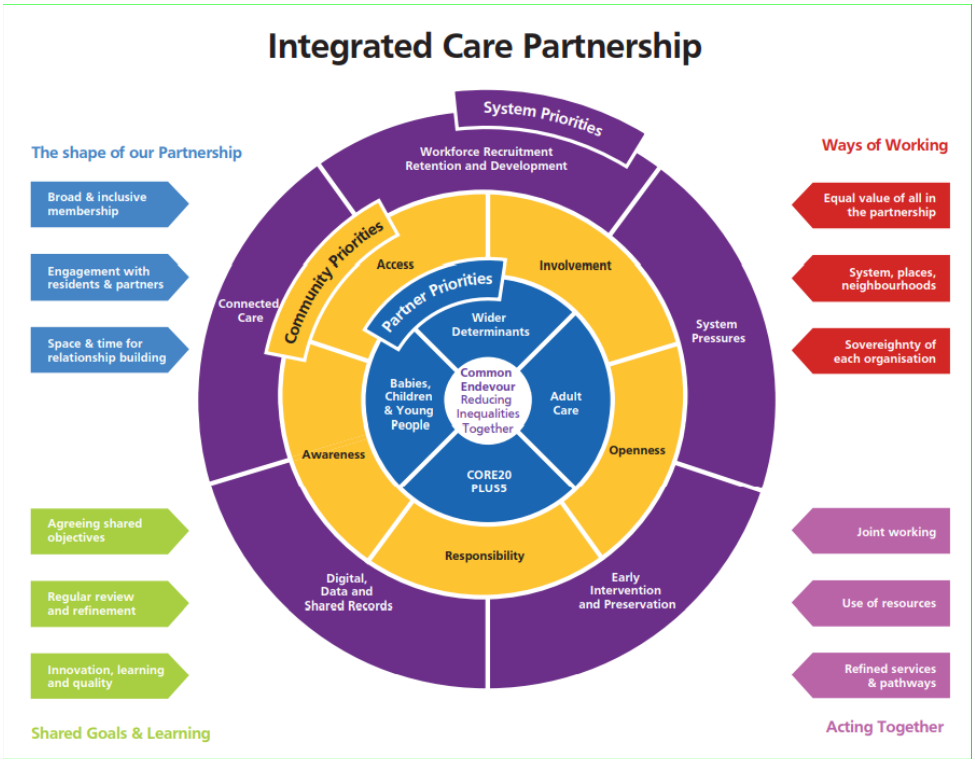
- Focus on reducing **health inequalities**, delivering against the Core20PLUS5 frameworks.
- Delivery of local, personalised, coordinated services through **integrated neighbourhood teams.**
- Making progress on reducing avoidable mortality in **cancer, cardiovascular disease and respiratory conditions**.
- Increasing **preventative activities** for tobacco cessation, healthy weight, and physical activity.

- Amplifying **clinical and professional leadership** using the Stewardship programme.
- Investing ‘up-stream’ in evidenced-based **interventions and preventative activities** taking place closer to home.
- Using **population health management** to support the targeting and setting of ambitious targets for prevention investment.
- Developing **demand and capacity models** underpinning integrated operational decision-making that is organisationally agnostic and focused to meet needs.
- Investing strategically in voluntary, community, faith and social enterprise (**VCFSE**) organisations to support wellbeing, prevention and early intervention.
- Evolving our **relationship with communities**.
- Emphasising **equality, diversity and inclusion** for our workforce and our patients.
- **Learning** and building on **innovative** practice.
- Considering **social value** in our approach, linking to our Anchor Programme (explained further below).

MSE ICS publishes a Joint Capital Resource Plan [hyperlinks] which details our plan for capital spending for the next financial year, along with details of any risks and mitigations.

Our Common Endeavour

The 10-year Integrated Care Strategy describes our shared priorities across our ICS:



In preparing the Integrated Care Strategy, we have also had regard for the regulatory and statutory requirements, particularly the four key aims set nationally for the ICS, these being:

- Improving outcomes in population health and health care.
- Tackling inequalities in outcomes, experience, and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development.

We have also had regard for the 'Triple Aim' established for NHS bodies that plan and commission services, which requires them to consider the effects of decisions on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both them and other relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by themselves and other relevant bodies.

Review and learning from 2023/24

The analysis section below describes in more detail the ICB's performance against the NHS Oversight Framework and the commitments made in the JFP.

Notwithstanding industrial action, in most areas the ICB has improved performance from the levels achieved in 2022/23, although there is still more to be done to achieve the performance levels expected and to which we aspire. The sections below describe how we have redesigned emergency care and some cancer pathways to improve our performance, as well as investing in place-based initiatives as part of our overarching approach to addressing inequalities. Investment in mental health, dentistry and primary care has been fundamental to delivering increased activity, acknowledging that delivery of performance often comes with premium costs.

The ICB managed its own financial performance in line with the original plan, as set out within the finance and accounts sections below. The ICS delivered against a revised deficit plan following renegotiation in year with NHSE. The outturn position for the system was a deficit of £29m. Financial grip, control and accountability will therefore be a priority during the year ahead.

Appointment of a joint Executive Director of System Recovery and continued leadership through both the Chief Executive Officers Forum and the sovereign organisations provides clarity of purpose and focus on delivery of our finance and performance recovery plan.

The results of the ICB Staff Survey were disappointing, but not surprising given the significant organisational change programme during 2023/24. Our workforce will therefore also be an area of focus both for the ICB, and the wider system, while partners align workforce requirements to the needs of our population and our resources and shift away from high numbers of temporary staff.

Performance Analysis

Introduction

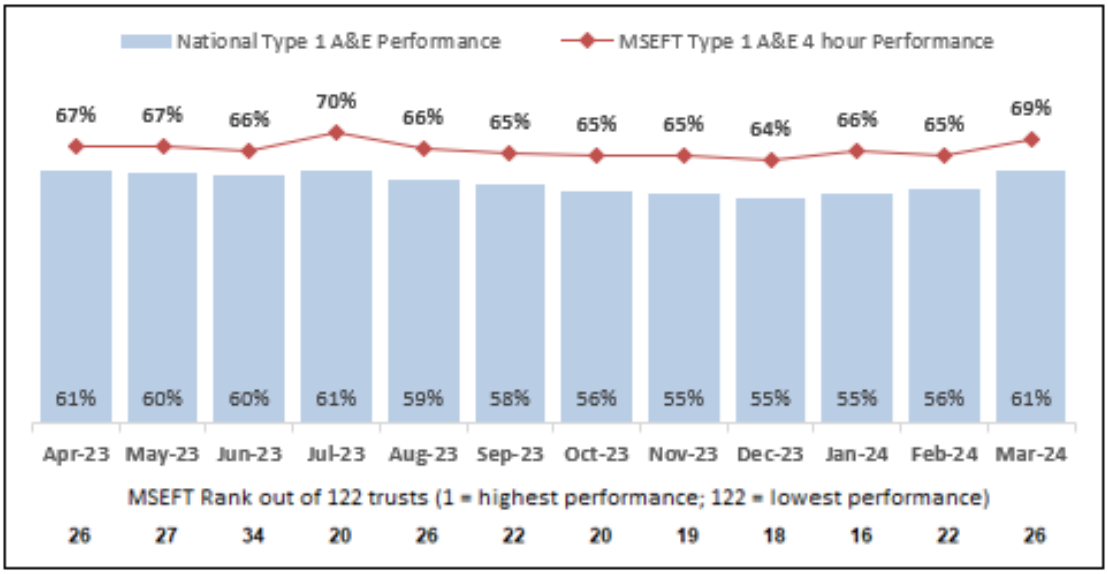
Mid and South Essex Integrated Care Board (MSE ICB or 'ICB') is responsible for reporting against the NHS Oversight Framework[1]. This framework provides the structure for the ICB to ensure oversight and performance of NHS constitutional standards for its population.

During 2023/24 the ICB, with partners, focused on recovery of performance and delivery of plans commenced in 2022/23 post COVID-19 pandemic. The below outlines the 2023/24 achievement and delivery for MSE and incorporates case studies to demonstrate how the ICB has worked to improve performance and patient care.

Urgent and Emergency Care (UEC)

In 2023/24 UEC planning for the emergency department four-hour standard (arrival to admission, transfer, or discharge) reflected the national operational planning ask to achieve 76% during March 2024. Recognising that the ICB uses other providers, the focus on Mid and South Essex NHS Foundation Trust (MSEFT) is because it is the biggest provider of UEC for the population of MSE.

The graph below shows the 2023/24 financial year performance for the A&E four-hour standard benchmarked against national performance. This shows that MSEFT is above national performance but below the operational performance requirement of 76%.



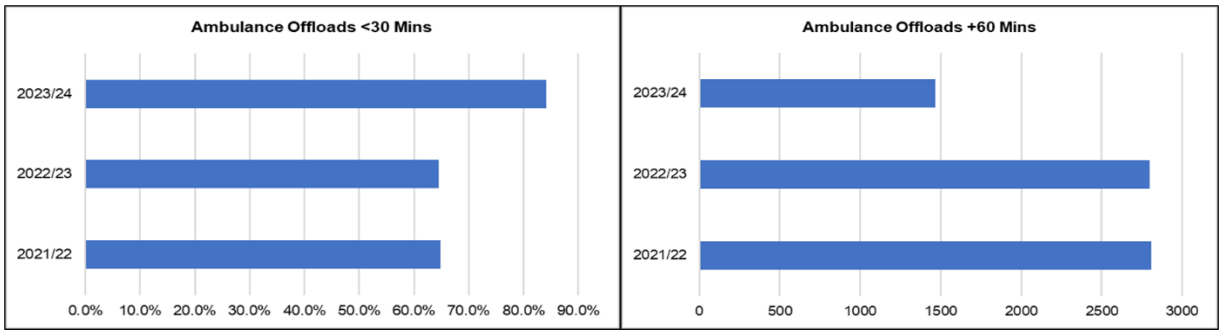
The improvements seen from January 2024 to March 2024 resulted from the UEC improvement programme with schemes implemented specifically to impact the performance within A&E, improving performance by 7% from 62% (2022/23) to 69%.

[1] PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk)

In addition, 88% of urgent community response calls were responded to within two hours (above plan).

The ICB Urgent Emergency Care Board continues to work with partners, to improve ambulance handover times. In 2023/24, 84.2% of ambulance handovers were completed in under 30 minutes, with the average handover time within MSE being lower than the NHS East of England regional average and showing significant improvement of 19.5% from the previous year.

Similarly, there has been a 47.66% reduction (in the last two years) in the volume of patients waiting 60 minutes or more to offload from an ambulance, shown in the graphs below.



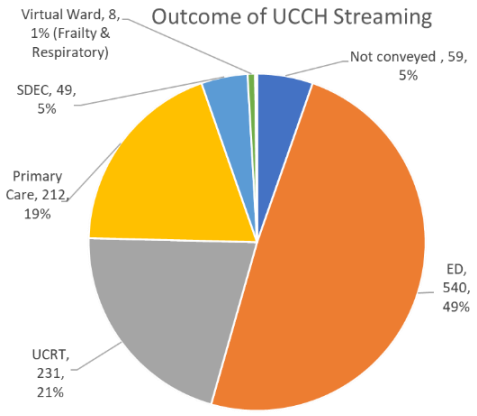
The Urgent Care Department for Mental Health and the Unscheduled Care Coordination Hub commenced in 2023/24; these have both supported the reduction in acute emergency admissions; with more patients receiving urgent care in their community. The continued impact of both schemes will be part of the 2024/25 programme of UEC work across the system.

Case study: Unscheduled Care Co-ordination Hub (UCCH) – UEC Stewardship Group

Ambulance crews called the Urgent Community Response Team (UCRT) if they were considering conveying a patient to the Emergency Department (ED). The UCRT would consider and, if appropriate, redirect patients to other sources of care.

Results over a 44-day period:

- 1101 patients referred to UCCH for review prior to ED conveyance.
- Approximately half of these were referred to alternative care pathways i.e., **not conveyed to ED** (50.9%)
- On days where the UCCH team was fully staffed just 23% were conveyed to ED (10 of 44 patients).



The System Coordination Centre (SCC), established to oversee and coordinate response to operational pressures across the MSE system, received accreditation from the NHSE national team for its collaboration and engagement with partners in the management of surges in UEC activity.

Cancer Care

Improving cancer care has been a priority of the ICB with new initiatives such as the targeted lung health checks projects delivered within two of our alliances (Thurrock and

Southend). The teledermatology project has led to more timely diagnosis of suspected skin cancer improving performance against the faster diagnostic standard for skin cancer from 25% to 69.2% (62-day skin performance). The reduction in demand achieved through this innovative pathway enabled those continuing on the suspected cancer pathway to be seen, diagnosed, and treated more quickly.

During 2023/24, the ICB and MSEFT met fortnightly with the national and regional NHSE teams to track delivery of the recovery of the system cancer backlog plan. At year-end the national NHSE team wrote to the MSE system acknowledging the improvement in the recovery of the cancer backlog and improving the 'faster diagnosis' performance during 2023/24 stating that "this is some of the most positive progress we have seen anywhere nationally and has been a significant contributor to the overall national position".

At the end of March 2024, 261 fewer people were in the MSEFT 62-day cancer backlog than at the start of the 2023/24 year.

Performance against the 28 day faster diagnostic standard reached 72% by year end, which means much reduced wait times from the point of referral with suspected cancer to learning whether the diagnosis is likely to be cancer, or not. This clearly ensures faster treatment for those who need it, and reassurance at a much earlier stage for those who do not have cancer.

The ICB will continue to support MSEFT in improving performance into 2024/25, acknowledging that there is further progress required to achieve national expectations and the standards to which the ICB aspires to, as shown in the table below.

Mid and South Essex NHS Foundation Trust (MSEFT): Cancer Waiting Times (March 2024)

Standards: For people with suspected cancer:

- *To not wait more than 28 days from referral to getting a cancer diagnosis or having cancer ruled out.*
- *To receive first definitive treatment within 31 days from decision to treat*
- *To start drug, radiotherapy, and surgery subsequent treatments within 31 days*
- *To receive their first definitive treatment for cancer within 62 days of receipt of urgent referral.*

Pathway	Standard	Metric	Mar-24
28 Day Faster Diagnosis Standard	>=75%	Performance % Rank (1= highest) No. of Trusts	72.0% 121 141
31 day first treatment	>=96%	Performance % Rank (1= highest) No. of Trusts	80.3% 136 139
31 day subsequent treatment Drug Treatments	>=98%	Performance % Rank (1= highest) No. of Trusts	94.9% 105 122
31 day subsequent treatment Radiotherapy Treatments	>=94%	Performance % Rank (1= highest) No. of Trusts	57.3% 58 60
31 day subsequent treatment Surgery	>=94%	Performance % Rank (1= highest) No. of Trusts	45.1% 131 133
62 day standard	>=85%	Performance % Rank (1= highest) No. of Trusts	40.2% 130 138
62 day standard (Screening)	>=90%	Performance % Rank (1= highest) No. of Trusts	82.4% 46 125
62 day standard (Upgrade)	N/A	Performance % Rank (1= highest) No. of Trusts	66.7% 124 142

Mid and South Essex Cancer Board (including cancer alliance, patient representatives, specialised commissioning, and cancer stewards) has worked with MSEFT on a cancer improvement programme that supports clinical and service improvements, reduces waiting times, and improves experience across cancer services.

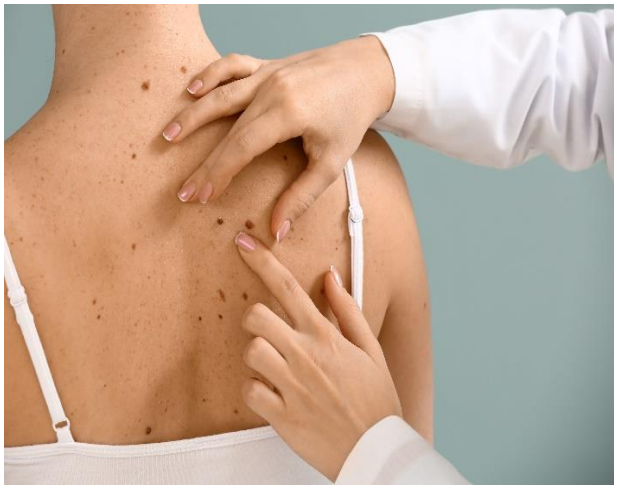
Case study: targeted lung health checks, improving patient care.

Since 2020, people living in Southend and Thurrock (aged between 55 and 75), were invited to have a free NHS lung health check, which identified people at risk of developing lung cancer. Those at higher risk were offered a scan, then referred for treatment if needed.

More than 100 local people have now had previously undiscovered lung cancer found and treated.

Over 17,000 checks (Feb 2024) have been completed. In addition, nearly 10,000 CT scans and 561 referrals to follow up care, linked to cardio-vascular disease, gallbladder, respiratory, breast, gastro, urology, liver and renal findings.

Case study: skin cancer faster diagnostics - teledermatology.



As of 18 March 2024, 5933 cases were seen in the teledermatology service:

- Over 5,700 patients attended community based medical photography clinics.
- 97% of referrals triaged within 2 days.
- 32.95% continued on the urgent suspected cancer pathway (1.5% due to not meeting the criteria).
- 12.13%of cases were referred on to an alternative acute pathway
- 4.1% of patients were referred to Community Dermatology.
- 50.51% of referrals were returned to Primary Care with advice and guidance.

Elective Care Referral to Treatment (RTT)

Despite the impact of industrial action on elective care activity levels, 743 fewer patients were waiting over 65 weeks for their first definitive treatment; 1858 fewer patients waiting over 52 weeks for their first definitive treatment and over 7000 more patients have completed their RTT admitted pathway compared to the previous year (2022/23).

During 2023/24 the ICB and MSEFT met fortnightly with the national and regional NHSE teams to track delivery of the recovery of the system RTT elective waiting times plan.

Working together, the ICB and MSEFT implemented the national Patient Initiated Digital Mutual Aid System (PIDMAS). This programme was nationally defined for long waiting patients to choose, following contact, to be referred to an alternate provider for their

procedure. The ICB commissioned activity from both independent sector and community providers to support a reduction in referral growth.

Diagnostics

During 2023/24 work had been ongoing via the ICB Diagnostic Board to understand the delivery plans in place across both community and acute providers to achieve the 31 March 2025 commitment for providers to achieve no more than 5% of patients waiting 6 weeks or more for a diagnostic test and no patients waiting 13+ weeks.

Risks to delivery had been identified and were being mitigated using additional workforce and capacity to meet the increased diagnostic demand due to both waiting list size and demand from referrals. Increasing list sizes and demand continue to challenge the position. Demonstrating successful efforts to increase capacity, over 117,450 more diagnostic tests were undertaken at MSEFT in 2023/24 compared to 2022/23.

There were 204 fewer people waiting over 13 weeks from referral to diagnostic imaging, and 76% of people were waiting less than 6 weeks from referral to diagnostic test.

The diagnostic 6-week standard remained the same as the 2022/23 position.

The MSE system has a programme to develop, implement and mobilise community diagnostic centres (CDCs) as per the national expectation for systems. These centres will provide alternate additional diagnostic capacity to support reduction in waiting times and to deliver care closer to home. The CDC programme is overseen via the ICB Diagnostic Board.

More than 3,566 patients received their diagnostic test via the Mid and South Essex Community Diagnostic Hub (as of March 2024).

Case study: Thurrock Community Diagnostic Centre.

The Alistair Farquharson Centre (AFC) will become the new Thurrock CDC.

Demolition work started in January 2024. The project looks to refurbish the 2 wings of the AFC and add a large extension to the centre of the building. Led by the Thurrock Alliance.

Artist impression of the new Thurrock CDC

Mental health

For NHS **talking therapies** the 6- and 18-week waiting time standards for people referred to the Improving Access to Psychological Therapies (IAPT) programme had been sustainably achieved across MSE throughout 2023/24. 52% of people achieved 'reliable recovery' through access to talking therapies. The mental health team continue to work closely with the alliances (and PCNs) to promote the uptake of access to talking therapies in the coming year.

There was a 4% increase in the number of patients with dementia who were diagnosed and added to the dementia register compared to 2022/23. Alliances will support the continued growth of the register size to be 66.7% of estimated prevalence in the coming year (an additional 3-4% growth for 2024/25).

Across MSE, the Early Intervention in Psychosis (EIP) standard of people receiving a recommended package of care within 2 weeks of referral was sustained during 2023/24.

Overall, there were 30 fewer people in an inappropriate out of area placements than 2022/23. This means more patients with serious mental illness are receiving care closer to home.

Collaboration with partners, within alliances and as part of initiatives to reduce health inequalities remains the key to our continued progress to improve the experience of our residents accessing mental health services.

Case study: Health inequalities – mental health joint response vehicle

"Since March 2023, I have been working for the local ambulance service… My role is to help introduce new and better ways of working, to improve access and outcomes for patients suffering with their mental health. I am also helping to upskill ambulance clinicians and strengthen pathways so that the patients using the 999 system can gain access to the right mental health support early without the need for attendance to an emergency department…. This now brings mental health care and support to the patient, and in most cases, the patients' own homes. The service is now covering mid and south Essex, 7 days a week 13.00hrs to 01.00hrs when we know we usually see the greatest number of people needing help."

Claire Fuller, Mental Health Nurse

The following table explains the amount and proportion of expenditure incurred by the ICB in relation to mental health.

Financial Years	**2023/24 £000's**	**2022/23 £000's**
Mental health spend	£215,019	£149,611
ICB programme allocation	£2,682,786	£1,870,000

Financial Years	2023/24 £000's	2022/23 £000's
Mental health spend as a proportion of ICB programme allocation	8%	8%

The ICB intends to declare, via the Chief Executive Compliance Statement, that it met it's Mental Health Investment Standard obligations for the 2022/23 financial year.

Our External Auditors, KPMG, were engaged to perform an Assurance Engagement which is intended to give reasonable assurance that the ICB met its obligations under the Mental Health Investment Standard for the 2022/23 financial year.

KPMG have issued a disclaimed opinion in this regard, based on them not being able to fully validate the ICB's expenditure for this area the full wording of which can be found on the ICB website from July 2024.

The 2022/23 financial year was complex, in that the first quarter of the accounts were via the five former Clinical Commissioning Groups, whilst quarters two to four were via the newly formed ICB.

The ICB recognise the high-level recommendation being made in this regard, and have already put processes in place, since the inception of the ICB to ensure that, moving forwards, expenditure which is eligible to be put against the Mental Health Investment Standard can be fully validated.

Primary care – general practice, pharmacy, optometry, and dentistry

Improving access to primary care services

The ICB supported local practices to improve their offer to patients. Collectively, practices delivered 490,000 more consultations in 2023/24 than in 2022/23. In total, practices delivered 6.2m consultations for MSE patients. 5m of these consultations (81% of all appointments) were undertaken within two weeks of a patient contacting their practice. The increase in capacity was partly driven by the expansion of the primary care workforce. There are now 600 new staff within the wider primary care workforce in MSE. These staff have been recruited by PCNs through the Additional Roles Reimbursement Scheme (ARRS) and include 130 clinical pharmacists, 60 care coordinators, 55 paramedics and 45 physiotherapists, as well as social prescribers and other key members of the primary care team.

As part of our Primary Care Access Recovery Programme, practices and PCNs have been implementing several other changes to better support patients. These included the introduction of cloud-based telephony solutions, care navigation and implementation of pathways that allow patients to self-refer to services without having to see someone in a practice (for example. The Pharmacy First service). Several practices have also implemented a 'total triage' solution that allows them to understand the clinical needs of all patients presenting to the practice and then determine the optimal way to support them. These changes will continue to be rolled out across MSE during 2024/25.

The case study below depicts the journey for Chelmsford Medical Partnership in the Mid Essex Alliance, whom in June 2023, implemented a total triage system in their practice. Creating a central hub where every patient contact is managed by a team of

GPs, GP assistants and reception staff, allows all requests for appointments to be reviewed and managed by one team. In most cases the team allocates patients to the most appropriate appointment slot/member of staff within the practice, on the same day the request is received, thereby almost eliminating the 8am queues.

Case Study: total triage – reducing the 8am rush

Staff said "the quality of contacts has dramatically improved, we are seeing the right patient first time, rather than patients having multiple contacts".

Patients said: "The communication between the administrative staff & me was great. They explained the process clearly via the messaging system and sent me a booking link that morning with appointments at my local surgery.".

"I used to dread being on hold for 40 minutes… [it] takes 30 seconds to use - I had to book to have stitches out and had an appointment within 10 minutes of my request and had to book 2 appointments for my son and he was seen an hour later. Really lovely nurse and doctor in both cases".

Improving dental services

In April 2023, the ICB was delegated the responsibility for the commissioning of pharmacy, optometry, and dental services. The ICB is keen to ensure that this new responsibility allows us to better serve our population. Within dental services, we have implemented two key pilot service developments. Firstly, we have worked closely with practices across our geography to offer improved access for people presenting with urgent dental needs. Approximately 10,000 residents have already benefitted, as we have commissioned additional capacity at weekends, weekday evenings and on bank holidays to enable quicker access to services. We have recently fully integrated this service with NHS111 and our hospital emergency departments.

The second key pilot has seen us link dental practices with care homes to ensure that the oral health needs of our older people within care homes are better provided for. This pilot is already having enormous impact for many patients that have received the service. The dental practices work with the care home staff to provide advice on how they can support their residents in improving oral health. All 8,417 care home beds are covered by the scheme, and we will look to publish the outcome of this pilot in 2024/25.

Alongside these developments, we have also increased the overall capacity of dental services locally, although we recognise that there are still improvements to be made. During the latter part of the year, we carried out additional work to reduce the waiting times for orthodontic services locally. We have ambitious plans that we look to implement in 2024/25.

Optometry

In our first year of the delegation of optometry services, the ICB has sought to further develop the already established relationship with the Local Optometry Committee to further develop ophthalmology services across MSE. Optometry already plays an important role within the ICB's Ophthalmology Transformation programme. Representatives from the Local Optometry Committee have become members of the

ICB's Primary Care Commissioning Committee and as such have helped inform how optometry services can support the wider ambitions for recovery access to primary care services. Our Connected Pathways team continue to promote services and pathways to make local optometry providers the first point of contact for eye problems in MSE.

A diagnostic hub was opened in February 2024 in Orsett to enable remote technician-led diagnostic imaging for glaucoma and medical retina, with remote assessment by clinicians in the hospital. This was modelled on the Moorfields Brent Cross hub. This is now operational and working well. Another community based diagnostic hub is scheduled for July 2024 to further support ophthalmology and timely treatment. Due diligence must be carried out to ensure that evidence is available before any extra activity on single point of access, or any other optometry-led pathways are actioned.

Community Pharmacy

Community pharmacies across MSE have continued to play a vital role in the delivery of NHS services. This role has been further enhanced through the roll out of Pharmacy First, a national initiative that sees pharmacies able to provide interventions for specific presenting conditions such as insect bites and other common ailments. Almost all community pharmacies have embraced this opportunity and we expect to see this become a core part of their offer going forwards.

Alongside this development, the Local Pharmaceutical Committee are now represented on the ICB's Primary Care Commissioning Committee. This engagement is ensuring that community pharmacy will play a key role in primary care access recovery and the delivery of the longer-term primary care strategy that will be published in 2024/25.

Place based alliances

The strength of work at a local level is demonstrated by the partnerships formed by our place based local alliances, Basildon & Brentwood Alliance, Mid Essex Alliance, South East Essex (SEE) Alliance and Thurrock Alliance. The four alliances bring partners across health, social care, the voluntary, community, faith, and social enterprise (VCFSE) sectors together with local communities to support asset-based approaches. Alliance health inequality programmes have supported grants for more than 100 funded initiatives engaging our VCFSE partners aimed at narrowing the gaps in health inequalities across our neighbourhoods with projects that increased foodbank provision, provided cost of living resources, supported unpaid carers, care home staff resilience, mental health support through green initiatives, children's supervised toothbrushing and many more.

Case study: Population health improvement – greening Southend

Greening Southend Queensway has been launched to improve outdoor green spaces and support the improvement of the community's health and care.

The project, delivered by mental health and wellbeing charity Trust Links and funded by the SEE Alliance Health Inequalities grant funding gives people living in the Victoria Ward access to green spaces. As a coastal community it has been identified as having pockets of deprivation hidden amongst relative affluence and data shows residents have multiple health conditions such as severe mental illness and chronic obstructive pulmonary disease.

The project gets residents involved in physical activities outside to improve their own communities, while improving residents' mental and physical health, as well as decreasing social isolation.

Alliances take a lead role in delivering and coordinating local programmes, supporting the priorities and ambitions of the ICB and wider system. Shining a spotlight on narrowing the gap in health inequalities, the wider determinants of health, prevention and evidence-based interventions will better enable local health services to meet the needs of the local population. These needs differ in each geographical area, so the closeness of our alliances to communities best enables each community's specific needs to be met. Additionally, the close working relationship of the alliance teams enables us to learn where projects are beneficially scalable across alliance geographies.

Integrated Neighbourhood Teams (INTs)

The INT concept is not about creating new services, it is centred in collaboration and utilising existing teams to work together in a coordinated and purposeful way. Integrated neighbourhoods will evolve within an iterative process of continued improvement, adapting in line with feedback from the local population, best practice, and shared learning.

In each alliance area we have used an innovative approach to the design and delivery of INTs that has sought to combine the power of relationships and a data informed evidence-based approach.

We already have existing mature models working in nine neighbourhoods across our four alliance areas. These include models focusing on cohorts of residents with specific needs, such as frailty and mental health, and partners coming together to deliver targeted health and wellbeing events. Our ambition is to establish and embed integrated working models in all neighbourhoods.

Case study: Mobilising communities – Central Basildon INT

643 patients with high attendances in primary care and A&E amassed 12,000 GP appointments. The approach reduced attendances by 48%. 6,000 GP appointments freed up, with patients being supported through care co-ordination, with a 30% reduction in A&E attendances for this cohort.

Health & Wellbeing Café - Participants noticed positive changes since attending the cafe and talked about feeling happier, calmer, and more centred. There was evidence that feelings of wellbeing were not just during the cafe session, they also seemed to have a positive impact on life beyond the cafe and small healthy lifestyle changes were mentioned with a sense of pride.

Transfer of Care Hubs (TOCHs)

In line with national guidance and best practice, alliance partners have focussed on creating TOCHs, establishing one in each alliance area. Each TOCH helps to divert patients from the acute hospital into community pathways including the emerging INTs to support effective and safe discharge of patients from hospital.

Working closely with health, care and VCSFE partners, discharge processes are being enhanced to improve flow and the experience and outcomes for patients. Admission avoidance arrangements are also being amplified, optimising available resources to support greater independence and the home first ethos.

Delivering at place

Wherever possible Alliances are working with their PCNs to deliver improved service levels locally. This includes the completion of the new dementia self-assessment toolkit that is being tested, with a view to showcasing dementia care across the system.

Through joint working with the Southend, Essex, and Thurrock Learning Disability (LD) Forum, alliances continue to promote access to and delivery of LD health checks through our PCNs.

Similarly, through PCNs there is regular training for GPs to ensure an increased uptake of serious mental illness (SMI) health check performance. Residents with needs relating to LD and SMI can also suffer from physical illness/conditions that can be identified and managed effectively through health checks, helping our residents to stay well. With this focus the alliances and their PCNs are working actively to reduce health inequalities in some of our most vulnerable patient groups.

Through the delivery of local enhanced services, GPs are helping to implement schemes to promote hospital avoidance such as operating multimorbidity clinics where clinical interventions determined within the PCN are helping to manage cardiovascular disease.

During 2024/25, we will continue to develop local community diagnostic centres within Thurrock, Pitsea, Braintree and Southend to increase diagnostic capacity and deliver services closer to home.

Digital, data, technology, and business intelligence

As part of delivering our strategic ambitions for digital, data and business intelligence the ICB and its partners have made some significant progress across our four strategic programmes of work. We have established a strategic data platform built on modern technology with self-service dashboards that comprises intelligence around urgent and emergency care and performance, population health management, finance, and focus areas across primary, community, mental health, acute and social care.

We have commenced the implementation of our digital patient interface – putting patient records into the hands of our residents with an exciting roll-out planned which will increase the scope and capabilities of that platform. Recognising the importance of digital inclusion, this programme is linked into wider patient engagement activities which will progress through next year.

We have successfully procured a partner to help enable the sharing of patient records to support direct care, providing the right information at the right place and right time for our clinical workforce. This enables our clinicians to make improved decisions on care needs and should reduce the need for patients to repeat their medical histories.

We have supported our providers in securing significant investment opportunities for the implementation of a new electronic patient record system which spans acute, mental health and community health services. The implementation of this programme will be a first in type for the country and provides real benefit to patients, particularly those who have both physical and mental health needs.

Spanning the interface of digital and clinical services, we have been able to support the continued development of the virtual hospital in 2023/24. The Urgent Community Response Team (UCRT) and three virtual wards, covering frailty, respiratory patients and heart failure, in addition to the acute-led Hospital@Home service are operating across MSE.

Case study: virtual hospital – digital, data and technology

- As of February 2024, virtual wards have been at 100% occupancy with the exception of respiratory.
- Avoiding admissions to a physical hospital not only alleviates system bed pressures but reduces infection risks on physical hospital wards during a time of high occupancy.
- The UCRT operates across MSE, with a single point of access offering a two-hour response time. It supports patients in their own homes (including nursing and residential care comes) for up to 48 hours, with others transferred to the virtual wards where clinically appropriate for up to 14 days.
- The virtual wards are multidisciplinary with medical oversight and leadership. The team includes registered nurses, physiotherapists, occupational therapists, rehabilitation assistants and health and care support workers.

Improve quality

The ICB Nursing and Quality Directorate has focused on working with residents and system partners, to improve the care and experience of people in MSE through influence, oversight, and assurance.

2023/24 has seen the implementation and development of the MSE System Quality Group and Quality Committee. These have become strategically significant forums that have strengthened the system quality oversight and wider learning for all key providers and partners. We have ensured that we include the voice of our residents and patients at the centre of our meetings by inviting our lay Patient Safety Partners as members of both meetings, and by hearing patient stories and experiences, when considering the quality of areas of health and care quality.

The Nursing and Quality Directorate hold several statutory responsibilities on behalf of the ICB, working with partners across MSE to ensure that we all relentlessly focus on improving the quality of care being delivered, whilst safeguarding our most vulnerable residents from harm. Areas of ongoing focus include:

All Age Continuing Care (AACC)

The All Age Continuing Care (AACC) Team has throughout 2023/24 continued to successfully support the timely discharge of residents from our acute hospitals. They have championed the plan of getting people 'home first' wherever possible. The team works closely with all our local authorities to ensure that residents are thoroughly assessed to receive care in accordance with the national framework and is dedicated to getting people the right care, in the right place, at the right time and by the right person. Team members work openly and transparently with partners and providers to deliver an integrated, and innovative service.

Importantly this year, the Children's Team have developed and finalised an information pack for children and young people, who will be transitioning from children's to adults' services. 'Transition' is the process of preparing, planning, and moving from children's services to adult services.

For young people with complex needs, the process of transition should start when a young person reaches the age of 14 and should be an ongoing process until the age of 18. For Continuing Health Care, transition is at the age of 18 although many other services such as Special Education Needs, and Disabilities (SEND) continue to support a young person's transition into adult services until they reach the age of 25 years.

The team want to ensure young people and their families receive the right support at the right time. The information pack aims to provide families and professionals with the information needed to understand and support young people during their transition from children to adult services and focus specifically on young people transitioning from Childrens services into NHS Continuing Healthcare (CHC). The team are continuing to seek feedback from children and young people, and their families to ensure that any changes to information and support are enacted quickly to best meet their needs.

Special educational needs and disabilities (SEND)

In August 2023, the substantive Executive Chief Nursing Officer (CNO) commenced in role in the ICB and became the executive lead and senior responsible officer (SRO) for SEND. As part of their role, the CNO has engaged with all three local authority strategic partners to ensure that health services are actively engaged in supporting children and young people with Special Educational Needs and Disabilities (SEND), and their families, across MSE. This has also included an oversight of relevant health services currently commissioned, and the completion of a Neurodiversity Demand and Capacity review, which will inform future commissioning decisions in 2024 that focusses on equitable provision of a needs-led holistic service model, and a focus on minimising diagnostic delays.

The CNO has accepted the chair of the SEND Action Plan (SENDAP) Strategic Board for Southend City Council, following its inspection in 2023, to offer supportive challenge and scrutiny against actions being undertaken to improve service provision. Furthermore, the ICB's Designated Clinical Officer (DCO) for SEND is fully engaged in all operational groups across MSE to offer advice and guidance on the quality of Education, Health, and Care Plans (EHCPs) for children and young people.

It is recognised that the performance of delivering EHCPs within statutory timeframe has not been achieved across MSE. By working closely with partners across Southend, Essex, and Thurrock, the ICB team are supporting the development of, or delivery against, agreed SEND Strategies that will ultimately improve the timely support being provided to our most vulnerable children and young people, and their families.

Safeguarding

Throughout 2023/24 the Safeguarding team have redesigned the offer to strategic partners through the development of an all-age safeguarding approach and assurance framework to ensure that there is sufficient oversight and scrutiny of safeguarding practice in all sectors of healthcare, in line with the ICB's statutory responsibilities. Executive leadership for all-age safeguarding is provided by the Executive Chief Nursing Officer.

An area of focus in 2023/24 was the improvement in understanding of the Mental Capacity Act (2015), through the provision of wide-ranging training and support to health partners. This has been overseen by the Designate Nurses for Safeguarding within the ICB, working in close partnership with safeguarding leads in provider organisations and across primary care services.

The Safeguarding team also developed and implemented several audits to ensure safeguarding standards are achieved across the system, with supportive assurance visits being undertaken in all sectors of healthcare where areas for improvement have been identified. Further details relating to Children and Young People's Safeguarding can be found below.

Infection prevention and control

The infection prevention and control (IPC) team have continued with supportive oversight and assurance in collaboration with system partners relating to all relevant IPC guidance. Healthcare associated infections such as Methicillin resistant Staphylococcus aureus bacteraemia have increased across the system and *Clostridioides* difficile infection cases have reduced. The ICB's IPC team have

continued to support providers in meeting the required standards of infection prevention and control practice, offering assurance visits to support the team to improve and help manage and reduce cases as far as possible.

Quality Oversight and Assurance

The Quality Teams have continued to work closely with providers to support them in being prepared for Care Quality Commission (CQC) inspections. Current CQC ratings of main providers are outlined below:

Provider	**Rating**
Provide Community Interest Company	Outstanding
Essex Partnership University NHS Foundation Trust (EPUT) Community	Requires Improvement
Mid and South Essex NHS Foundation Trust (MSEFT)	Requires Improvement
North East London NHS Foundation Trust Community Services	Good
East of England Ambulance Service NHS Trust	Requires Improvement

Essex Partnership University NHS Foundation Trust (EPUT) mental health services

The MSE ICB Quality Team and ICS partners continue to work closely with EPUT to ensure that mental health service provision has ongoing and robust oversight of the quality and safety of care. This continues in response to the significant concerns raised through multiple means and the soon to commence Lampard Inquiry (previously the Essex Mental Health Independent Investigation).

Primary care

From July 2022 ICBs assumed delegated responsibility for primary medical services. Pharmacy and optometry services are hosted by Hertfordshire and West Essex ICB. However, MSE ICB is responsible for providing quality assurance to general practice and dentistry.

Key achievements 2023/24

- A full quality assurance cycle is in progress to undertake supportive visits to general practice across MSE.
- The team have established quality risk processes to ensure the ICB is aware of any increasing quality risks regarding primary care across MSE.
- The team have developed the primary care quality hub to allow all providers to access and utilise links relating to patient safety incident investigations / complaints / CQC changes in regulation and expectation.

- There is clear evidence of strengthened relationships between the ICB and primary care providers, with providers engaging in quality assurance visits as a means to improve the standards of care provision in line with national best practice standards.

Best practice examples of leading cross partnership transformation

Local maternity and neonatal system (LMNS)

The LMNS continues to strive to improve services, one example of this is the Trust meeting the requirements for year five of the Maternity Incentives Scheme, which supports the delivery of safer maternity care.

In addition, the Trust has reduced both the maternity staff vacancy and turnover rate, as part of an ongoing focus on recruitment and retention. These measures are ongoing and ensure the workforce can provide consistent, high-quality care.

Moving forward, the LMNS are focused on implementing the NHS three-year delivery plan for maternity and neonatal services, whilst recognising the progress that has been made including new perinatal pelvic health services and transitional neonatal care services now in place across the system.

Implementation of the ICB patient safety agenda

Following the appointment of a full-time Patient Safety Specialist (PSS) in September 2022, significant progress has been made in implementing the National Patient Safety Strategy within the ICB and wider ICS. All acute and community providers transitioned to the Patient Safety Incident Review Framework (PSIRF) within the national timeframe, and smaller providers are making good progress. A PSIRF peer review forum has been mobilised to oversee and support effectiveness of systems for improvement following patient safety incidents, and to support providers.

The ICS Patient Safety Specialist Network meeting has been refreshed and relaunched as an ICS Patient Safety Collaborative with the intention of widening membership to include hospices, independent providers, and social care. All acute and community providers have Patient Safety Partners on board who are ensuring that the patients' voice is present during meetings. Further work is planned for 2024 in measuring the impact of these roles and developing a system wide support network for the role. A system wide patient safety summit is planned for November 2024, where partner organisations will be sharing learning from across the system.

Children and young people (CYP) safeguarding

ICBs are responsible for the statutory duties set out in the Children Act 2004 and the Working Together to Safeguard Children (statutory guidance) 2023. In addition, NHSE *Safeguarding Children, Young People, and Adults at Risk in the NHS - Safeguarding Accountability and Assurance Framework* (SAAF) sets out the safeguarding roles, duties, and responsibilities of all NHS organisations, including ICBs.

The ICB:

- Complies with section 10 and section 11 of the Children Act 2004 and any subsequent statutory guidance relating to vulnerable groups.

- Provides effective clinical, professional, and strategic leadership to child safeguarding, including the quality assurance of safeguarding through their contractual arrangements with all provider organisations and agencies, including from independent providers.

- Participates in the multi-agency safeguarding arrangements (MASA) / safeguarding partnerships as one of the three statutory safeguarding partners, alongside the local authority and police. The ICB is a partner of three local safeguarding children's partnerships: Essex Safeguarding Children Board (ESCB), Thurrock Local Safeguarding Children Partnership (TLSCP) and Southend Safeguarding Partnership (SSP).

Below, there are the respective links for each of the partnerships' latest published annual reports and MASA, demonstrating the ICB's delivery against safeguarding statutory duties for 2023/24.

Essex Safeguarding Children Board (ESCB)

- https://www.escb.co.uk/media/2727/annual-report-2020-21.pdf

- ESCB Multi-Agency Safeguarding arrangements 2023-24 (hyperlink)

Thurrock Local Safeguarding Children Partnership (TLSCP)

- https://www.thurrocklscp.org.uk/assets/1/lscp_annual_report_2021-22.pdf

- TLSCP Multi-Agency Safeguarding Arrangements Jan 2023 (hyperlink)

Southend Safeguarding Partnership (SSP)

- SSP Annual Report 2022/23 (hyperlink)

- SSP Safeguarding Partnership Arrangements (hyperlink)

The ICB employs the expertise of designated clinical experts, who are strategic system and place leads for safeguarding with the team having an 'all age safeguarding approach'.

The safeguarding team collaborates across the ICB to ensure that there are effective governance and quality assurance arrangements in place. This includes supporting GPs and PCNs for their roles in safeguarding adults at risk, child protection and meeting the needs of children in care.

A Safeguarding Assurance Framework has been developed, which will be reflected in the quality strategy in 2024. It has brought together a health safeguarding strategic system group, which has co-produced a document set to provide health system safeguarding assurance to the local, regional, and national requests/requirements and priorities (information sharing; female genital mutilation; Prevent; partnership working; modern slavery and human trafficking; domestic abuse; mental capacity and deprivation of liberty safeguards). This document primarily aims to:

- Maintain the SAAF statutory reporting process to local, regional, and national requests.

- Ensuring the SAAF programmes are explicitly contained within the ICS's Joint Forward Plan.
- Listening to the voice of children and young people, especially children in care, care leavers and young carers.
- Supporting workforce development strategies in the changing NHS landscape.
- Working with partners on locally identified matters e.g., domestic abuse, non-accidental injuries.
- Developing digital solutions to improve the information sharing for children coming into care.
- Support the implementation of learning from local and national case reviews and serious incidents across the health economy.

Reducing health inequalities

Reducing health inequalities is central to our delivery within the MSE ICS. The ICB objective is to ensure we deliver equitable access, excellent experience, and optimal outcomes for all. The gap in life expectancy across MSE is as much as 10 years between some of the wealthiest and most deprived neighbourhoods. Within MSE the top three contributors to premature mortality attributable to socioeconomic inequalities are cancer, cardiovascular disease, and respiratory disease.

The MSE ICS established a Population Health Improvement Board (PHIB) (in November 2022) with representation from partners across the system to drive an integrated approach to inequalities improvement. This Board reports to both the MSE ICP to bring together the work around wider determinants of health and the ICB to deliver improvements around specific healthcare priorities.

The (PHIB) ensures that the needs of our population and existing health inequalities are understood, and areas of interventions prioritised with an emphasis on moving towards prevention of ill health. It does this by considering the Joint Strategic Needs Assessments undertaken by the three local authorities and by adopting a population health management (PHM) approach.

During 2023/24 the ICB had developed an integrated data set that pulls together data across the health and care system. This drives a population segmentation tool and provides insights where health inequalities exist at an alliance and PCN level. Work has commenced on a health inequalities dashboard to support priority setting and tracking impact of current interventions.

The ICB Health Inequalities Information Statement, published alongside this annual report, provides key outputs from the PHM team, insight to where health inequalities exist, and an overview of actions being taken at a system and alliance level to address these gaps.

In 2023/24 the MSE health inequalities programme focused on delivering a culture of addressing health inequalities across all business areas. The ICB continues to ensure that equitable access is achieved using equality and health inequalities impact

assessments to identify impacts of service changes and set out appropriate mitigations to ensure health inequalities are addressed.

The ICB has adopted the NHS Core20PLUS5 frameworks for both adults and children and young people to prioritise activities both across the system and through the local work delivered by alliance partnerships.

Below are some examples of achievements from the health inequalities work:

- Invested in the development of a digital equality and health inequalities impact assessment tool 'ImpactEQ' to ensure high quality assessments are delivered consistently with an emphasis on co-designing of services with residents and engaging with those from vulnerable groups.

- Hosted the first joint conference with the Royal College of GPs to showcase the work across MSE and provide insights on impactful interventions.

- Established wellbeing cafes across Basildon and Brentwood Alliance in collaboration with community and voluntary sector groups to support residents with the greatest and most complex health and social needs.

- Delivery of healthy lifestyle clinics in Thurrock Alliance with a focus on reducing obesity for a target cohort of over 9,000 patients.

- Utilisation of an outreach vehicle to deliver a holistic health and wellbeing service with a focus on hypertension case finding, health screening, access to weight management and tobacco cessation services.

- MSE was the first health and care system in the east of England to commission Pride in Practice to offer free training, support assessment and accreditation of over 25 practices.

- Improving access to health services for Gypsy, Roma, traveller, and showman communities by establishing a monthly programme of visits to key sites to deliver preventative health interventions and encourage registration with a GP practice.

- Launch of pneumococcal vaccine awareness and education campaign with easy-to-read document to support awareness and access among those with learning disabilities.

- Introduction of the smoke free pathway in maternity with provision of in-house smoking cessation behaviour support.

- 92,000 residents participating in the BP@Home system and distribution of a further 2,000 blood pressure machines across 80 practices in areas of greatest deprivation and health need.

- Roll-out of lung cancer screening in Thurrock and Southend with over 17,000 checks completed resulting in over 100 local people with previously undiscovered lung cancer, found and treated.

- Pilot for early years oral health improvement in Thurrock with delivery of supervised toothbrushing through the family hubs.

- Anchor programme (see case study on page 37).

MSE ICB continues to make progress against the NHS health inequalities planning priorities:

- **Priority 1: Restore NHS services inclusively.** An elective recovery equality health impact assessment was completed that sets out mitigating actions to increase access and improve outcomes. The gap in waiting times between the most and second most deprived areas halved in the last 12 months.

- **Priority 2: Mitigate against digital exclusion.** A digital inclusion framework was established with principles adopted across partner organisations. New digital transformation Additional Roles Reimbursement Scheme (ARRS) roles appointed alongside existing social prescribing link works and health and wellbeing coaches to support the use of health apps and improve digital and health literacy.

- **Priority 3: Ensure datasets are complete and timely.** Year on year improvement in ethnicity recording with 95% of primary care records having a recorded ethnicity.

- **Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes.** The ICB continues to accelerate work through adoption of Core20PLUS5 frameworks.

- **Priority 5: Strengthen leadership and accountability.** Clear leadership roles established with senior responsible officer, system, and alliance clinical leadership for health inequalities, and PCN health inequalities leads. PHIB and supporting governance structures embedded.

The statement on information on health inequalities provides a more extensive overview of the programme of work and outcomes about the Core20PLUS5 framework and five planning priorities.

In 2022/23 the ICB received an additional £3.4m health inequalities funding from NHSE. The funding was utilised to support innovative partnership solutions to reduce health inequalities. During 2023/24, over 70 projects were implemented to support delivery of the Core20PLUS5 framework and local population needs as identified by the four alliances. The ICB has engaged the University of Essex to evaluate the outcomes and learn lessons for future scale and spread of the work.

Public sector equality duty

The ICB recognises and meets the requirements of the public sector equality duty, which applies to both workforce and service delivery. The ICB publishes the required information on its website Interim Equality Objectives - Mid and South Essex Integrated Care System (ics.nhs.uk) [hyperlinks] with additional service delivery actions published as part of the Joint Forward Plan (Joint Forward Plan - Mid and South Essex Integrated Care System (ics.nhs.uk) [hyperlinks].

The Equality and Human Rights Commission, which oversees compliance with the Equality Act, recently reviewed all ICBs. As part of that review the ICB met with the Commission. Whilst the feedback from the Commission was favourable there were actions suggested to strengthen the objectives and improve the clarity of our service delivery actions which will be addressed during the forthcoming year.

Equality Delivery System (EDS) 2022

Within the system, NHS providers have agreed to work together to implement the EDS 2022 on an ICS footprint. The EDS has three sections or 'domains'. For Domain 1: Commissioned or provided services. The theme selected for 2022/23 was maternity and antenatal mental health services.

Both services were reviewed against the eleven outcomes, to measure successes and challenges with protected characteristic groups and vulnerable community groups using evidence and insight. MSEFT and EPUT have engaged with service users, patients, community, and faith groups and with other stakeholders who support or represent the views of patients, to gain feedback on current service provisions and how they can be improved to meet the needs of groups of patients. The outcome of the assessment alongside those in Domains 2 and 3 are published on the ICB website.

EDS action plans have been developed for both services and are being monitored via the health inequalities delivery group and through the individual NHS organisational governance.

For 2023/24, the MSE system has collectively selected the following services for a Domain 1 review:

- Urgent Community Response Team delivered via EPUT.
- Inpatient Detox service delivered via EPUT.
- Learning Disability services delivered by MSEFT.

The engagement work with patients and those with lived experience has been completed alongside the evidence review. Delivering the action plan against the assessment will begin during 2024/25.

Health and wellbeing strategy

The ICB engages regularly with the three Health and Wellbeing Boards of the upper tier local authorities (Essex County Council, Southend City Council and Thurrock Council). Members of the ICB regularly attend Health and Well Being Boards by agreement. Regular updates are provided on the work of the ICB specifically and NHS providers more broadly. There are also regular presentations on specific strategic priorities and care areas, for example, primary care development, pharmacy, optometry, and dentistry delegation.

Senior representatives from each upper tier local authority sit on the ICB Board and the ICB Executive Director of Strategy and Corporate Services supports agenda setting for the Health and Wellbeing Boards, maintaining a close working relationship with the three chairs. Due to the heavy programme of work for the ICB (with the Health and Wellbeing Boards being required to receive and comment on both the Integrated Care Strategy and the Joint Forward Plan) the Health and Wellbeing Boards have not been asked to specifically receive and comment on this annual report at this time, although a verbal update on the themes within this report was provided to the Boards in March 2024.

The annual report will be brought to all three Health and Wellbeing Boards at the earliest opportunity and the ICB is confident that there is regular engagement in the spirit of an ICS and the Health and Wellbeing Boards will be aware of and engaged in the work presented in this annual report.

The ICB participates fully in the work of the three Health and Wellbeing Boards and their work continues to underpin our priorities as an ICB. The ICB supports the development of Joint Strategic Needs Assessments and Local Health and Wellbeing Strategies and meets with the three chairs of the Health and Wellbeing Boards and the three directors of public health regularly to share insights, data, and business intelligence.

The three chairs of the Health and Wellbeing Boards sit as vice chairs of our ICP, and other senior officers, including directors of adult social care and directors of public health also attend. This ensures close cooperation, regular sharing of ideas and opportunities and prompt and effective resolution of strategic issues as and when they occur.

Engaging people and communities

During 2023/24 we have continued to deliver our duty (Health Act 2022) with our healthcare planners to involve the public in developing NHS services. This duty is known as “working with people and communities”.

Despite organisational transformations in 2023, our commitment to engaging with the public, particularly underserved groups, has remained strong. We are in the process of revising our "Working with People and Communities" strategy to further this commitment.

Although the new strategy has not yet been published, we have continued to involve the public, particularly those from groups who experience worse health outcomes, have limited access to care and generally experience poorer quality of care. This engagement supports NHS planning and delivers two of the core ICB duties of delivering improved services and reducing health inequalities.

Digital engagement initiative: MSE Virtual Views

In November 2023, we introduced MSE Virtual Views, a web-based platform that has developed our approach to public engagement and consultation. It features interactive capabilities like forums, polls, and workshops, accommodating both digital and face-to-face engagement. The platform's analytics enable us to craft engagement strategies that reflect the diverse makeup of our community. It has also enabled us to link the work of alliances through bespoke hubs, that helps ensure insight gained at a more local level is captured and fed into our decision-making processes.

There is also a function for the participant to choose which language they would like it in, helping us reach those communities where English is not their first language.

Virtual Views allows us not only to target populations via postcode data, but those with specific health conditions, if they are a carer, or a member of staff for example. We also encourage people who sign up to provide their demographic characteristics, age, ethnicity, the more information provided the better targeted and more suitable our engagement can be.

During the initial five months since the system went live, we have had 12,794 unique visits to the site. https://virtualviews.midandsouthessex.ics.nhs.uk/ [Hyperlinks]

Public consultation

Our most extensive consultation to date revolved around proposed changes to community hospital services and launched on 24 January 2024 running for 11 weeks to 11 April. We invited local people to give their views on potential changes to:

- The locations where we provide some of our inpatient services for community hospital intermediate care and stroke rehabilitation, and freestanding midwife-led birthing services.

- The possibility of moving all other patient services at St Peter's Hospital, Maldon to other locations.

Leveraging MSE Virtual Views, we garnered more than 5000 online survey responses, setting a record for our participation feedback. To ensure wide-reaching accessibility, we distributed consultation materials in various formats and languages, organised in-person events, and made use of local distribution networks for consultation documents and surveys to support those without digital accessibility to participate.

The process also included a consultation hearing at Maldon Town Hall, where members of the public were offered the opportunity to present their evidence to a panel of NHS leaders. It was live streamed on You Tube to maximise the number of people able to watch and be engaged in the process.

The insight received during the consultation process is being collated into an independently analysed outcome report which will form part of the decision-making business case due to be considered in the summer of 2025.

Research Engagement Network (REN)

The establishment of the REN in November 2023 aims to ensure that health and social care research aligns with the community's needs. By focusing on marginalised groups, the REN promotes research practices that effectively address health inequalities. Through an expression of interest process, we successfully received 25 applications from the targeted community groups, resulting in 18 organisations being offered grants. 19 community champions from these groups are being funded and trained to support the REN programme.

Collaborative working

We continue to work collaboratively with our partners such as local authorities and voluntary and community sector organisations to engage with residents and avoid duplication, sharing resources and insight across the system.

Topics we have explored with our population include women's health and the menopause, using the insights gained to shape our policies and practices. Programmes like the Shared Care Record and information usage projects have also benefitted from these partnerships and insights.

Our three Healthwatch organisations have again been supportive and constructively challenged our approaches where appropriate, helping us to adapt our work as needed.

We have also continued to work with our dedicated readers panel, who help support the development of our communications approaches and content to ensure they are accessible and understandable to the public.

ICP: spring conversations

The 'Spring Conversations' events offered a vehicle for discussing the strengths and challenges within health and care, fostering collaborative approaches among healthcare partners and community members. The ‘Spring Conversations’ focused on supporting the development of our Integrated Care Strategy and Joint Forward Plan.

Community assembly

Our community assembly, drawn from a wide range of community and voluntary sector partners continued to meet and provide much-valued insight throughout 2023/24.

This included a session to help identify the key priorities for the ICP to focus delivery on from the overarching integrated care strategy.

Following the ICB restructure and a change in personnel the opportunity was taken to “pause and reflect” on the assembly’s role.

One-to-one conversations were undertaken with members of the assembly leadership team to identify challenges and opportunities.

A key theme was the desire to see the assembly operate in a more strategic space and to lessen the frequency of meetings but make them more impactful.

Work is now underway with the leadership group to progress how we develop going forward.

Supporting our workforce and social value

ICB corporate review

Having been established for 18 months, the ICB embarked on a corporate review to understand the effectiveness of its systems of governance, operating model, and decision making. The aim of the review was to identify improved ways of working to support the recovery model and strengthen governance.

Consequently, ICB teams have embarked on several projects to improve risk management, health & safety, contracting and organisational budget management practices. Implementation of digital solutions for risk management, Board/committee papers management, contract management and business intelligence are underway to support improvement projects.

ICB workforce

During 2023/24, the ICB underwent a reorganisation to achieve the 30% reduction in staff costs required by NHSE. Consequently, the impact on staff morale has been significant, evidenced through the results of the staff survey, with our ICB having the lowest staff survey results in England.

In the final quarter of the year, the HR team supported the ICB through a period of 'repair and recover' where organisational mission and vision and its core values were refreshed, being co-produced with staff. Programmes of work were established to reinvigorate staff networks, improve mandatory training compliance, staff appraisals, and wellbeing.

Moving into 2024/25 the ICB organisational development plan moves through a period of 'reset & rebuild' as well as 're-focus & re-energise' where the focus will include publication of a new people management strategy, focussing on development of staff and building morale as well as learning and recognition to celebrate ICB achievements.

System workforce planning

Following the COVID-19 pandemic, workforce levels have not yet rebased to pre-covid activity and consequently there is a need to right-size establishment and reduce temporary staffing. As part of system workforce planning within our acute trust, consideration has been given to how we can improve the social value of recruitment and retention, employing workforce within our geographical area and consequently reinvesting in MSE.

Case study: Anchor Programme – supporting our workforce

In partnership with health and care (local councils) and the education sector in mid and south Essex, MSEFT (as one of the largest employers in the region) aims to provide more opportunities for young people, reduce their environmental impact and create volunteering opportunities, through the Anchor programme.

The programme brings high-quality local employment, supports staff in their professional development, and reaches out to local partners to help them succeed.

Basildon Hospital is the pilot site, with the programme set to expand to include all three hospital sites and communities across mid and south Essex later this year.

2023/24 has brought into focus the inter-relationships of activity, workforce, and finance; identifying the need for stronger accountability and a culture of leadership and accountability to facilitate more effective financial control. It has also identified the need for a 'left shift' in the alignment of workforce outside of acute to primary and community care and virtual ward to enable greater agility in moving staff to pivot to priorities.

Clinical and professional leadership - stewardship

The ICB has developed 10 stewardship groups including ageing well, cancer, children and young people, dermatology, diabetes, eyes, mental health, musculoskeletal, stroke and urgent and emergency care. These include 82 stewards from at least 14 health and care organisations including primary, secondary and community care, voluntary sector, ICB and residents. We also have a central stewardship programme team to support the efforts and outputs from the programme.

Some selected highlights from projects completed over the last year include:

Area	Achievement
Cancer:	Improved skin cancer faster diagnostic standard (FDS) performance from 25% to 69%, reducing the number of people waiting longer than 62 days from 1240 in August 2022, to 109 in February 2024.
MSK:	Led development of our Fracture Liaison Service, due to launch in May 2024, which will see more than2500 people each year, and more than£450K benefits within the NHS delivered each year.
UEC:	Implemented the Unscheduled Care Coordination Hub (UCCH), resulting in just 50% of calls being conveyed to hospital, avoiding 140 conveyances per month.
Diabetes:	Increased referrals into national Type 2 path to remission programme from fewer than 30 to more than100 per month (highest in the region).
Ageing Well:	1. Identified over 12,000 people with frailty needs. 2. Achieved a 50% reduction in the number of people going to hospital multiple times in the last year of their life (often a marker of poor joined up care). 3. Seen up to a 70% reduction in hospital re-admission rates where FrEDA (an award-winning electronic template for evidence-based interventions such as medication reviews and care planning) has been adopted at a local level i.e., INTs. 4. Supported the virtual hospital to deliver care to over 3500 patients in their own homes in partnership with our community providers.
Stroke:	Underpinned and fronted our system public consultation on community stroke rehabilitation and intermediate care beds, with 14 events, 2 podcasts, 87,000 social media impressions and 11,000 web page visits and counting.

The stewardship approach and successes have received national recognition during 2023-24 as follows:

- **NHS Confederation CEO Matthew Taylor visited** us twice in the last six months to spend time with our stewards, to hear more about the stewardship model and achievements in MSE.

- **HSJ Awards (2023) Data-Driven Transformation Award** for Ageing Well stewards work on the Frailty End-of-Life Dementia Assessment (FrEDA) and Electronic Frailty Care Coordination System (eFraCCS).

- **HFMA Costing Award (2023)** to the MSE Costing Hub for innovative approach to system-wide costing within stewardship.

Environmental matters (sustainability)

In October 2020, the Greener NHS national programme published its new strategy, Delivering a Net Zero National Health Service [hyperlinks]. This report highlighted that left unabated climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma, and cancer. The report set out trajectories and actions for the entire NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence (such as the supply chain).

As part of the NHS, MSE ICS must play its part in reducing the environmental impact and carbon footprint of its operation. MSE ICS's first Green Plan was published in March 2022 to align with the NHS Long-Term Plan. Progress against the system's plan, and the plans for individual NHS organisations will be reviewed in 2024/25 to inform an updated Greener NHS Plan for MSE. As the ICS and ICB develop, and work programmes become clearer, the areas of focus of this Green Plan will be developed, and sustainability will be seen as business as usual.

MSE is keen to support all those working within our health and care system to play a role in helping the NHS to reduce its environmental impact. Empowering our staff to act is key to both delivering on the Greener NHS ambitions, but also a priority for many of our staff who want to see the NHS act to address climate change. The MSE ICS Sustainability Forum promotes and coordinates the development and implementation of sustainability initiatives, to ensure that members meet the diverse health needs of people in existing and future communities, and to promote wellbeing, social value, reducing health inequalities and inclusion.

Established governance arrangements

Each NHS organisation is required to have a Board level lead for their Greener NHS programme. For the ICB, this is Emily Hough, Executive Director of Strategy and Corporate Services.

As part of the overall governance arrangements, and on behalf of the system, the MSE Operational Steering Group was established in May 2022 by MSEFT, with agreed terms of reference, chaired by the Director of Specialist Services. This group was revised in September 2023, to have a more focused look at cost saving initiatives and energy management. It's now chaired by the Head of Sustainability within MSEFT. The ICB will be working more collaboratively with the group during 2024/25 to ensure there is a true system focus to how we address sustainability.

A Greener NHS Programme Board for MSE is being re-established to bring together the organisational leads for this work. The MSE ICS Sustainability Forum will report into this group.

Links to social value

It is extremely important that there is a close relationship between sustainability and social value teams. This has been a focus this year and a series of workshops have been provided to demonstrate the linkages between the two areas. It is envisioned that a joint set of priorities will be identified, to help this work become more closely aligned.

Revised Green Plan and dashboard

MSE published its first Greener NHS plan in 2022. That plan is being reviewed with the goal of aligning a single set of system-wide targets. A dashboard has been developed to demonstrate progress against this plan. This revised plan is still in draft form but will be shared with the relevant committees in the coming months.

Successful projects and initiatives

The opportunity for immediate impact on sustainability lies with our providers who can effect change through their practices within estates and with suppliers. There have been a great deal of initiatives and projects that have been delivered this year across MSEFT. That will be reviewed during 2024/25 to determine whether they can be mirrored across other health organisations within MSE.

The ICB programme of work focuses on the redesign of the services we commission being closer to home and therefore reducing the carbon footprint of our patients. Further to this the ICB is now largely paperless and encourages flexible working with many staff working from home and travelling to the office when absolutely necessary.

Financial review

Our full statutory financial accounts are included from page 88. This section provides a summary of our 2023/24 12-month financial position. Our Head of Internal Audit offers an opinion on Financial Systems Key Controls and other matters which can be found on page 64. Our overall financial management arrangements and financial statements were subject to audit review and opinion by our external auditors, KPMG (hyperlinks), as part of their annual review of our accounts (see page 32 of the Annual Accounts section for their full audit opinion).

ICB funding

The MSE ICB in-year total healthcare funding was £2,682.8m and funding for running the ICB (called “running cost expenditure”) was £25.4m, resulting in total overall funding of £2,708.2m. ICB expenditure was £2,686m, resulting in £22.3m surplus for the financial year.

The ICB had an agreed plan to deliver £9.7m surplus to contribute towards the broader system position. The ICB retained £12.6m of funding received during the year in relation to the impact of industrial action to improve the ICB position by the same amount and offset the overall system position.

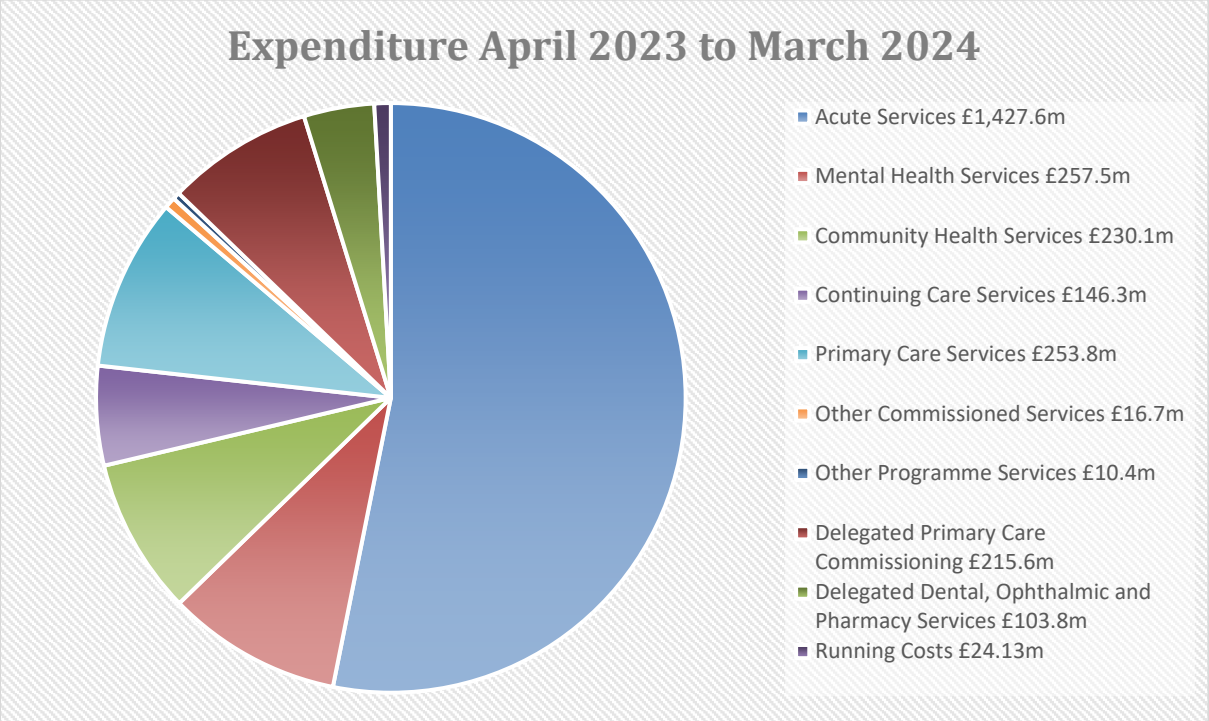
There was additional income received relating to the elective recovery fund (ERF). The ICB has a delegated primary medical services budget of £219.5m which included additional funding for Additional Roles Reimbursements for PCNs (ARRS) for commissioning general practice and a delegated budget for commissioning pharmacy, optometry and dentistry of £105m.

NHS planning guidance requires ICBs to meet the ‘Mental Health Investment Standard’ (MHIS). This requires ICBs to demonstrate that expenditure on mental health services has grown year on year. In 2023/24 the ICB has achieved the MHIS by increasing all mental health related expenditure by 9.2%.

How your money was spent

In 2023/24 we spent £2,661.8m on healthcare services and a further £24.1m on running costs, totalling £2,686m.

The following chart shows the major areas of expenditure for healthcare (including ICB running costs).



Capital spending

The ICB did not receive an individual capital allocation for 2023/24, but accessed primary care capital held by NHSE on behalf of the ICB towards primary care estates projects and GP IT.

Paying our suppliers and providers

National rules mean the ICB must aim to pay all valid invoices by the due date or within 30 days of receiving them, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. In 2023/24 the ICB met three targets and came very close to achieving the fourth target (based on invoice numbers and value of expenditure) for NHS and non-NHS invoices (see note 6 of the financial statements for details).

The ICB adheres to the Prompt Payment Code. The government designed this initiative with the Chartered Institute of Credit Management (hyperlinks) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence that any organisation adhering to the code will pay them within clearly defined terms and that proper processes are in place to deal with any disputed payments. The ICB has committed to:

- Paying suppliers on time.
- Giving clear guidance to suppliers and resolving disputes as quickly as possible.
- Ensuring the national measures for payment performance do not include any delays in payment during the time that an invoice is on hold.

2024/25 financial plans and looking to the future

In line with the NHSE planning process, the 2024/25 Financial Plan was submitted on 12 June 2024 with a breakeven position for the ICB. Allocations for 2024/25 have been given on a system level and it is expected that the ICB will achieve its control total noting any risks and mitigations.

The ICB will continue to work with system partners over the coming months to prioritise programmes of work towards achieving a financially sustainable health and social care system.

The ICB manages the system allocation to buy services for the population of MSE. MSEFT and EPUT are part of our system control total, and our finances are reported separately and together to NHSE. As a system we expect to have a shortfall between our available funding and the spending we expect to incur during the year. We continue to work together with our regulators to improve our financial position aiming and ensure the sustainability of our services.

ACCOUNTABILITY REPORT

[Insert signature]

Tracy Dowling
Interim Chief Executive of Mid and South Essex Integrated Care Board

24 June 2024

Accountability Report

The accountability report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

Composition of Governing Body

As at 31 March 2024, the composition of the ICB Board was as follows:

- Professor Michael Thorne CBE, Chair
- Tracy Dowling, Interim Chief Executive Officer
- Dr Giles Thorpe, Executive Chief Nursing Officer
- Dr Matthew Sweeting, System Medical Director
- Lisa Adams, Interim Executive Chief People Officer
- Jennifer Kearton, Executive Chief Finance Officer
- Dr Neha Issar-Brown, Non-Executive Member
- George Wood, Non-Executive Member
- Joseph Fielder, Non-Executive Member

Partner members

- Paul Scott, Essex Partnership University NHS Foundation Trust
- Matthew Hopkins, Mid and South Essex NHS Foundation Trust
- Peter Fairley, Essex County Council

- Mark Harvey, Southend City Council
- Ian Wake, Thurrock Council
- Dr Anna Davey, Primary Care Partner Member

The following officers and Associated Non-Executive Members also attended and contributed to the Board:

- Prof Shahina Pardhan, Associate Non-Executive Member
- Dr Geoffrey Ocen, Associate Non-Executive Member
- Mark Bailham, Associate Non-Executive Member
- Emily Hough, Executive Director of Strategy and Corporate Services
- Barry Frostick, Chief Digital Information Officer
- Pam Green, Alliance Director – Basildon and Brentwood
- Dan Doherty, Alliance Director – Mid Essex
- Rebecca Jarvis, Alliance Director – South East Essex
- Aleksandra Mecan, Alliance Director — Thurrock

Committee(s), including Audit Committee

The Governance Statement (below) describes the sub-committees of the Board as set out within the Functions and Decision Map within the Governance Handbook.

Register of Interests

At all formal meetings of the Board and its committees, members must declare if they have an interest in any agenda items under discussion in accordance with the ICB Conflicts of Interest Policy.

The ICB maintains a register of interests declared by Board members, a copy of which is provided at all Board meetings. The full register of Board members' interests is on our website: Mid and south Essex ICB Board Register of Interests (hyperlinks).

Personal data related incidents

There are processes in place for incident reporting and investigation of serious incidents. No serious incidents requiring investigation involving personal data were reported to the Information Commissioner in 2023/24.

Modern Slavery Act

The ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Modern Slavery Act statement for the period ending 31 March 2024 is published on the website at Modern Slavery Act statement — Mid and South Essex Integrated Care System (ics.nhs.uk) (hyperlink)

Statement of Accountable Officer's responsibilities

Under the National Health Service Act 2006 (as amended), NHS England (NHSE) has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Mid and South Essex Integrated Care Board and of its income and expenditure, Statement of Financial Position, and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHSE, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that officer shall be appointed by NHSE.

NHSE has appointed the Chief Executive Officer to be the Accountable Officer of the Mid and South Essex Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the Mid and South Essex Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Mid and South Essex Integrated Care Board's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Tracy Dowling
Interim Chief Executive of Mid and South Essex Integrated Care Board

24 June 2024

Governance Statement

Introduction and context

MSE the ICB is a body corporate established by NHSE on 1 July 2022 under the National Health Service Act 2006 (as amended).

The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2023 and 31 March 2024, the ICB was not subject to any directions from NHSE issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body (the Board) is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The ICB's Constitution, which is based upon the NHSE ICB model constitution template, was approved by the Board at its inaugural meeting on 1 July 2022. The Constitution is supported by other documents setting out the ICB's governance arrangements, namely: Standing Orders; Scheme of Reservation and Delegation (SoRD); Standing Financial Instructions (SFIs); Governance Handbook, which includes a Functions and Decisions Map; and key policies.

The Constitution sets out the ICB's governance arrangements, roles and responsibilities of the Board and its membership.

Membership of the Board is set out on page 45 of the Members Report.

The Board met in public on six occasions during 2023/24 at different venues across MSE. Attendance at meetings is recorded. Each meeting was well attended and was quorate.

The Board also held two extraordinary meetings in private, the first in November 2023 to discuss the [financial] rapid reset and recommitment arrangements asked of the ICB by NHSE, and a second in January 2024 to consider the Community Beds Pre-Consultation Business Case.

Members provided oversight and scrutiny of performance and the delivery of ICB objectives and made well informed decisions to support the development of the ICB and the Integrated Care Partnership Strategy.

Any urgent decisions required between scheduled Board meetings were taken in accordance with the Constitution and ratified at the next scheduled meeting.

Board seminars were held monthly to further the development of the Board, undertake training, and discuss topical and emerging issues such as financial and operational planning, health inequalities, fraud, bribery and corruption, conflicts of interest, procurement, information governance, patient safety, and safeguarding.

The Board will undertake an annual review of its effectiveness by July 2024.

ICB Committees

To support the Board in carrying out its duties effectively, committees reporting to the Board are formally established to provide assurance on matters within each committee's remit as set out in their terms of reference. The current committee structure is set out below.

Audit Committee

The Audit Committee provides the Board with an independent and objective view of the ICB's financial systems, financial information and compliance with laws, regulations and directions governing the ICB insofar as they relate to finance, good corporate governance including the management of risks, conflicts of interest and freedom to speak-up arrangements, information governance, security including cyber-security, emergency preparedness, resilience, and response (EPRR), business continuity management (BCM), sustainability and the ICB's responsibility to act effectively, efficiently, and economically.

As of 31 March 2024, the committee comprised of three members (with the fourth partner member position being vacant). The committee was chaired by George Wood, Non-Executive Member of the Board.

During 2023/24, the committee met on five occasions. In addition, virtual approval of the ICB's new Provider Accreditation Policy; the revised Information and Governance Framework and Policy; and a recommendation to the ICB Board to approve the delegation of 59 specialised services to the ICB from 1 April 2024 was sought and given.

Decisions were quorate in line with the committee's terms of reference (minimum of two members) on all occasions, including virtual decisions which were ratified at subsequent meetings.

During 2023/24 the committee continued to focus upon ensuring the review of the systems, policies, procedures, and processes fundamental to the governance of the organisation. Minutes of ICB sub-committees were also received to provide the audit committee with oversight of established governance.

The committee received assurance from internal audit of key systems and processes and, in addition to routine reporting, received updates on counter-fraud initiatives and investigations and implementation of audit recommendations. The committee reviewed the ICB's draft accounts and approved the final accounts and management response to the auditor for 2023/24 on behalf of the Board. The committee noted that whilst the ICB maintains its compliance with the Mental Health Investment Standard for 2022/23, the External Auditors (KPMG) were unable to fully validate the expenditure incurred, which is explained fully on page 19 above.

The committee regularly reviewed the ICB's Board Assurance Framework (BAF) and maintained oversight of associated risk management processes and procedures.

In line with NHSE guidance on the management of conflicts of interest, the Chair of the Audit Committee acts as the ICB's Conflicts of Interest Guardian and Freedom to Speak Up Guardian. Assurance that the ICB was adhering to NHSE mandatory guidance on the management of conflicts of interest was received via the annual internal audit of conflicts of interest for 2023/24 which identified 'substantial' assurance.

The committee undertook a review of its effectiveness during 2023/24. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen the effectiveness of the committee has been developed.

Remuneration Committee

The Remuneration Committee determines the remuneration, other terms and conditions and arrangements for termination of employment for the Chief Executive, Executive Directors, and others on the Very Senior Manager (VSM) pay scale, and other Board members except Non-Executive Members. To avoid conflicts of interest, the remuneration of Non-Executive Members is determined by a separate Non-Executive Member Remuneration Panel.

The committee also has responsibility for agreeing the pay framework for any ICB clinical staff working outside of Agenda for Change (AfC) terms and conditions, oversees off-payroll contracts, any payments outside AfC pay policy and determines arrangements for termination of employment or special payments.

As of 31 March 2024, the committee comprised of three members. The committee was chaired by Joe Fielder, Non-Executive Member of the Board.

During 2023/24 the committee met on ten occasions. Decisions were quorate in line with its terms of reference (minimum of two members) on all occasions. The work of the committee focussed upon action required following implementation of the ICB's initial staffing structure and further organisational change in the latter part of the financial year, approval of new and revised policies prior to their adoption by the Board, approval of very senior managers' remuneration, the ICB's Workforce Race Equality Standard report and Gender Pay Gap report.

The committee undertook a review of its effectiveness during 2023/24. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen the effectiveness of the committee has been developed.

Quality Committee

The Quality Committee provides assurance to the Board that there is an effective system of quality governance and internal control across the ICS that supports it to deliver sustainable, safe, and high-quality care.

Key areas reviewed by the committee included arrangements for monitoring the quality of provider contracts; patient safety policies and procedures including the new Patient Safety Incident Response Framework (PSIRF), review of the provider Quality Accounts 2022/23; serious incidents and never events; updates on special educational needs and disabilities (SEND) services; learning disabilities; infection prevention and control strategy; safeguarding escalations; approval of policies; all age continuing care; review of patient safety and quality risks; medicines optimisation; mental health services; community services; maternity services; complaints and a review of any virtual decisions taken outside of formal committee meetings.

Deep-dive reviews into specific areas, which included lived experience stories, including end of life care, assisted conception, eating disorders and sepsis were also discussed by the committee.

The committee is also notified of the outcome of inspections undertaken by regulatory bodies, such as the Care Quality Commission (CQC), and the outcome of inquests and inquiries to consider if further action is required and/or if any matters need to be escalated to the Board.

As of 31 March 2024, the committee comprised of seventeen members, including representation from main provider organisations and one of the ICB's Patient Safety Partners. The committee is chaired by Dr Neha Issar-Brown, Non-Executive Member of the Board, with Prof. Shahina Pardhan, Associate Non-Executive Committee acting as Deputy Chair. Meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The committee met on six occasions during 2023/24. Decisions were quorate in line with the committee's terms of reference (minimum of six members) on all occasions.

The committee undertook a review of its effectiveness during 2023/24. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan was developed to enhance how the committee operates going forward.

Finance and Investment Committee

The Finance and Investment Committee (FIC) provides oversight and assurance to the Board in the development and delivery of robust, viable and sustainable financial plans and associated financial performance of services commissioned by the ICB in the context of system working.

The committee receives reports on monthly financial reporting, key financial risks, progress against the system efficiency programme, delivery of financial statutory

requirements, capital investment, estates, business cases for approval, and updates from system financial groups. The committee also approves any new or updated finance policies prior to their adoption by the Board. From January 2024, the new Provider Selection Regime Review Group became a sub-group of FIC.

As of 31 March 2024, the committee comprised of eight members, with the Partner Member S151 Officer position being vacant. The committee is chaired by Joe Fielder, Non-Executive Member of the Board. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The committee met on thirteen occasions during 2023/24. Decisions were quorate in line with the committee's terms of reference (minimum of four members) on all occasions. Two urgent decisions between meetings were also taken to commission the Fracture Liaison Service and to support the Outline Business Case for the MSEFT procurement for a single integrated operating model for pathology.

The committee undertook a review of its effectiveness during 2023/24. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan has been developed to shape the work of the committee going forward to strengthen its effectiveness and focus on performance in the context of financial sustainability.

System Oversight and Assurance Committee

The System Oversight and Assurance Committee provides oversight and challenge, focusing upon the system's performance against agreed outcome measures, NHS constitutional standards, transformation programmes, and key safety and quality measures.

During 2023/24 the committee continued to concentrate on addressing significant challenges relating to the recruitment and retention of staff across the MSE workforce; the quality and safety of services; performance, including clearing backlogs that arose during the COVID-19 pandemic relating to services including diagnostics, cancer, elective care; and improving system finances. At each meeting the committee agreed escalations regarding any significant concerns to the Chief Executives Forum (Health) and sovereign Boards of the ICB / provider organisations.

As of 31 March 2024, the committee had twenty members. The committee is co-chaired by George Wood, Non-Executive Member of the ICB, and Simon Wood, Regional Director for Strategy & Transformation, NHSE.

The committee met on ten occasions during 2023/24. All meetings were quorate. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The committee undertook a review of its effectiveness during 2023/24. This assessment identified that the committee had contributed to collaborative working across the system, holding partners to account and escalating issues to the Chief Executive's Forum, but that its effectiveness could be improved. Consequently, the terms of reference are being revised to redesign how the committee operates and functions alongside the other sub-committees of the Board.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee's purpose is to provide oversight and assurance to the ICB on the exercise of the ICB's delegated primary care commissioning functions (including general practice, pharmacy, optometry, and dental services) and associated improvement and transformation programmes.

The committee received reports on primary care contracts, the quality and safety of primary care services, the 'Working Together Scheme,' primary care workforce, and updates on progress against actions taken following the 'Fuller Stocktake' report. Issues relating to primary care estates and information and technology were also considered by the committee.

As of 31 March 2024, the committee had eleven members. The committee is chaired by Sanjiv Ahluwalia, Associated Non-Executive Member. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The committee met on ten occasions during 2023/24, including an 'away day' deep dive in issues facing primary care. Decisions were quorate in line with the committee's terms of reference (minimum of four members) on all occasions.

The committee undertook a review of its effectiveness during 2023/24. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen the effectiveness of the committee has been developed.

Clinical and Multi-Professional Congress

The Clinical and Multi-Professional Congress (a committee of the ICB Board but referred to hereafter as 'congress') contributes to the overall delivery of the 'Triple Aim' of ICSs to deliver better health and wellbeing for everyone; better quality of health and care services; and sustainable use of health and care resources.

The work of the congress is driven by programmes of work within the ICB requiring expert clinical advice and assurance. Congress discharges its duties when reviewing, scrutinising, advising, and providing assurance on the programmes of work presented to it.

During 2023/24 the work of the congress included reviewing proposals for a single integrated pathology service, musculo-skeletal transformation, urology service reconfiguration, Tier 3 weight management, and the review of community capacity. The congress also received an update on system efficiencies and action being taken to support this.

As of 31 March 2024, the congress had 17 members, with one position vacant. The congress was chaired by Dr Matt Sweeting, Executive Medical Director. Congress meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The congress met on 6 occasions during 2023/24 and were quorate in line with the congress' terms of reference (minimum of eight members), on all occasions.

The congress undertook a review of its effectiveness during 2023/24. This assessment identified that the congress had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen the effectiveness of the congress has been developed.

Executive Committee

The Executive Committee was established as a formal sub-committee of the ICB Board in January 2024 to provide oversight and assurance regarding the operational management of the ICB, including scrutiny of proposed business cases, making recommendations regarding strategic direction, providing support for investment in line with the ICB Scheme of Reservation and Delegation, and identification of key issues and risks requiring discussion by or escalation to the Board.

The membership of the committee includes executive members of the ICB which as of 31 March 2024 comprised 11 members.

The committee met weekly from 9 February 2024, with 9 meetings held during 2024. Business conducted by the committee included consideration of business cases; review of performance; oversight of operational delivery; development of ICB strategy, risk appetite and organisational structure; oversight of financial sustainability within the ICB and wider system as well as the developing programme of organisational development.

Alliance Committees

Each of the four alliances (Basildon and Brentwood, Mid Essex, South East Essex and Thurrock) have established formal committees of the ICB Board. The purpose of the alliances and their respective committees includes contributing to the overall delivery of the ICS's objectives to create opportunities for the benefit of residents, to support health and wellbeing, to bring care closer to home and to improve and transform services. The alliances work closely with local partner organisations and provide oversight and assurance to the ICB Board on local issues.

The work undertaken by each of the alliances is set out in the Performance Overview section of this report.

Better Care Fund (including Improved Better Care Fund) governance

The ICB is a member of six formal groups/Boards to fulfil the governance requirements of the Better Care Fund (BCF). This consists of four Partnership Boards with Essex County Council (3 local and 1 countywide), a Partnership Board with Thurrock Council, and a Management Group with Southend City Council.

In line with the terms of the individual section 75 Better Care Fund Agreements held individually with each of the upper tier local authorities, decision-making relating to the BCF is delegated to nominated representatives of the ICB and nominated representatives of each of the upper tier local authorities.

Utilisation of the BCF funds was in line with national guidance and as detailed within the section 75 agreements. Reporting focused on expenditure on the approved services and performance against the nationally defined metrics.

UK Corporate Governance Code

The ICB, along with other NHS bodies, is not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the ICB and best practice.

The annual review of Board effectiveness for 2023/24 will include an assessment which encompasses the relevant principles of the UK Corporate Governance Code.

The Board follows best practice in relation to providing effective leadership, having an appropriate balance of skills, experience, independence, and knowledge to enable Board members to discharge their duties and responsibilities effectively, presenting a balanced and understandable assessment of the ICB's position in its financial and other reporting and ensuring that remuneration is set appropriately.

Discharge of Statutory Functions

The ICB has reviewed the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. This review was initially supported by an assurance mapping exercise undertaken by the ICB's internal auditors during January 2023 which mapped the ICB's statutory duties against its committee structure, governance documents, policies, and procedures. This was followed by an in-depth assignment of duties to individuals and directorates within the ICB and a review of the ICB's corporate governance arrangements during 2023/24.

As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

The ICB's Scheme of Reservation and Delegation was updated in January 2024 to take account of the introduction of the Provider Selection Regime, the ICB's organisational restructure and review of its governance arrangements, and changes required in preparation for the delegation of Specialised Services by NHSE from April 2024.

Risk management arrangements and effectiveness

The ICB is committed to ensuring that risk management forms an integral part of its philosophy, practices, and business plans, rather than viewed or practised as a separate programme, and that responsibility for implementation is accepted at all levels of the ICB.

The ICB's Risk Management Policy encompasses both clinical and non-clinical risks and the ICB's risk appetite statement, which assists managers to identify when risk levels are tolerable or where further action is required to reduce risk ratings to an acceptable level. The policy will be reviewed during early 2024/25 to take account of new operational arrangements to manage risks and provide assurance to the Board. The Board seminar meeting in April 2024 will also focus on the Board defining the ICB's risk appetite and strategic objectives for the coming year.

The Policy is based on the Australia/New Zealand risk management model and sets out the risk management system, supporting processes and reporting arrangements which aim to protect patients, the public, staff and the ICB's assets and reputation.

Risks on the ICB's risk register are mapped against objectives set out within the Mid and South Essex Integrated Care Strategy 2023–2033 as well as directorates and responsible committees.

The ICB has identified its top strategic areas of risk which are monitored via the ICB's Board Assurance Framework (BAF). As of 31 March 2024, these risk areas were:

- **Workforce** – risks associated with the ICB and partner organisations not taking effective action to improve recruitment and retention of permanent staff to reduce reliance on bank / agency staff; and not taking effective action to ensure there is a reliable pipeline of staff to fill future vacancies.

- **Primary care** – because of workforce pressures and demand outstripping capacity, patient experience and pathways potentially may not adequately meet the needs of our residents.

- **Capital** – insufficient capital to support all system needs, necessitates prioritisation, and reduces our ability to invest in new opportunities, for transformational impact.

- **Hospital flow** – risk that the ICB and provider organisations are unable to effectively manage / coordinate the capacity across the system and consequently the inability to deliver effective care to patients.

- **Diagnostics, elective care, and cancer performance** – risk of not meeting relevant NHS constitutional performance standards.

- **System financial performance** – the system is financially challenged. Failure to deliver the financial plan could place increase pressure on the whole system impacting on our ability to deliver our intended outcomes.

- **Health inequalities** – identification of groups at most risk of experiencing health inequalities and taking action to reduce these by improving access and outcomes.

- **Mental health services quality assurance** – services identified as experiencing significant issues impacting on patient safety, quality and access which could result in poor patient outcomes.

The full BAF is reviewed by the Audit Committee and by the ICB Board at its meetings, which are held in public. Committees also maintain oversight of risks on the BAF that link to their terms of reference.

Capacity to handle risk

During 2023/24 the ICB had the following arrangements in place:

- Clear ownership of risks, with responsible directors and lead officers identified, with escalation arrangements in place to the Board.

- A Board Assurance Framework within which the latest updates from lead officers were recorded and reported to relevant committees and the Board.

- Recording and investigation processes for incidents, including identification of learning.

- Triangulation of learning from incidents, complaints, and claims (should they arise) as a standing item on the agenda of the Quality Committee.

- Monitoring of completion of Equality and Health Inequality Impact Assessments, Quality Impact Assessments and Privacy Impact Assessments.

- Regular review of anti-fraud, bribery, and security arrangements by the Audit Committee.

- Emergency planning, resilience and response and business continuity management policies and procedures.

The ICB's Freedom to Speak-Up (FTSU) arrangements, including the appointment of a Board level FTSU Guardian and FTSU Champions, also support risk management by providing a framework for employees to raise concerns in line with the Public Interest Disclosure Act 1998. During 2023/24 the ICB undertook a review of the FTSU Policy.

The ICB is committed to identifying the causes of incidents, claims and complaints. The principal objective is to identify themes and 'system failures,' rather than focusing on individual failures. The introduction of the Patient Safety Incident Response Framework supports this work by advocating a co-ordinated and data-driven approach that prioritises compassionate engagement with those affected and prompts a significant cultural shift towards systematic patient safety management.

Stakeholders, including staff, patients and the public have been involved in the risk management process, for example by ensuring that relevant staff were identified to input into any risk assessments in their function or area of work. ICB staff and contractors were made aware of agreed risk reporting procedures and contracts clearly stated the responsibilities of contracted personnel about risk identification, reduction, mitigation, and reporting. Feedback on risk issues was encouraged via the ICB's complaints and enquiries services and through its public engagement and consultation mechanisms, for example, patient stories at Quality Committee meetings, engagement with the public and other stakeholders on the ICB's plans for services, such as, the public consultation on community beds undertaken during the latter part of 2023/24.

The effectiveness of these risk management arrangements is summarised under the 'Review of the Effectiveness of Governance, Risk Management and Internal Control' section, which includes the monitoring, review, and management of the BAF by the Audit Committee and Board.

Risk assessment

Risk assessment is undertaken through the application of the risk management framework. This includes assessment through regular review of the risk register by risk leads, committees and the ICB Board, seeking preventative risk measures and the management of risk through:

- Commitment to identifying the underlying or root causes of incidents, complaints, and claims (should they arise).

- Promoting an open, just, and non-punitive culture.

- Driving an ongoing information and education programme which empowers and supports Board members and staff in the risk management process generally, and in relation to specific areas of risk.

- All staff being familiar with the anti-fraud, anti-bribery, and security policies and through training and raising awareness via the issuing of fraud alerts, guided by the ICB counter-fraud services.

- All staff being familiar with the terms of the Conflicts of Interest, Gifts and Hospitality and Standards of Conduct Policies.

- Registers of Interests being produced for Board and committee meetings and those sub-committees with decision-making powers, or capacity to influence decisions made by the ICB, so that the relevant Chair can ensure that potential, perceived or real conflicts of interest are managed appropriately.

Other sources of assurance

Internal control framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of control in place is set out within the ICB governance handbook, its policy framework and is described in the Board, Committee and Risk Management sections of this statement. The overarching governance framework has been reviewed by internal audit, the outcome of which informs the Head of Internal Audit Opinion and concluded that the ICB had appropriate arrangements in place.

Annual audit of conflicts of interest management

The ICB annual internal audit of conflicts of interest 2023/24 identified ‘substantial’ assurance that a robust system of control is in place to identify, manage and monitor conflicts of interest.

Data Quality

The oversight and management of data quality is embedded within the System Oversight and Assurance Committee and other relevant groups, for example the Elective Care Board. Where concerns around data quality are highlighted a focus group is established to identify the root cause of those concerns and seek appropriate resolution that both addresses the concern raised and reduces the risk of reoccurrence. Resolution reports are shared and approved through the governance framework, at which point the focus group is stood down.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The ICB prioritises the establishment of robust information governance systems and processes to safeguard patient and corporate data. Arrangements to achieve this include broadening staff training initiatives with a heightened emphasis on cyber security awareness and handling of personal information. Considering recent restructuring, new Information Asset Owners (IAOs) have been appointed; the information governance team collaborates closely with IAOs to ensure accurate representation of assets and information in the ICB Records of Processing Activity (ROPA). The Information Governance Team also works closely with the Business Intelligence function to ensure that data supporting commissioning decisions is accessible throughout the system, extending to ICS partners and GP Practices, in accordance with the guidelines outlined in the ICB Data Access Request Service agreement.

As of 31 March 2024, the ICB was on course to meet all mandatory assertions in relation to the requirements of the Data Security and Protection Toolkit 2023/24 (due for submission at the end of June).

Complaints and Patient Experience

The ICB receives concerns, complaints and enquires from patients, carers, family members and Members of Parliament. Where the complaint requires the ICB to liaise with an external provider the ICB is required to obtain the consent of the individual to refer to the relevant provider.

From 1 July 2023, responsibility for Primary Care Complaints was devolved from NHSE to the ICBs. This increased volume of complaints had a major impact on review and response times and has continued to impact to date.

From April 2023 to Mar 2024, there were 1809 new complaints, concerns and enquiries opened, and 1454 closed. This was an increase of 143% compared to 2022/23.

Themes and trends included difficulty accessing GP appointments, GP registration issues, prescribing, access to medication and clinical care.

Learning from complaints is shared with Providers, primary care alliances and internal stakeholders to inform pathways and services and improve patient experience

Complaints to Parliamentary and Health Service Ombudsman

Where a complainant receives a formal response to their complaint, but they do not feel the complaint has been appropriately addressed. In the first instance, they would be encouraged to respond to the ICB, outlining why they are not satisfied. However, if they remain unsatisfied, they are advised of their right to escalate their complaint to the Parliamentary and Health Service Ombudsman (PHSO).

In 2023/24, twelve complaints were referred to the PHSO. Of these, five were stage 1 enquires; four were stage 2 primary investigations, and two were stage 3 detailed investigations.

The areas of concern raised to PHSO included Personal Health Budget requests, Freedom of Information and Choice Agenda, continuing healthcare assessments and retrospective appeals, neuro rehabilitation, dental care, access to medication and individual funding request appeals.

Business critical models

The ICB supports the principles of the Macpherson Report and is committed to embedding best practice in relation to quality assuring our prioritised business critical models and other functions. Work will be on-going in 2024/25 to fully identify all business-critical models used by the ICB to gain assurance over their use in accordance with NHSE guidance.

Third party assurances

The ICB relies on several third-party providers for the provision of payroll and pension services, procurement advice and commissioning support (highlighted below).

Whittington Health NHS Trust provide payroll and pension services to the ICB. The ICB continues in a positive relationship with Whittington Health, with regular virtual MS Teams meetings held between Whittington and ICB Human Resources Managers.

NHS Business Services Authority provides and maintains the Electronic Staff Record used by the ICB to record Human Resources (HR) files, manage leave, training, and HR processes in relation to its staff. Grant Thornton UK LLP undertook the independent audit and concluded that (limited to the testing undertaken) in all material respects controls described were fairly presented and suitably designed and operating effectively to achieve their control objectives.

The ICB retains the services of *Attain* to ensure probity during procurement processes. The Finance & Investment Committee receives procurement reports at each meeting and a register of procurement decisions, which is published on the ICB's public-facing website, is reviewed by the Audit Committee to ensure rigour is being applied. Internal and external audits reviewing procurement decisions and processes include coverage of the work undertaken by Attain which is reported to the Audit Committee.

Arden and Greater East Midlands (AGEM) Central Support Unit (CSU) provide digital, financial and other transactional based services. The ICB holds a monthly contract review meeting with AGEM to monitor all aspects of the contract and review performance against service level agreements and key performance indicators. This includes extended services such as back-ups and business continuity planning.

For GPIT and Primary Care Enabling Services exceptions or escalations are reported to the Primary Care Digital Board. The Audit Committee maintains oversight of cyber security and the associated business continuity planning and arrangements for maintaining corporate, operational, and clinical services in the event of a loss of either IT or data due to a cyber-attack. The ICB receives copies of all NHS Digital CareCert alerts and confirmation when AGEM has updated against them.

Deloitte LLP conducted the audit of the Commissioning Support Unit (CSU) collaborative, which included AGEM regarding the operation of the National Calculating Quality Reporting Service (CQRS) primarily an approvals, reporting and payments calculation system for General Practitioner (GP) Practices. The service auditor report concluded that the description of the control environment fairly represented the organisation activities; that the controls were suitably designed to provide reasonable assurance as to the achievement of control objectives; and that (limited to the controls tested) they were operating with sufficient effectiveness to provide reasonable assurance that those objectives were achieved.

Mazars LLP undertook the audit of Capita Business Services Limited who provide the Primary Care Support England (PCSE) system; used for the processing of GP, Ophthalmic and Pharmacy payments and pensions administration, operated on behalf of NHSE (and delegated to the ICB). A qualified opinion was presented outlining that the description of control systems adequately reflected those in operation and were suitably designed to operate effectively. Testing generally concluded the controls were operating effectively (limited to the controls tested). However, for one control objective relating to logical access compliance with the control could not be fully evidenced. NHSE provided a letter of assurance to the ICB that the measures were in place to work with Capita regarding any control issues identified and that there continued to be improvements within the operation of their systems and the outcomes of service auditor reports over recent years.

NHS Shared Business Services Limited (NHS SBS) provides finance and accounting services to the ICB. PricewaterhouseCoopers LLP undertook the independent audit of the control environment within SBS and concluded that (notwithstanding the operation of carved-out subservice organisations, that were not included within the audit) the description of controls set out within the report by SBS fairly represented the finance and accounting services during the period; that controls were suitably designed to provide reasonable assurance; and that (limited to the controls tested) they were operating effectively during the year to achieve their objective.

Grant Thornton UK LLP undertook the independent audit of NHS SBS in relation to the prescription payments process system operated on behalf of the ICB and relevant to controls over financial reporting. Subservice organisations were excluded from the audit. Sufficient evidence was obtained to provide a reasonable basis for their opinion that controls were suitably designed and implemented throughout the period; that those controls were operated effectively during the period.

NHS Business Services Authority also provides the Dental Payments Process system, that underwent an independent service audit by Grant Thornton UK LLP. The audit report concluded that in all material respects, limited to the controls and testing undertaken, there was reasonable assurance that the description of controls fairly represented that operated during the year, that the control objectives were suitably designed and operated effectively to achieve their objectives.

Control issues

There were no specific control issues identified through internal assurance or internal audit reviews that undermine the integrity or reputation of the ICB or wider NHS.

The following performance issues were identified by the ICB during the year and were being managed as follows:

Ambulance Services – An ambulance handover recovery plan was in place, overseen by the ICB Transformation and Improvement Urgent Emergency Care (UEC) Board. Twice daily system calls were held with EEAST and MSEFT via the system control centre. The SOAC received the performance and actions being undertaken to mitigate performance risks. Significant progress had been made to recover ambulance performance by working closely with system partners. During January 2024 performance improved by 4.91%, with further improvement in February 2024 by 6.14%. The improvement had been driven by collaborative working from system partners implementing interventions and improvement schemes, and an increased escalation process.

Performance against cancer constitutional standards – a recovery plan was in place with oversight via the ICB Transformation and Improvement Cancer Board, reporting performance and escalations to SOAC. Representatives from the system attended the national tier 1 meetings (every two weeks) chaired by the regional team who were overseeing performance improvements and 62-day recovery targets. 62-day recovery was part of the MSEFT undertakings and has a separate focussed SOAC meeting to ensure continued momentum and review progress to recover performance against the 62-day target; ensuring the trajectory is on track without deterioration or sustaining recovery when achieved. Real progress had been made in year, which was expected to continue into 2024/25.

Elective recovery – a recovery plan was in place with oversight via the ICB Transformation and Improvement Elective Board which reports performance and escalation to SOAC. Representatives from the system attended the national tier 1 meetings (every two weeks) chaired by the regional team overseeing performance improvements and 78-week wait recovery. 52-week wait recovery is part of the MSEFT undertakings which had a separate focussed SOAC meeting to ensure continued momentum and oversee sustainable recovery.

System financial performance - the system invoked the forecast outturn protocol process and consequently agreed a revised financial position with NHSE, noting that the ICB itself will maintain its break-even position. A ‘triple lock’ process was instigated at the end of the year to increase financial scrutiny, which required certain financial decisions to be referred to and overseen by NHSE. System financial performance will therefore be a focus of the work of the ICB and partner organisations during 2024/25, with robust governance around decision making to manage the financial position going forward.

Mental health – following a CQC inspection, rapid risk review, and establishment of the Essex mental health independent inquiry, an EPUT recovery plan was established with oversight via the MSE Partnership Board with reports and performance escalated to SOAC. There are also service improvement plans in place with EPUT, with trajectories for achievement/recovery updated via the relevant SOAC report.

Maternity – the section 31 notice issued in respect of maternity and midwifery services at MSEFT by the CQC (October 2020), included specific improvement actions reflected in the Trust's Maternity Improvement Plan. The MSE Local Maternity and Neonatal System (LMNS) Committee and the MSEFT Maternity Assurance Committee, as a sub-group to the Trust Board oversaw continued progress to implement the improvement plan. The LMNS Senior Responsible Officer briefed SOAC on Section 31 reporting. Maternity was part of the MSEFT legal undertakings monitored via a separate focussed SOAC meeting to ensure continued momentum and progress. This meeting included NHSE representation, the ICB Chief Nurse/SRO for the LMNS/Maternity and MSEFT representatives.

Workforce – challenges specific to MSE include those relating to quality, performance, and cost (for example, the overuse of temporary staffing) were discussed and monitored by SOAC. Workforce strategy was driven at a national and regional level and the People Board continued to bring system partners together to oversee and monitor progress to address workforce challenges.

All Age Continuing Care (AACC) – the AACC team, who were the team leading the ICB continuing care (CHC) programme and delivery had five workstreams (children and young people, retrospective reviews, CHC, discharge to assess and fast track). All five workstreams had a backlog. Backlog recovery plans were developed to reduce the risk both for patient outcomes and the ICB in terms of financial risk. Additional work was undertaken in quarter three introducing new models of care working with the Mid and South Essex Hospice Collaborative. Quarter four saw additional work for discharge to assess to review the ICB model, recover the backlog and identify the model for best outcomes.

Delivery of 4-hour A&E standard - urgent and emergency care improvement programme care groups and system pillars workstreams identified improvement initiatives and schemes that commenced throughout February for full realisation benefits in March 2024, which underpin the improvement in emergency department performance from 62% (2022/23) to 69% (2023/24).

Review of economy, efficiency & effectiveness of the use of resources

The ICB reported a £22.3m surplus for the year, whereas the system reported a deficit of £29m.

The ICB's Finance and Investment Committee and the Board each received regular financial reporting during the year and had the opportunity for detailed review of the financial position.

The ICB Finance and Investment Committee continued to monitor the ICB's procurement and planning arrangements to ensure value for money from commissioned services.

The ICB's 2023/24 running (management) costs were within nationally permitted expenditure limits.

The internal auditor reviewed the ICB's financial systems and processes, including the arrangements for financial reporting and confirmed that the ICB had substantial arrangements in place. The external auditor's comments on arrangements for securing economy, efficiency, and effectiveness in use of resources in 2023/24 are included in their report immediately after the annual accounts (see page 32 onwards).

Delegation of functions

The ICB established formal arrangements for the delegation of functions through its Scheme of Reservation and Delegation (SORD).

The SORD established formal arrangements with local authority partners to execute functions such as learning disability services via section 75 of the NHS Act 2006 and associate collaborative agreements.

Arrangements were established with Hertfordshire and West Essex ICB and Suffolk and North East Essex ICB for the management of community pharmacy and optometry contract management, children and young people mental health services, the individual placements team and for the contract management of the home oxygen service, and East of England Ambulance service contract.

The delegation of functions to the ICB from NHSE included general practice, pharmacy, optometry, and dental services.

Counter fraud arrangements

An accredited Local Counter Fraud Specialist (LCFS), who was an employee of the ICB's internal auditors, was contracted to undertake counter fraud work proportionate to identified risks. The Audit Committee received an update from the LCFS regarding any counter-fraud initiatives or investigations at each meeting and reported progress and outcomes against each government counter fraud functional standard.

There was executive support and direction from the Chief Finance Officer for a proportionate proactive work plan to address identified risks. The Chief Finance Officer was the identified member of the executive team named within the Anti-Fraud, Bribery and Corruption Policy who was proactively and demonstrably responsible for tackling fraud, bribery, and corruption.

The ICB was committed to robustly investigating all reports of fraud, bribery and corruption and would seek to recover lost NHS funds were proportionate and necessary.

At the end of the financial year, the ICB submitted a self-assessment to the NHS Counter Fraud Authority against the government counter fraud functional standards. The Chief Finance Officer and Chair of the Audit Committee authorised the assessment prior to submission.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2023 to 31 March 2024 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Reasonable assurance could be given that there was a generally sound system of internal control, designed to meet the organisation's objectives, and that controls were generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, puts the achievement of particular objectives at risk.

During the period, internal audit issued the following audit reports:

Assignment	Assurance Opinion
Financial governance	Substantial
Risk management and assurance framework	Reasonable
Conflicts of interest	Substantial
Quality management / governance	Reasonable
Fit and proper person test	Reasonable
Corporate governance	Reasonable
Delegated primary care	Substantial
Key financial systems	Substantial
Payroll	Substantial

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control was informed by the work of the internal auditors, executive managers, and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review was also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Board.
- The Audit Committee.
- Remuneration Committee.
- Quality Committee.
- Finance and Investment Committee.
- System Oversight and Assurance Committee.
- Primary Care Commissioning Committee.
- Clinical and Muti-professional Congress.
- Executive Committee

- Alliance Committees
- Internal Audit.
- External Audit.

Conclusion

I concur with the Head of Internal Audit Opinion that during 2023/24 there had been a generally sound system of internal control, designed to meet the organisation's objectives, and that controls have been generally applied consistently.

Action plans to implement any outstanding recommendations from audits were in place and will continue to be monitored during the 2024/25 financial year.

I confirm that there are no risks which may affect the ICB's licence or serious lapses in control.

Tracy Dowling
Interim Chief Executive of Mid and South Essex Integrated Care Board

24 June 2024

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

For 2023/24 the membership of the remuneration committee was as follows:

- Joe Fielder, Non-Executive Member (Chair)
- Peter Fairley, Partner Member (until May 2023)
- Mark Harvey, Partner Member (from October 2023)
- Dr Neha Issar-Brown, Non-Executive Member
- Prof. Shahina Pardhan, Associate Non-Executive Member (from July to September 2023)

Governance of the Remuneration Committee is reported within the governance statement above.

HR and remuneration advice was provided by the Executive Chief People Officer, Director of Human Resources and HR business partners, and the committee was informed by local and national guidance on remuneration matters.

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	-21%	-21%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-4%	-4%

The ICB has undertaken a restructure during 2023/24, reducing staff numbers by 30%, resulting in an overall reduction in average staff costs. A number of directors, including the highest paid in 2022/23: July 2022 to March 2023, left the ICB, resulting in a reduction in directors' costs. The basis of calculation has been revised to only include agency staff in post at March 2024, to be consistent with the treatment of permanent staff. Annualised pay for permanent staff is now based on their salary as at March 2024.

Pay ratio information

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile,

median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration, against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in MSE ICB in the financial year 2023/24 was £210K - £215k (2022/23 Jul-22 - Mar-23: £265K - £270k), and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay Ratio information table:

2023-24	25th percentile	Median	75th percentile
Total remuneration (£)	£32,171	£48,007	£60,983
*Salary component of total remuneration (£)	£32,171	£48,007	£60,983
Pay ratio information	6.6 : 1	4.4 : 1	3.5 : 1

2022-23 (July 22 to March 23)	25th percentile	Median	75th percentile
Total remuneration (£)	£34,449	£50,198	£67,394
*Salary component of total remuneration (£)	£34,449	£50,198	£67,394
Pay ratio information	7.8 : 1	5.3 : 1	4.0 : 1

*No performance pay and bonus payments are paid by the ICB, therefore both salary component and total remuneration are the same.

In 2023/24, 0 employees received annualised remuneration in excess of the highest-paid director (2022/23 Jul-22 - Mar-23: 0)

During the reporting period 2023/24, remuneration ranged from £1k to £212k (2022/23 Jul-22 - Mar-23: £6k to £266k) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers and very senior managers

Senior managers are subject to Agenda for Change terms and conditions, except for those roles which are subject to the VSM (Very Senior Managers) framework. The

salaries of governing body members are determined by remuneration committee with national and local guidance (provided by the Chief Finance Officer and Director of Human Resources) being considered in all decisions.

Remuneration of Very Senior Managers

Remuneration of very senior managers was determined by the ICB Remuneration Committee in accordance with its terms of reference.

Policy on the duration of contracts, notice periods and termination payments

The duration of contracts is determined by the duration of the roles and responsibilities to be undertaken. The contracts of the Chief Executive Officer, directors and other staff are permanent unless applicable to a time-limited project or funding, in which case contracts will be offered on a fixed term.

The notice period applying to the Chief Executive Officer is six months. For directors and other senior managers, the notice period is three months. Any termination payments would be in accordance with relevant contractual, legislative and HMRC requirements.

Senior manager remuneration (including salary and pension entitlements)

ICB remuneration reports 2023-24

This ICB remuneration report for 2023-24 is shown in two sections, representing the salary and allowances and pension entitlements of the senior leadership of the ICB.

ICB salary and allowances table:

This includes the ICB specific remuneration report table of directors and senior managers.

ICB pension table:

This includes the ICB specific pension entitlements of directors and senior managers.

Mid and South Essex ICB Remuneration Report 2023-24

Salaries and Allowances of Senior Managers (subject to audit):

Notes	Name	Title	2023/24					Date served	
			Salary (bands of £5,000) £000	Expense Payments (taxable) (nearest £100) £	Other Remuneration (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) [1] £000	Total (bands of £5,000) £000	Commenced	Ceased
	Executive Directors								
2	Tracy Dowling	Interim Chief Executive Officer	75-80	0	0	50-52.5	125-130	20-Nov-23	
2	Anthony McKeever	Chief Executive Officer	130-135	0	0	40-42.5	175-180	01-Jul-22	18-Nov-23
	Jennifer Kearton	Chief Finance Officer	140-145	0	0	102.5-105	245-250	10-Oct-22	
3	Dr Giles Thorpe	Executive Chief Nursing Officer	90-95	100	0	77.5-80	170-175	14-Aug-23	
3	Frances Bolger	Interim Chief Nursing Officer	35-40	0	0	0-2.5	35-40	12-Sep-22	05-Sep-23
4	Dr Matt Sweeting	Interim Medical Director	65-70	0	0	97.5-100	165-170	14-Aug-23	
5	Dr Ronan Fenton	System Medical Director	20-25	0	0	0	20-25	01-Jul-22	01-Sep-23
6	Lisa Adams	Interim Executive Chief People Officer	145-150	0	0	7.5-10	155-160	28-Jun-23	
6	Dr Ruth Jackson	Executive Chief People Officer	65-70	0	0	0	65-70	01-Jul-22	14-Sep-23
	Governing Body Members								
	Professor Michael Thorne CBE	Chair	65-70	0	0	0	65-70	01-Jul-22	
	Dr Neha Issar-Brown	Non-Executive Member	15-20	0	0	0	15-20	01-Jul-22	
	George Wood	Non-Executive Member	15-20	100	0	0	15-20	01-Jul-22	
	Joseph Fielder	Non-Executive Member	15-20	100	0	0	15-20	01-Jul-22	
7	**Partner Members**								
8	Dr Anna Davey	Primary Care Partner Member	10-15	0	0	0	10-15	01-Jul-22	
	Paul Scott	Partner Member, Essex Partnership University NHS FT	0	0	0	0	0	01-Jul-22	
9	Matthew Hopkins	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Aug-23	
9	Hannah Coffey	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Jul-22	28-Jul-23
	Peter Fairley	Partner Member, Essex County Council	0	0	0	0	0	01-Jul-22	
10	Ian Wake	Partner Member, Thurrock Council	0	0	0	0	0	May 23	
10	Les Billingham	Partner Member, Thurrock Council	0	0	0	0	0	17-Nov-22	May 23
	Mark Harvey	Partner Member, Southend City Council	0	0	0	0	0	13-Mar-23	

	Notes:
1	The pension-related benefit figures do not represent cash payments made to an individual's pension provider. The quoted figures provided by NHS Pensions Agency are an estimate of the increase in the accrued pension over their estimated pensionable life. Each organisation reports a disclosure value appropriate to the length of time the senior manager was employed by their organisation.
2	Anthony McKeever filled the role of Chief Executive until 18th November 2023. Tracy Dowling became Interim Chief Executive on 20th November 2023.
3	Frances Bolger filled the role of Interim Chief Nursing Officer until 5th September 2023. Dr Giles Thorpe became Executive Chief Nursing Officer on 14th August 2023.
4	Dr Matt Sweeting became Interim Medical Director on 14th August 2023. He was employed by Mid & South Essex NHS FT and was seconded to the ICB. He has subsequently been appointed as permanent Medical Director.
5	Dr Ronan Fenton filled the role of System Medical Director until 1st September 2023. He was employed by Mid & South Essex NHS FT and was seconded to the ICB.
6	Dr Ruth Jackson filled the role of Executive Chief People Officer until 14th September 2023. Lisa Adams was appointed Interim Executive Chief People Officer on 28th June 2023.
7	Partner Members are paid by their respective partner organisations and are not paid by the ICB, with the exception of Dr Anna Davey, who is engaged by the ICB on a sessional basis.
8	In addition to the Partner Member role, Dr Anna Davey filled a Clinical Lead role. Remuneration for this role was in the £40k-£45k band and is in addition to the figure quoted above.
9	Hannah Coffey filled the role of Partner Member, Mid and South Essex NHS FT until 28th July 2023. Matthew Hopkins was appointed as the Partner Member, Mid and South Essex NHS FT on 1st August 2023.
10	Les Billingham was replaced by Ian Wake as Partner Member, Thurrock Council in May 2023.

Salaries and Allowances of Senior Managers (subject to audit):

Notes	Name	Title	2022/23 (July 22 to March 23)					Date served	
			Salary (bands of £5,000)	Expense Payments (taxable) (total to nearest £100)	Other Remun-eration (bands of £5,000)	All Pension Related Benefits (bands of £2,500)[1]	Total (bands of £5,000)	Commenced	Ceased
			£000	£	£000	£000	£000		
	Executive Directors								
	Anthony McKeever	Chief Executive Officer	150-155	0	0	45-47.5	195-200	01-Jul-22	
2	Jennifer Kearton	Director of Resources	65-70	0	0	50-52.5	115-120	10-Oct-22	
2,3	Dawn Scrafield	Interim Director of Resources	55-60	0	0	20-22.5	75-80	01-Jul-22	09-Oct-22
4	Frances Bolger	Interim Chief Nursing Officer	40-45	0	0	0	40-45	12-Sep-22	
4	Rachel Hearn	Chief Nursing Officer	10-15	0	0	35-37.5	45-50	01-Jul-22	24-Jul-22
5	Dr Ronan Fenton	System Medical Director	70-75	0	0	0	70-75	01-Jul-22	
	Dr Ruth Jackson	Executive Chief People Officer	100-105	0	0	0	100-105	01-Jul-22	
	Governing Body Members								
	Professor Michael Thorne CBE	Chair	45-50	0	0	0	45-50	01-Jul-22	
	Dr Neha Issar-Brown	Non-Executive Member	10-15	0	0	0	10-15	01-Jul-22	
	George Wood	Non-Executive Member	10-15	300	0	0	10-15	01-Jul-22	
	Joseph Fielder	Non-Executive Member	10-15	0	0	0	10-15	01-Jul-22	
6	**Partner members**								
7	Dr Anna Davey	Primary Care Services Partner Member	5-10	0	0	0	5-10	01-Jul-22	
	Paul Scott	Partner Member, Essex Partnership University NHS FT	0	0	0	0	0	01-Jul-22	
	Hannah Coffey	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Jul-22	
	Peter Fairley	Partner Member, Essex County Council	0	0	0	0	0	01-Jul-22	
8	Les Billingham	Partner Member, Thurrock Council	0	0	0	0	0	17-Nov-22	
8	Ian Wake	Partner Member, Thurrock Council	0	0	0	0	0	01-Jul-22	16-Nov-22
9	Mark Harvey	Partner Member, Southend City Council	0	0	0	0	0	13-Mar-23	
9	Benedict Leigh	Partner Member, Southend City Council	0	0	0	0	0	17-Aug-22	12-Mar-23
9	Tandra Forster	Partner Member, Southend City Council	0	0	0	0	0	01-Jul-22	16-Aug-22

	Notes:
1	The pension-related benefit figures do not represent cash payments made to an individual's pension provider. The quoted figures provided by NHS Pensions Agency are an estimate of the increase in the accrued pension over their estimated pensionable life. Each organisation reports a disclosure value appropriate to the length of time the senior manager was employed by their organisation.
2	Dawn Scrafield filled the role of Director of Resources on an interim basis until 9th October 2022. Jennifer Kearton became Interim Director of Resources on 10th October and was confirmed as Director of Resources on 1st February 2023.
3	Dawn Scrafield was employed by Mid & South Essex NHSFT and her costs were recharged to the MSE ICB during the period.
4	Rachel Hearn filled the role of Chief Nursing Officer until 24th July 2022. The role remained vacant until Frances Bolger took up the role of Interim Chief Nursing Officer on 9th October 2022.
5	Dr Ronan Fenton is employed by Mid & South Essex NHS FT and was seconded to MSE ICB during the period.
6	Partner members are paid by their respective partner organisations and are not paid by the ICB, with the exception of Dr Anna Davey, who is engaged by the ICB.
7	In addition to the partner member role listed above, Dr Anna Davey filled a Clinical Lead role. Remuneration for this role was in the £20k-£25k band.
8	Les Billingham replaced Ian Wake as Partner member for Thurrock Council on 17th November 2022.
9	Mark Harvey replaced Benedict Leigh as Partner member for Southend City Council on 13th March 2023. Benedict Leigh previously replaced Tandra Forster as Partner member for Southend City Council on 17th August 2022.

Pension entitlements of directors and senior managers 2023-24

Pension entitlements of directors and senior managers (subject to audit):

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2024 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2024 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2023 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2024 £000	Employers contribution to stakeholder pension £000
Executive Directors									
Tracy Dowling	Interim Chief Executive Officer	2.5-5	0	5-10	0	0	34	122	0
Anthony McKeever	Chief Finance Officer	0	0	0	0	0	0	0	42
Jennifer Kearton	Executive Director of Finance & Estates	2.5-5	40-42.5	35-40	95-100	415	244	721	0
Dr Giles Thorpe	Executive Chief Nursing Officer	2.5-5	32.5-35	35-40	110-115	495	175	841	0
Frances Bolger	Interim Chief Nursing Officer	0	0	0	0	0	0	0	1
Dr Matt Sweeting	Interim Medical Director	2.5-5	7.5-10	30-35	80-85	451	85	631	0
Lisa Adams	Interim Executive Chief People Officer	0-2.5	0	0-5	0	0	7	12	0

The pension-related benefit figures quoted do not represent cash payments made to an individual's pension provider. The quoted figures provided by NHS Pensions Agency are an estimation of the increase in the accrued pension over their estimated pensionable life. Where an individual joins the pension fund after a significant gap, this can result in a higher estimate than would normally be expected. However, the pension benefit figures are expected to return to normal levels in the second year of disclosure.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future as a result of these legal proceedings.

Pension entitlements of directors and senior managers 2022-23 (July 22 to March 23)

Pension entitlements of directors and senior managers (subject to audit):

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2023 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5,000) £000	Cash equivalent transfer value at 1st July 2022 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2023 £000	Employers contribution to stakeholder pension £000
Executive Directors									
Anthony McKeever	Chief Executive Officer	0	0	0	0	0	0	0	47
Jennifer Kearton	Director of Resources (CFO)	2.5-5	2.5-5	30-35	50-55	346	49	415	0
Rachel Hearn	Chief Nursing Officer	0-2.5	0	35-40	65-70	590	9	602	0
Dawn Scrafield	Interim Director of Resources	0-2.5	0-2.5	60-65	110-115	880	46	952	0

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2024. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

CETVs are calculated in accordance with SI 2008 No.10500 Occupational Pension Schemes (Transfer Values).

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure is required. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement for loss of office

For the 2023/24 accounting period there were none.

Payments to past directors

For the 2023/24 accounting period there were none.

Staff Report

Number of senior managers

In 2023/24, the ICB had 88 senior managers.

Staff numbers and costs (subject to audit)

EMPLOYED STAFF		
Employee category	Headcount	WTE
Permanent	375	348.97
Fixed-term	43	30.68
TOTAL	418	379.65
AGENCY & INTERIM		
TOTAL	105	44.17
GRAND TOTAL	**523**	**421.82**

Staff composition

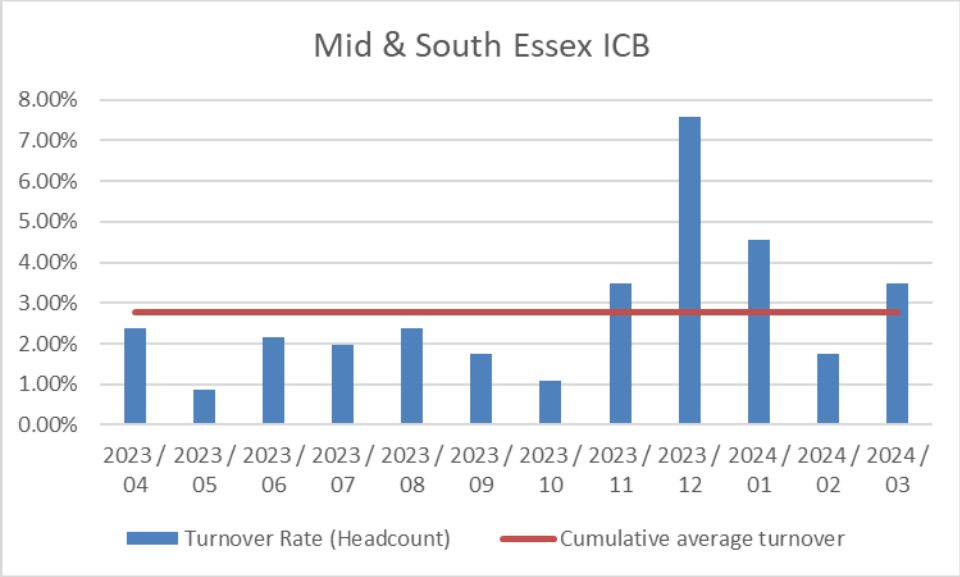
Pay Band	3	4	5	6	7	8a	8b	8c	8d	9	VSM	Other	Grand Total
								Senior Managers					
Female	4	43	35	71	46	52	34	25	16	8	7	61	402
Male	1	10	3	6	14	8	7	11	9	7	5	40	121
Grand Total	5	53	38	77	60	60	41	36	25	15	12	101	523

Sickness absence data

Average FTE	Average Sick Days per FTE	FTE-Days recorded Sickness Absence	FTE-Days Available
431.39	14.26	6151.19	157,890.26

Sickness absence data can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover percentages



Staff engagement percentages

MSE ICB participated in the NHS Staff Survey and the results have been presented across joint directorates and teams. The ICBs chose Picker to run the survey and results were published nationally on 7th March 2024.

The ICB had a response rate of 62%. Whilst this was 2% lower than the previous year it was significant as, at the time, the ICB was undergoing a large-scale organisational change programme that saw nearly 100 staff leave the ICB because of voluntary resignation, voluntary redundancy, and compulsory redundancy. The ICB's approach to the management of change was commended as best practice by the NHSE regional team and by the ICB Board.

Key themes were shared with the ICB executive team who commenced work with their teams to write action plans in response to the staff survey results. In addition, the ICB had a Staff Engagement group (since January 2022) and this group will be engaged with developing an action plan along with all other staff network chairs.

The ICB has several staff networks including LGBTQ+, diversity, women, Positive Ways to Wellness (a peer support group for staff with long terms conditions) and a number of staff champion groups which include wellbeing, Freedom to Speak up and Mental Health First Aiders. 70% of staff said that the ICB made reasonable adjustments to enable them to carry out their work which was above the national average of 63%.

75% of ICB staff said that they were satisfied with the opportunities for flexible working again above the national average of 68%.

The ICB was also a partner member in a system Staff Experience and Wellbeing Group and an Equality Diversity and Inclusion Group looking at key themes such as health and wellbeing, engagement, diversity, and inclusion and sharing best practice. Together we will build on these themes and actions for the 2024/25 survey, supporting the development of organisational planning in response to the survey and giving the opportunity to staff to shape the plan.

There were regular all-staff briefings to communicate key messages, as well as operational updates and regular updates on system priorities.

The ICB recently launched its values which were created by 250 ICB staff and reaffirmed its vison, mission and values post the restructure.

The ICB created a 3 Phase Organisational Development Plan which clearly outlined the many opportunities for staff to get involved in making the ICB a great place to work and an employer of choice, continuing to build on the ICS commitment:

> *"We will adopt a 'one workforce' approach, making people feel more valued, empowered, developed, and respected to support recruitment and retention"*
>
> *Commitment from ICS partner made during ICP Strategy design.*

Only 28% of staff would recommend the ICB as a place to work which was significantly below the national average of 52% but this was against a backdrop of significantly impactful organisational change. However, in terms of attraction rates the ICB was very attractive in the recruitment market showing high levels of interest by high calibre applicants.

Alongside this, the ICB reviewed its recruitment practices to make them values based and inclusive. This is part of a new ICB People Management Strategy which looks at all elements of people management throughout the employees' journey from start to finish.

Staff policies

The ICB had a comprehensive set of HR policies to support managers and staff through this employment journey and was creating a manager's toolkit to allow easy access to all policies and guidance notes. Both the People Management Strategy and the managers toolkit will be promoted via monthly Managers Learning Networks.

All ICB policies were reviewed and updated in the light of any legislative changes and reviewed biannually as required by the ICB.

The ICB created a new Menopause Strategy that has been through its ratification process to include engaging with the women's network and was published on the staff

intranet. The ICB (as required by a national directive) adopted and published a new Freedom to Speak up (FTSUP) / Whistleblowing Policy.

The ICB has a FTSU Guardian, 2 Senior FTSU Officers and FTSU Champions. The ICB adopted the national FTSU Policy and was receiving disclosures from ICB and primary care staff. Staff who disclose information were offered wellbeing support and anonymity is protected. The ICB HR team met regularly with the FTSU Champions to discuss promotion and embedding of this policy and the FTSU Guardian reported high level themes to the ICB Board.

Health and wellbeing

The ICB commissioned Optima to provide both the occupational health service and the Employee Assist Programme (EAP) service. During the organisational change process, a company called Renovo was commissioned to provide complimentary support for staff which included developmental sessions, coaching and career advice. These sessions were very well utilised. Their services were accessed over 550 times during the process. The ICB is committed to improving the health and wellbeing of its staff, having wellbeing conversations as part of regular one to one sessions and appraisals.

Equality, Diversity, and Inclusion (ED&I)

In November 2023, the ICB Board met to review the national ED&I High Impact Framework which required improvement evidence against 6 prescribed areas:

- Chief executives, chairs and Board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
- Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
- Develop and implement an improvement plan to eliminate pay gaps.
- Develop and implement an improvement plan to address health inequalities within the workforce.
- Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.
- Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

The ICB was working internally and with partners to create a comprehensive data set to evidence progress both as a system and as an ICB. The system ED&I group provided an opportunity to share best practice and to hold each other to account for delivery. In March 2024, the People Board undertook a deep dive into the inclusion data for MSE, as well as creating space to understand the lived experience of those staff that have protected characteristics acknowledging the intersectionality of all staff.

The ICB developed and published a Workforce Race Equality Standard (WRES) report and action plan that staff had the opportunity to contribute to and the ICB will further develop the Workforce Disability Equality Standard (WDES) report and action plan in 2024. These will be regularly monitored to ensure progress against agreed objectives.

The ICB also prepared and published a Pay Gender Gap Report which showed that both the ICB and the NHS still had a bias in the totality of what men and women earned.

Progress against these plans was and continues to be driven and monitored by the ICB Inclusion and Belonging Steering Group, Chaired by the Executive Chief Nursing Officer.

The ICB executive team participated in the MSE reciprocal mentoring for inclusion programme through the NHS Leadership Academy, a commitment that was made by the executive teams from across the system. This scheme will be refreshed and relaunched in 2024/25.

Health and safety

The ICB's Health and Safety Policy sets out responsibilities of the ICB and those of employees under the Health and Safety Work Act 1974. Health and safety, fire safety and manual handling were included in the mandatory training programme for all ICB staff.

Risk assessment and inspections identified health and safety issues for which action was taken to reduce risks to staff and other users of ICB premises. Although ICB staff continue to work in a hybrid way, regular health, and safety inspections, building system tests and maintenance continued throughout the year.

The ICB stress risk assessment was being updated, stress anxiety and depression was the highest cause of sickness absence in the ICB, the system and the NHS as a whole.

Trade union facility time reporting requirements

There was no Trade Union Facility Time in 2023/24.

Expenditure on consultancy

Administrative	£309k
Programme	£473k

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2024, for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2024	13
Of which, the number that have existed:	
for less than one year at the time of reporting	7
for between one and two years at the time of reporting	6
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB has confirmed that all existing off-payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2023 to 31 March 2024, for more than £245[(1)] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2023 to 31 March 2024	33
Of which:	
No. not subject to off-payroll legislation[(2)]	30

No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	3
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2023 to 31 March 2024:

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during reporting period[1]	0
Total no. of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the reporting period. This figure should include both on payroll and off-payroll engagements. [2]	21

Losses and Special Payments

There were no losses or special payments made during the year.

Exit packages, including special (non-contractual) payments [subject to audit]

Table 1: Exit Packages 2023/24

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£	Whole numbers only	£	Whole numbers only	£	Whole numbers only	£
Less than £10,000	-	-	4	29,991	4	29,991	-	-
£10,001 to £25,000	-	-	15	267,733	15	267,733	-	-
£25,001 to £50,000	1	44,018	22	771,172	23	815,190	-	-
£50,001 to £100,000	-	-	19	1,437,221	19	1,437,221	-	-
£100,001 to £150,000	3	394,405	8	943,819	11	1,338,224	-	-
£150,001 to £200,000	1	160,000	3	480,000	4	640,000	-	-
Over £200,001	-	-	-	-	-	-	-	-
Total	5	598,423	71	3,929,936	76	4,528,359	-	-

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change Section 16. Exit costs in this note are accounted for in full in the year of departure. Other departures related to Voluntary Redundancies as shown below.

Table 1: Exit Packages 2022/23 (July 2022 to March 2023)

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	3	45,440	0	0	3	45,440	0	0
£25,001 - £50,000	1	43,804	0	0	1	43,804	0	0
£50,001 - £100,000	3	199,040	0	0	3	199,040	0	0
£100,001 - £150,000	2	250,703	0	0	2	250,703	0	0
£150,001 –£200,000	4	640,000	0	0	4	640,000	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	13	1,178,987	0	0	13	1,178,987	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change Section 16. Exit costs in this note are accounted for in full in the year of departure.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	**71**	**3,390**
TOTAL	**71**	**3,390**

Parliamentary Accountability and Audit Report

MSE ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the financial statements of this report at page 31 of the Annual Accounts. An audit certificate and report is also included in this Annual Report.

ANNUAL ACCOUNTS

Tracy Dowling
Interim Chief Executive of Mid and South Essex Integrated Care Board

24 June 2024

Entity name:	NHS Mid and South Essex Integrated Care Board
	Statutory Accounts
This year	**1-Apr-23 to 31-Mar-24**
Last year	1-Jul-22 to 31-Mar-23
This year ended	**31-Mar-24**
Last year ended	31-Mar-23
This year commencing:	**01-Apr-23**
Last year commencing:	01-Jul-22

Contents

Statement of Comprehensive Net Expenditure for the year ended 31 March 24

	Note	**1-Apr-23 to 31-Mar-24 (1 Year) £'000**	1-Jul-22 to 31-Mar-23 (9 Months) £'000
Income from sale of goods and services	2	(47,564)	(10,386)
Total operating income		**(47,564)**	**(10,386)**
Employee benefits	4	38,110	28,205
Purchase of goods and services	5	2,703,294	1,842,034
Depreciation and impairment charges	5	462	505
Provision expense	5	(8,931)	4,043
Other operating expenditure	5	557	9,336
Total operating expenditure		**2,733,492**	**1,884,123**
Net operating expenditure		**2,685,928**	**1,873,737**
Finance costs	8	21	19
Other gains & losses	7	6	(6)
Total net expenditure for the year/period		**2,685,955**	**1,873,750**

The notes on pages 7 to 31 form part of this statement

Statement of Financial Position as at 31 March 24

	Note	1-Apr-23 to 31-Mar-24 £'000	1-Jul-22 to 31-Mar-23 £'000
Non-current assets:			
Right-of-use assets	10	2,195	2,815
Total non-current assets		**2,195**	**2,815**
Current assets:			
Trade and other receivables	11	17,736	9,644
Total current assets		**17,736**	**9,644**
Total assets		**19,931**	**12,459**
Current liabilities			
Trade and other payables	13	(143,315)	(166,301)
Lease liabilities	10	(285)	(216)
Borrowings (book overdraft)	14	(2,523)	(2,808)
Provisions	15	(1,396)	(5,538)
Total current liabilities		**(147,519)**	**(174,863)**
Total assets less total current liabilities		**(127,588)**	**(162,404)**
Non-current liabilities			
Lease liabilities	10	(2,125)	(2,729)
Provisions	15	(7,385)	(13,967)
Total non-current liabilities		**(9,510)**	**(16,696)**
Assets less liabilities		**(137,098)**	**(179,100)**
Financed by taxpayers' equity			
General fund		(137,098)	(179,100)
Total taxpayers' equity		**(137,098)**	**(179,100)**

The notes on pages 7 to 31 form part of this statement

The financial statements on pages 3 to 6 were approved by the Governing Body on 24 June 2024 and signed on its behalf by:

Interim Chief Executive Officer
Tracy Dowling

Statement of Changes In Taxpayers' Equity for the year ended 31 March 24

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for 2023-24 (Apr-23 to Mar-24)		
Balance at 01 April 23	(179,100)	**(179,100)**
Changes in ICB taxpayers' equity for 2023-24 (Apr-23 to Mar24)		
Net operating expenditure for the financial year	(2,685,955)	**(2,685,955)**
Net recognised ICB expenditure for the financial year	**(2,685,955)**	**(2,685,955)**
Net funding	2,727,957	**2,727,957**
Balance at 31 March 24	**(137,098)**	**(137,098)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23 (Jul-22 to Mar-23)		
Balance at 01 July 22	-	**-**
Changes in ICB taxpayers' equity for 2022-23 (Jul-22 to Mar-23)		
Net operating expenditure for the financial period	(1,873,750)	**(1,873,750)**
Transfers by absorption (from) other bodies	(92,271)	**(92,271)**
Net recognised ICB expenditure for the financial period	**(1,966,021)**	**(1,966,021)**
Net funding	1,786,921	**1,786,921**
Balance at 31 March 23	**(179,100)**	**(179,100)**

The notes on pages 7 to 31 form part of this statement

Statement of Cash Flows for the year ended 31 March 24

	Note	**1-Apr-23 to 31-Mar-24 £'000**	1-Jul-22 to 31-Mar-23 £'000
Cash flows from operating activities			
Total net expenditure for the financial year/period		(2,685,955)	(1,873,750)
Depreciation and amortisation	5	462	505
Movement due to transfer by modified absorption		-	(76,532)
Other gains & losses		6	(6)
Increase in trade & other receivables	11	(8,092)	(9,644)
(Decrease)/increase in trade & other payables	13	(22,986)	166,301
Provisions utilised	15	(1,793)	(254)
(Decrease)/increase in provisions	15	(8,932)	4,043
Net cash outflow from operating activities		**(2,727,290)**	**(1,789,337)**
Cash flows from investing activities			
Interest on right-of-use leases		21	19
Net cash inflow from investing activities		**21**	**19**
Net cash outflow before financing		**(2,727,269)**	**(1,789,318)**
Cash flows from financing activities			
Grant in Aid funding received		2,727,957	1,786,921
Repayment of lease liabilities		(403)	(411)
Net cash inflow from financing activities		**2,727,554**	**1,786,510**
Net increase/(decrease) in cash & cash equivalents	12	**285**	**(2,808)**
Cash & cash equivalents at the beginning of the financial year/period		(2,808)	-
Cash & cash equivalents (including bank overdrafts) at the end of the financial year/period		**(2,523)**	**(2,808)**

The notes on pages 7 to 31 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint Arrangements**

The ICB has not been part of any pooled budget arrangements in 2023-24. The ICB has operated Better Care Funds during 2023-24 under Section 75 agreements with Essex County Council, Southend City Council and Thurrock Council. The arrangements under which the Better Care Funds operated in 2023-24 do not constitute pooled budgets as the risks of each scheme remained with the respective commissioners. See Note 18 for further information.

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages, and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.10.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The long-term HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning, or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement of the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of book overdrafts, due to outstanding payments due to clear after year-end.

1.12 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.14 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.15.1 **Financial Assets at Amortised Cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover, had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical Accounting Judgements in Applying Accounting Policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
The ICB has operated Better Care Funds with Essex County Council, Southend City Council and Thurrock Council during 2023-24, under section 75 agreements. These arrangements have been reviewed and all parties have agreed these do not constitute pooled budgets, as the risks of each scheme have remained with the respective commissioner. See Note 18 for further information.

1.20.2 **Sources of Estimation Uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
Prescribing Creditor - The charges are a combination of Prescription Pricing Authority reporting currently having a time lag of two months which generates the main proportion of the balance and the time lag of the cash advance payments for prescribed drugs. The accrual is based on the estimated balance for 2023-24 that will be payable in 2024-25.

1.21 **New and Revised IFRS Standards In Issue but Not Yet Effective**

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.
The ICB does not anticipate any significant impact from the above Standards, that have not yet been adopted.
● IFRS 18 was issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM and therefore it is not yet possible to confirm how this will impact on our accounts in the future.

2 Operating Revenue

	1-Apr-23 to 31-Mar-24 (1 Year) £'000	1-Jul-22 to 31-Mar-23 (9 Months) £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	8,309
Non-patient care services to other bodies	9,961	915
Prescription fees and charges*	13,131	-
Dental fees and charges*	19,978	-
Other contract income	4,494	1,162
Total income from sale of goods and services	**47,564**	**10,386**
Total operating income	**47,564**	**10,386**

* The budget for the commissioning of Dental and Pharmacy services was delegated to the ICB in 2023-24.

3 Disaggregation of Income - Income from Sale of Goods and Services (contracts)

	Non-patient care services to other bodies	**Prescription fees and charges**	**Dental fees and charges**	**Other contract income**
	£'000	**£'000**	**£'000**	**£'000**
Source of revenue				
NHS	3,555	-	-	-
Non NHS	6,406	13,131	19,978	4,494
Total	**9,961**	**13,131**	**19,978**	**4,494**
Timing of revenue				
Over time	9,961	13,131	19,978	4,494

4 Employee Benefits and Staff Numbers

4.1.1 Employee Benefits

	1-Apr-23 to 31-Mar-24 (1 Year)		
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee benefits			
Salaries and wages	24,627	1,020	**25,647**
Social security costs	3,073	-	**3,073**
Employer contributions to NHS pension scheme	4,448	-	**4,448**
Other pension costs	87	-	**87**
Apprenticeship levy	118	-	**118**
Termination benefits	4,737	-	**4,737**
Gross employee benefits expenditure	**37,090**	**1,020**	**38,110**
Net employee benefits	**37,090**	**1,020**	**38,110**

	1-Jul-22 to 31-Mar-23 (9 Months)		
	Permanent Employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	18,879	2,937	**21,816**
Social security costs	1,975	3	**1,978**
Employer contributions to NHS pension scheme	3,006	1	**3,007**
Other pension costs	104	-	**104**
Apprenticeship levy	31	-	**31**
Termination benefits	1,269	-	**1,269**
Gross employee benefits expenditure	**25,264**	**2,941**	**28,205**
Net employee benefits	**25,264**	**2,941**	**28,205**

4.2 Average Number of People Employed

- Whole Time Equivalent (WTE)

	1-Apr-23 to 31-Mar-24		
	Permanently employed	**Other**	**Total**
Total number of people employed (WTE)	**428.61**	**19.22**	**447.83**

	1-Jul-22 to 31-Mar-23		
	Permanently employed	Other	Total
Total number of people employed (WTE)	**426.47**	**66.08**	**492.55**

4.4 Exit Packages Agreed in the Financial Year/Period

	1-Apr-23 to 31-Mar-24 Compulsory redundancies		**1-Apr-23 to 31-Mar-24 Other agreed departures**		**1-Apr-23 to 31-Mar-24 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	4	29,991	4	29,991
£10,001 to £25,000	-	-	15	267,733	15	267,733
£25,001 to £50,000	1	44,018	22	771,172	23	815,190
£50,001 to £100,000	-	-	19	1,437,221	19	1,437,221
£100,001 to £150,000	3	394,405	8	943,819	11	1,338,224
£150,001 to £200,000	1	160,000	3	480,000	4	640,000
Over £200,001	-	-	-	-	-	-
Total	**5**	**598,423**	**71**	**3,929,936**	**76**	**4,528,359**

	1-Jul-22 to 31-Mar-23 Compulsory redundancies		1-Jul-22 to 31-Mar-23 Other agreed departures		1-Jul-22 to 31-Mar-23 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	3	45,440	-	-	3	45,440
£25,001 to £50,000	1	43,804	-	-	1	43,804
£50,001 to £100,000	3	199,040	-	-	3	199,040
£100,001 to £150,000	2	250,703	-	-	2	250,703
£150,001 to £200,000	4	640,000	-	-	4	640,000
Over £200,001	-	-	-	-	-	-
Total	**13**	**1,178,987**	**-**	**-**	**13**	**1,178,987**

4.5 Analysis of Other Agreed Departures

	1-Apr-23 to 31-Mar-24 Other agreed departures		1-Jul-22 to 31-Mar-23 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	71	3,929,936	-	-
Total	**71**	**3,929,936**	**-**	**-**

4.6 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.
An outline of these follows:

4.6.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.6.2 Full Actuarial (Funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

5 Operating Expenses

	1-Apr-23 to 31-Mar-24 (1 Year) Total	1-Jul-22 to 31-Mar-23 (9 Months) Total
	£'000	£'000
Purchase of goods and services		
Services from other ICBs and NHS England	6,702	5,295
Services from Foundation Trusts	1,481,685	1,046,688
Services from other NHS Trusts	149,995	96,974
Services from Other WGA bodies	1	762
Purchase of healthcare from non-NHS bodies	457,335	352,257
Purchase of social care	590	87
General dental services and personal dental services	76,371	-
Prescribing costs	214,805	158,178
Pharmaceutical services	37,115	-
General ophthalmic services	11,759	3
GPMS/APMS and PCTMS	221,879	148,446
Supplies and services – clinical	68	52
Supplies and services – general	24,204	19,736
Consultancy services	782	1,287
Establishment	2,483	3,725
Transport	214	323
Premises	11,944	4,662
Audit fees	181	263
Other non statutory audit expenditure		
· Other services	90	33
Other professional fees	4,956	2,294
Legal fees	327	360
Education, training, and conferences	(192)	610
Total purchase of goods and services	**2,703,294**	**1,842,034**
Depreciation charges		
Depreciation	462	505
Total depreciation charges	**462**	**505**
Provision expense		
Provisions	(8,931)	4,043
Total provision expense	**(8,931)**	**4,043**
Other operating expenditure		
Chair and non-executive members	170	110
Grants to other bodies	363	9,112
Other expenditure	24	114
Total other operating expenditure	**557**	**9,336**
Total operating expenditure	**2,695,382**	**1,855,919**

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	**1-Apr-23 to 31-Mar-24 Number**	**1-Apr-23 to 31-Mar-24 £'000**	1-Jul-22 to 31-Mar-23 Number	1-Jul-22 to 31-Mar-23 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	57,325	847,172	42,108	523,153
Total non-NHS trade Invoices paid within target	55,645	788,329	40,563	495,465
Percentage of non-NHS trade invoices paid within target	**97.07%**	**93.05%**	**96.33%**	**94.71%**
NHS payables				
Total NHS trade invoices paid in the year	1,610	1,688,030	983	1,165,895
Total NHS trade invoices paid within target	1,541	1,683,761	929	1,161,666
Percentage of NHS trade invoices paid within target	**95.71%**	**99.75%**	**94.51%**	**99.64%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	1-Apr-23 to 31-Mar-24 £'000	1-Jul-22 to 31-Mar-23 £'000
Amounts included in finance costs from claims made under this legislation	1	-
Total	**1**	**-**

7 Other Gains and Losses

	1-Apr-23 to 31-Mar-24 £'000	1-Jul-22 to 31-Mar-23 £'000
Gain/(loss) on disposal of right-of-use assets other than by sale	6	(6)
Total	**6**	**(6)**

8 Finance Costs

	1-Apr-23 to 31-Mar-24 £'000	1-Jul-22 to 31-Mar-23 £'000
Interest		
Interest on lease liabilities	20	19
Interest on late payment of commercial debt	1	-
Total interest	**21**	**19**
Total finance costs	**21**	**19**

9 Net (Loss) on Transfer by Absorption

Transfers as part of a reorganisation are accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector.

	1-Apr-23 to 31-Mar-24 Total £'000	1-Jul-22 to 31-Mar-23 Total £'000
Transfer of right-of-use assets	-	3,357
Transfer of cash and cash equivalents	-	5,381
Transfer of receivables	-	9,015
Transfer of payables	-	(88,148)
Transfer of provisions	-	(15,696)
Transfer of right-of-use liabilities	-	(3,380)
Transfer of borrowings	-	(2,588)
Transfer of PUPOC provision	-	(19)
Transfer of PUPOC liability	-	(193)
Net loss on transfers by absorption	**-**	**(92,271)**

10 Leases

10.1 Right-Of-Use Assets

	Buildings excluding dwellings	**Total**	***Of which: leased from DHSC group bodies***
	£'000	**£'000**	**£000**
Cost or valuation at 01 April 23	3,452	**3,452**	3,141
Additions	63	**63**	63
Disposals on expiry of lease term	(311)	**(311)**	-
Cost/valuation at 31 March 2024	**3,204**	**3,204**	**3,204**
Depreciation 01 April 23	637	**637**	562
Charged during the year	462	**462**	447
Disposals on expiry of lease term	(90)	**(90)**	-
Depreciation at 31 March 24	**1,009**	**1,009**	**1,009**
Net book value at 31 March 24	**2,195**	**2,195**	**2,195**

	Buildings excluding dwellings	Total	*Of which: leased from DHSC group bodies*
	£'000	£'000	£000
Cost or valuation at 1 July 22	-	-	-
Transfer from other public sector body	3,499	**3,499**	3,141
Additions	76	**76**	-
Derecognition for early terminations	(123)	**(123)**	-
Cost/valuation at 31 March 2023	**3,452**	**3,452**	**3,141**
Depreciation 01 July 22	-	-	-
Transfer from other public sector body	142	**142**	123
Charged during the period	505	**505**	439
Derecognition for early terminations	(10)	**(10)**	-
Depreciation at 31 March 23	**637**	**637**	**562**
Net book value at 31 March 23	**2,815**	**2,815**	**2,579**

10.2 Lease liabilities

	1-Apr-23 to 31-Mar-24	1-Jul-22 to 31-Mar-23
	£'000	£'000
Lease liabilities at 01 April 23	(2,945)	-
Additions purchased	-	(76)
Interest expense relating to lease liabilities	-	(19)
Repayment of lease liabilities (including interest)	(20)	411
Lease remeasurement	403	-
Derecognition for early terminations	177	119
Transfer (to) from other public sector body	38	(3,380)
Lease liabilities at 31 March 24	**(2,347)**	**(2,945)**

10 Leases Continued

10.3 Lease Liabilities - Maturity Analysis of Undiscounted Future Lease Payments

	31-Mar-24	**Of which: leased from DHSC group bodies**	31-Mar-23	Of which: leased from DHSC group bodies
	£'000	**£000**	£'000	£000
Within one year	308	308	468	(382)
Between one and five years	1,216	1,216	1,675	(1,522)
After five years	974	974	899	(899)
Balance at 31 March 2024	**2,498**	**2,498**	**3,042**	**(2,803)**
Effect of discounting	(88)		(97)	
Total	**2,410**		**2,945**	
Included in:				
- Current lease liabilities	285		216	
- Non-current lease liabilities	2,125		2,729	
Total	**2,410**		**2,945**	

10.4 Amounts Recognised in Statement of Comprehensive Net Expenditure

	1-Apr-23 to 31-Mar-24	1-Jul-22 to 31-Mar-23
	£'000	£'000
Depreciation expense on right-of-use assets	462	505
Interest expense on lease liabilities	20	19
Expense relating to short-term leases	-	5

10.5 Amounts Recognised in Statement of Cash Flows

	1-Apr-23 to 31-Mar-24	1-Jul-22 to 31-Mar-23
	£'000	£'000
Total cash outflow on leases under IFRS 16	403	411

10.6 Narrative

Phoenix Court, Basildon

The leasing activities falling under IFRS 16 relate to the administration premises at Phoenix Court, Basildon and associated car parking for the ICB.

There are also the below charges relating to this lease, which are excluded from the calculation of the liability and asset.

- Rent Management Fees
- Rates
- Service Charge
- Facilities Management

The ICB receives an annual charging schedule from NHS Property Services in relation to these costs

Thurrock Borough Council Civic Offices

The leasing activities falling under IFRS 16 relate to the administration premises at the Thurrock Borough Council Civic Offices for the ICB.

There are also the below charges relating to this lease, which are excluded from the calculation of the liability and asset.

- Service Charge
- Landlord's costs
- Utilities

The ICB holds the lease directly with Thurrock Borough Council and ended the lease in June 2023 as part of the estate rationalisation.

Fair Havens Hospice

The leasing activities falling under IFRS 16 relate to office space at the Fair Havens Hospice for the ICB's use.

The lease for Fair Havens includes access to office space and associated working facilities. common areas, access routes, toilet facilities and car parking. The ICB holds the lease directly with Fair Havens Hospice and ended the lease in May 2023 as part of the estate rationalisation.

St.Edmund's Community Hall

The leasing activities falling under IFRS 16 related to car parking facilities at St.Edmund's Community Hall.

The ICB receives an annual charging schedule from NHS Property Services in relation to the costs.

Wren House

The leasing activities falling under IFRS 16 relate to the administration premises at Wren House, Hedgerows Business Park, Chelmsford for the ICB.

The ICB receives an annual charging schedule from NHS Property Services in relation to the costs and ended the lease in Sept 2023 as part of the estate rationalisation.

11 Trade and Other Receivables

	31-Mar-24	31-Mar-23
	£'000	£'000
NHS receivables: revenue	3,626	5,712
NHS accrued income	-	122
Non-NHS and Other WGA receivables: revenue	7,927	1,174
Non-NHS and Other WGA prepayments	795	2,255
Non-NHS and Other WGA accrued income	629	47
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	2,373	-
VAT	2,384	333
Other receivables and accruals	2	1
Total trade & other receivables	**17,736**	**9,644**

11.1 Receivables Past Their Due Date but Not Impaired

	31-Mar-24	**31-Mar-24**	31-Mar-23	31-Mar-23
	DHSC group bodies	**Non DHSC group bodies**	DHSC group bodies	Non DHSC group bodies
	£'000	**£'000**	£'000	£'000
By up to three months	99	1,409	(12)	31
By three to six months	372	177	-	2
By more than six months	(13)	9	63	10
Total	**458**	**1,595**	**51**	**43**

12 Cash and Cash Equivalents

	1-Apr-23 to 31-Mar-24 £'000	1-Jul-22 to 31-Mar-23 £'000
Balance at 01 April 23	(2,808)	-
Transfer from other public bodies under absorption	-	2,793
Net change in year / period	285	(5,601)
Balance at 31 March 24	**(2,523)**	**(2,808)**
Bank overdraft: Government Banking Service	(2,523)	(2,808)
Total bank overdrafts	**(2,523)**	**(2,808)**

The ICBs cash position is reported in the financial statements as a negative balance of £2,523k at 31 March 24 (£2,808k at 31 March 23), due to outstanding payments due to clear after year-end. As at 31 March 24, the ICB had a net positive balance deposited in its Government Banking Service bank account of £915k. (31 March 23 £2,023k)

13 Trade and Other Payables

	31-Mar-24 £'000	31-Mar-23 £'000
NHS payables: revenue	16,385	5,161
NHS accruals	2,342	13,853
Non-NHS and Other WGA payables: revenue	23,895	52,282
Non-NHS and Other WGA accruals	92,799	81,955
Non-NHS and Other WGA deferred income	1,195	271
Social security costs	342	374
Tax	428	353
Payments received on account	-	12
Other payables and accruals	5,929	12,040
Total trade & other payables	**143,315**	**166,301**

Other payables include £1,449k outstanding pension contributions at 31 Mar 24 (£1,720k 31 Mar 23).

14 Borrowings

	31-Mar-24 £'000	31-Mar-23 £'000
Bank overdrafts:		
· Government Banking Service	2,523	2,808
Total borrowings	**2,523**	**2,808**

15.1 Repayment of principal falling due

	31-Mar-24 £'000	31-Mar-23 £'000
Within one year	2,523	2,808
Total	**2,523**	2,808

15 Provisions	**Current 31-Mar-24 £'000**	**Non-current 31-Mar-24 £'000**	Current 31-Mar-23 £'000	Non-current 31-Mar-23 £'000
Restructuring	(0)	469	4,084	-
Legal claims	-	-	2	-
Continuing care	1,057	4,824	1,057	13,021
Other	339	2,092	395	946
Total	**1,396**	**7,385**	**5,538**	**13,967**
Total current and non-current		**8,781**		**19,505**

	Restructuring £'000	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2023	**4,084**	**2**	**14,078**	**1,341**	**19,505**
Arising during the year	469	-	745	1,344	**2,558**
Utilised during the year	(4)	(2)	(1,787)	-	**(1,793)**
Reversed unused	(4,080)	-	(7,154)	(256)	**(11,490)**
Balance at 31 March 2024	**469**	**-**	**5,882**	**2,429**	**8,780**
Expected timing of cash flows:					
Within one year	(0)	-	1,057	339	**1,396**
Between one and five years	469	-	4,824	2,092	**7,385**
Balance at 31 March 2024	**469**	**-**	**5,881**	**2,431**	**8,781**

Restructuring provisions

A restructuring provision has been made as the ICB have a requirement to reduce costs by 30%. Engagement on the restructure began during March 23. With the information available the ICB estimated the remaining potential one-off costs which could come to bear throughout 2024-25, as a result of decisions made during 2023-24. These costs are associated with displacement of staff, retraining or redeployment on the basis of the new organisational form.

Legal claims provision

A provision had been made for legal proceedings against an individual for the non-payment of debt, this has now been fully utilised.

Continuing health care provisions

Under the Accounts Direction issued by NHS England on 12 Feb 2014, NHS England is responsible for accounting for liabilities relating to NHS continuing health care (CHC) claims relating to periods of care before establishment of the CCGs/ICBs. However, the legal liability remains with the ICB and has been provided for.

An additional provision is included to cover the cost of reimbursing residents for CHC amenity top ups back to 2012 as per the national CHC guidance. The provision was calculated based on a year's packages extrapolated back to 2012 and reduced during Q1 2022-23 following further investigation and then released in full during 2023-24 as it is no longer required.

Other provisions

A provision has been created for dilapidation of rented buildings, estimated at 7.5% per year of occupation and for returning Brentwood Community Health to its original condition following the end of temporary arrangement to use the space for clinical purposes during covid.
A provision has been created following the Manchester ruling to cover the impact on providers that will require additional funding following this ruling. The Manchester ruling has found that healthcare assistants (HCAs) in hospitals across Manchester have been performing clinical duties that are above their pay grade.

16 Financial Instruments

16.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the ICB and internal auditors.

16.1.1 Currency Risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations and therefore has low exposure to currency rate fluctuations.

16.1.2 Interest Rate Risk

The ICB borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The ICB therefore has low exposure to interest rate fluctuations.

16.1.3 Credit Risk

Because the majority of the ICB revenue comes from parliamentary funding, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 Liquidity Risk

ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

16.1.5 Financial Instruments

As the cash requirements of ICBs are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with ICBs expected purchase and usage requirements and ICB is therefore exposed to little credit, liquidity or market risk.

16 Financial Instruments Continued.

16.2 Financial Assets

	Financial Assets measured at amortised cost 31-Mar-24 £'000	Total 31-Mar-24 £'000
Trade and other receivables with NHSE bodies	2,128	**2,128**
Trade and other receivables with other DHSC group bodies	3,019	**3,019**
Trade and other receivables with external bodies	9,411	**9,411**
Total at 31 March 24	**14,558**	**14,558**

16.3 Financial Liabilities

	Financial Liabilities measured at amortised cost 31-Mar-24 £'000	Total 31-Mar-24 £'000
Loans with external bodies	2,523	**2,523**
Trade and other payables with NHSE bodies	4,804	**4,804**
Trade and other payables with other DHSC group bodies	16,636	**16,636**
Trade and other payables with external bodies	122,321	**122,321**
Total at 31 March 24	**146,284**	**146,284**

17 Operating Segments

The ICB has only one segment; commissioning of healthcare services.

18 Joint Arrangements - Interests In Joint Operations

Better Care Funds

Essex County Council

The ICB has operated a Better Care Fund of £67,924k during 2023-24, together with Essex County Council under a section 75 agreement.

This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. This conclusion has been reached as both parties have retained the financial risks associated with each of the schemes as existed before the fund was set up. The arrangements for each scheme within the Better Care Fund have been reviewed to determine the appropriate accounting treatment by the ICB and agreed with Essex County Council.

Thurrock Council

The ICB has operated a Better Care Fund of £13,477k during 2023-24, together with Thurrock Council, under a section 75 agreement.

This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. The lead commissioner for the Better Care Fund (BCF) in 2023-24 was Thurrock Council. The Health and Wellbeing Board (HWB) was charged with responsibility for the BCF. The HWB delegated monthly monitoring to the Better Care Fund (BCF) Delivery Group which reports to the Thurrock Integrated Care Alliance (TICA). The TICA comprises senior executives across the ICB and Thurrock Council and was jointly chaired by the Alliance Director of the ICB and the Director of Adult Social Care from Thurrock Council.

Southend City Council

The ICB has operated a Better Care Fund of £15,977k during 2023-24, together with Southend City Council under a section 75 agreement.

This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. This conclusion has been reached as both parties have retained the financial risks associated with each of the schemes as existed before the fund was set up. The arrangements for each scheme within the Better Care Fund have been reviewed to determine the appropriate accounting treatment by the ICB and Southend City Council. Control of the commissioning arrangements has been key to determining the nature of each scheme within the fund.

Transforming Care Partnership

The ICB has also been a party to a Transforming Care Partnership section 75 agreement with Essex County Council. This agreement determines the arrangements for funds released from discharged long-stay in-patients with learning disabilities as identified by the national Transforming Care programme. The costs of health packages for this cohort of patients have been accounted for by the ICB on a net accounting basis as the ICB is acting as Principal. Where funding is released to Essex County Council to fund community packages for patients who have been discharged this would have been accounted for by the ICB on a gross accounting basis as the local authority is acting as Principal. The arrangement is not considered to be one of Joint Control as both health and community packages continue to be commissioned by the respective partners, the local authorities take the risk of releasable funding being insufficient for community packages and the role of health partners on the Transforming Care Partnership is one of oversight and to check that the fund manager is spending the funds on the agreed purposes.

19 Related Party Transactions

Details of related party transactions with individuals are as follows:
Part one - Transactions with board members and those with significant influence over the ICB.

Transactions with the chair, chief executive or members of the board of directors are shown in the remuneration report. There are no other individuals who are considered to meet the definition of related parties under IAS24 as interpreted by the GAM 2023-24

Part two - Transactions in relation to interests declared by Governing Board Members

		Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
		£'000	£'000	£'000	£'000
Mid & South Essex NHS FT	Matthew Hopkins, ICB Board Partner Member (MSE FT) Hannah Coffey, ICB Board Partner Member (MSE FT)	1,121,908	(1,370)	9,283	(166)
Essex Partnership University NHS FT	Paul Scott, Partner Member, Essex Partnership University NHS FT Frances Bolger, Interim Chief Nursing Officer	218,557	(10)	1,366	(10)
Essex County Council	Peter Fairley, Partner Member, Essex County Council	86,674	(26,924)	895	(2,159)
North East London NHS FT	Joseph Fielder, Non-Executive Member	56,257	(10)	801	(10)
Barking, Havering & Redbridge University Hospitals NHS Trust	George Wood, Non-Executive Member	40,410	-	-	(494)
Thurrock Council	Ian Wake, Partner Member, Thurrock Council Les Billingham, Partner Member, Thurrock Council	17,983	(7,683)	441	(3,228)
Southend City Council	Mark Harvey, Partner Member, Southend City Council	19,512	(9,873)	30	(509)
Suffolk and North East Essex ICB	Frances Bolger, Interim Chief Nursing Officer Peter Fairley, Partner Member, Essex County Council	11,325	(263)	2,966	(12)
UCL Partners Limited	Anthony McKeever, Chief Executive Officer	9,682	-	339	-
Princess Alexandra Hospital	George Wood, Non-Executive Member	2,153	-	-	-
Colne Valley Primary Care Network	Anna Davey, Primary Care Services Partner Member	1,740	-	-	-
West Suffolk NHS FT	Tracy Dowling, Interim Chief Executive Officer	905	-	19	-
Essex Cares	Peter Fairley, Partner Member, Essex County Council	653	-	2	-
Health Innovation East	Tracy Dowling, Interim Chief Executive Officer	-	(4)	-	(4)

Part Three - Transactions in relation to practices where the GP has been a member of Governing Body

		Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
		£'000	£'000	£'000	£'000
Coggeshall Surgery	Anna Davey, Primary Care Services Partner Member	876	-	-	-

Part Four - Material transactions in relation to Department of Health and Social Care Bodies

The Department of Health is regarded as a related party. During the year the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department:

Barking, Havering & Redbridge University Hospitals NHS Trust
Barts and the London NHS Trust
East of England Ambulance Service NHS Trust
East Suffolk and North Essex NHS FT
Essex Partnership University NHS FT
Hertfordshire Partnership University NHS FT
Mid and South Essex NHS FT
North East London NHS FT
NHS Business Services Authority
NHS England and Improvement
NHS Property Services

In addition, the ICB has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Essex County Council, Southend City Council and Thurrock Council.

Part Five - Department of Health and Social Care

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of the ICB.

We have reviewed the list of individuals and entities and the ICB does not have any material disclosable transactions with any of the entities.

20 Events After the End of the Reporting Period
There are no events after the end of the reporting period which will have a material effect on the ICB financial statements.

21 Remote Contingent Liabilities
The ICB didn't have any Remote Contingent Liabilities at 31 Mar 2024, (31 Mar 2023 nil).

22 Losses and Special Payments

	Total Number of Cases 1-Apr-23 to 31-Mar-24 Number	**Total Value of Cases 1-Apr-23 to 31-Mar-24 £'000**	Total Number of Cases 1-Jul-22 to 31-Mar-23 Number	Total Value of Cases 1-Jul-22 to 31-Mar-23 £'000
Compensation payments	-	-	1	1
Extra Contractual Payments	-	-	1	83
Total	**-**	**-**	**2**	**84**

23 Gifts
The ICB didn't have any Gifts, in the current year or prior period.

24 Fees and charges
The ICB didn't have any Fees and charges, in the current year or prior period.

25 Financial Performance Targets
ICBs have a number of financial duties under the NHS Act 2006 (as amended). NHS ICB performance against those duties was as follows:

	1-Apr-23 to 31-Mar-24 Target (1 Year) £'000	**1-Apr-23 to 31-Mar-24 Performance (1 Year) £'000**	**Duty achieved?**
Expenditure not to exceed income	2,756,859	2,734,586	Yes
Revenue resource use does not exceed the amount specified in Directions	2,708,228	2,685,955	Yes
Revenue administration resource use does not exceed the amount specified in Directions	25,442	24,129	Yes

	1-Jul-22 to 31-Mar-23 Target (9 Months) £'000	1-Jul-22 to 31-Mar-23 Performance (9 Months) £'000	Duty achieved?
Expenditure not to exceed income	1,901,009	1,884,136	Yes
Revenue resource use does not exceed the amount specified in Directions	1,890,623	1,873,750	Yes
Revenue administration resource use does not exceed the amount specified in Directions	20,580	20,579	Yes

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS MID & SOUTH ESSEX INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Mid & South Essex Integrated Care Board ("the ICB") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2024 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 April 2024 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud, including the internal audit function, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported. The new revenue streams of Dentistry and Pharmaceutical income are similarly transferred directly by NHS England and therefore has a limited opportunity for manipulation and as such we have not identified a significant risk in relation to these revenue streams.

We also identified a fraud risk relating to the liabilities and related expenses for purchases not being completely identified and recorded in response to the requirement for the system to meet their agreed plan for the year ended 31 March 2024, creating an incentive

for management to understate the level of non-pay expenditure compared to that which has been incurred and the opportunity to manipulate the period-end balance sheet expenditure items such as accruals in order to achieve this.

We also identified a fraud risk relating to the liabilities and related expenses for purchases not being accurately recorded, or not existing, or the entity not having a present obligation. This is in response to the incentive for management to bring forwards expenditure from 2024-25 to mitigate financial pressures in future periods through the opportunity to manipulate the period-end balance sheet expenditure items such as accruals in order to achieve this.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual entries to Cash and Cash Equivalents, Revenue and Expenditure.
- Selecting a sample of year end accruals and inspect evidence of the actual amount paid after year end and other supporting information in order to assess whether the accrual exists and has been accurately recorded.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and from inspection of the ICB's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

Firstly, the ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the ICB's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2023/24.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 47, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement,

including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 47, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Mid & South Essex Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and

Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Mid & South Essex ICB for the year ended 31 March 2024 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Emma Larcombe
for and on behalf of KPMG LLP
Chartered Accountants
c/o Fora
20 Station Road,
Cambridge,
CB1 2JD

24 June 2024