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 2024 – March 2025

Contents

Chair’s Foreword

As I write this foreword to our Annual Report for 2024-2025, I am acutely aware that while we have made important strides, we are also confronted by some of the most challenging times our NHS has faced.

It is a privilege to lead NHS Mid and South Essex Integrated Care System, where collaboration remains at the heart of everything we do, but the road ahead is undeniably demanding. This past year has brought its share of achievements, but it has also highlighted the enormity of the challenges still before us. We have seen advances in patient care, strengthened integration within our system, and continued progress in areas such as preventive care and mental health services.

We’ve worked tirelessly to improve access to care, whether through cancer screening or urgent care services. These are significant steps forward, and I am proud of what we have accomplished together.

However, we also face a stark reality. Our system, like the wider NHS, is under strain. The impact of COVID-19 is still being felt, with demand for services continuing to grow and a workforce that, despite tireless dedication, is stretched.

We are also grappling with significant financial pressures. In particular, the need to reduce our organisational running costs by 50 per cent in line with the ask from central government is a challenge we cannot ignore.

This target will require us to make difficult decisions, reimagine how we deliver, and work even more collaboratively across our system and beyond.

While we celebrate the progress we have made, we still have much work to do. Our performance in some critical areas, such as cancer care, remains below the levels we aim for.

The journey ahead is tough, and we must be realistic about the challenges we face, especially with the ongoing financial constraints. But I am confident in the resolve and resilience of our team, from our frontline staff to our leadership, to continue pushing forward, despite these pressures.

Looking to the future, the need for transformation has never been more pressing. We will need to work smarter, think more innovatively, and make hard choices to ensure we can continue to provide high-quality care to the people of mid and south Essex.

The changes ahead may be difficult, but they are necessary if we are to build a more sustainable, resilient health system for the long term.

I want to thank everyone who continues to work with us in this ambitious yet crucial journey. I am confident that we can meet the challenge and continue to build a system that serves our population well, both now and in the future.

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

23 June 2025

PERFORMANCE REPORT

Introduction with Tom Abell

Taking up the role of Chief Executive at NHS Mid and South Essex over the past year has been both a privilege and a deeply sobering experience. While there is much to be proud of across our system, there is no escaping the scale of the challenge we face, whether in meeting the care needs of our population, sustaining services under financial pressure, or transforming delivery models to meet rising demand and expectations. We have much to do.

Our system is under strain. Like the wider NHS, we are still managing the very real consequences of the COVID-19 pandemic, grappling with intense demand in urgent and emergency care, striving to recover elective performance, and facing a constrained workforce stretched across services. These issues are not easily solved, and progress will take time, perseverance, and difficult choices.

But amidst this complexity, there is also hope and resilience. I've seen extraordinary commitment from staff across our system—whether in primary care, acute hospitals, community and mental health services, local councils, or the voluntary sector. Collaboration across partners has deepened, and we are starting to lay the foundations for more integrated, preventative, and person-centred care.

This year we have made some important steps forward: continuing to embed neighbourhood working, accelerating digital innovation, targeting inequalities, and developing our medium-term plan to address the challenges health and care services face locally. But we also recognise that the public rightly expects better access, more joined-up care, and greater transparency—and we must meet that expectation by delivering improvement, not just ambition.

As we move forward, we will need to maintain a clear-eyed focus on our performance—celebrating progress where it is earned and being honest about where we must do better. Our financial reality demands tough decisions, and we will only succeed if we continue to act as one system, putting the needs of our population and workforce at the centre of everything we do.

Thank you to everyone who continues to play their part. It is not an easy time, and the coming year will involve significant change, but together we can create a system that is more responsive, more resilient, and better able to serve the people of mid and south Essex.

Tom Abell
Chief Executive Officer of NHS Mid and South Essex Integrated Care Board

19 June 2025

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.

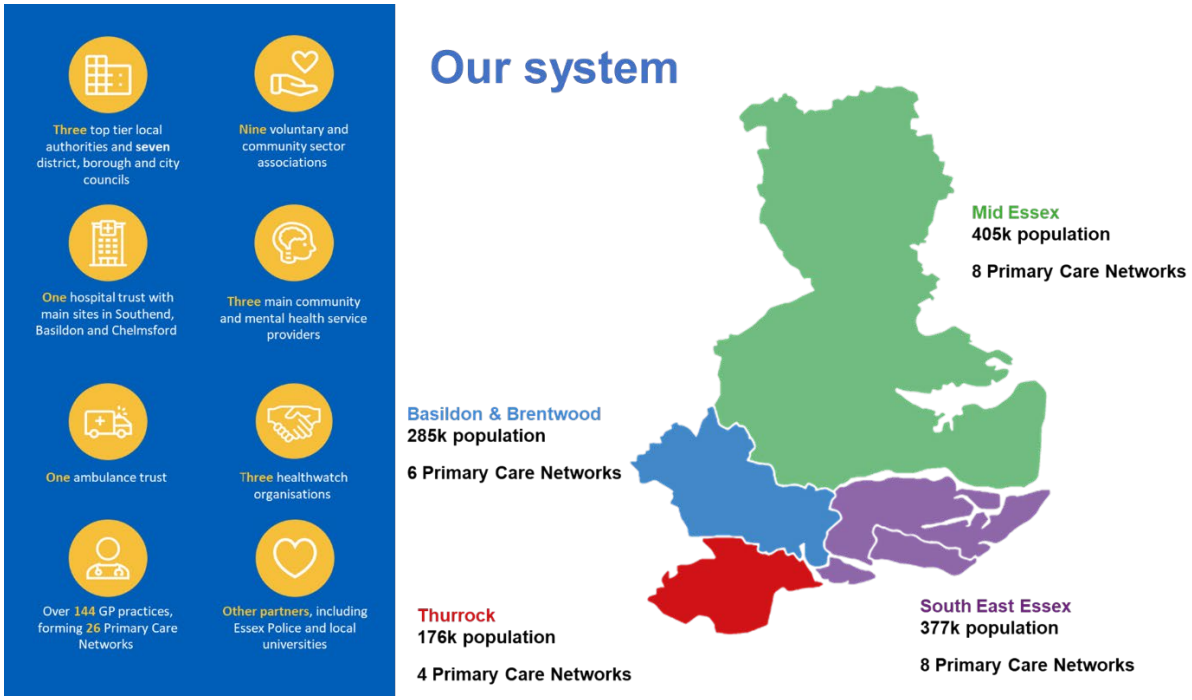
Following several years of locally led development, recommendations from NHS England (NHSE) and the passage of the Health and Care Act (2022), forty-two ICSs were established across England on a statutory basis on 1July 2022. The ICS is made up of two main Boards/committees:

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 24 local integrated neighbourhood teams (INTs).

Places: The areas covered by our four alliances in 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. 196 Community Pharmacies (as of March 2025). 107 Mandatory Service Providers of Optometric Services. 117 Primary Dental Providers and 15 Orthodontic Providers.

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 (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, refreshed in April 2024 and again in April 2025. 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] The refreshed plan (Section 2) provides the detailed assessment of the extent to which the ICB has exercised its functions in accordance with the plan, and highlights the work that has been delivered as a result, which is also reflected throughout this annual report.

Within the 2024-29 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:

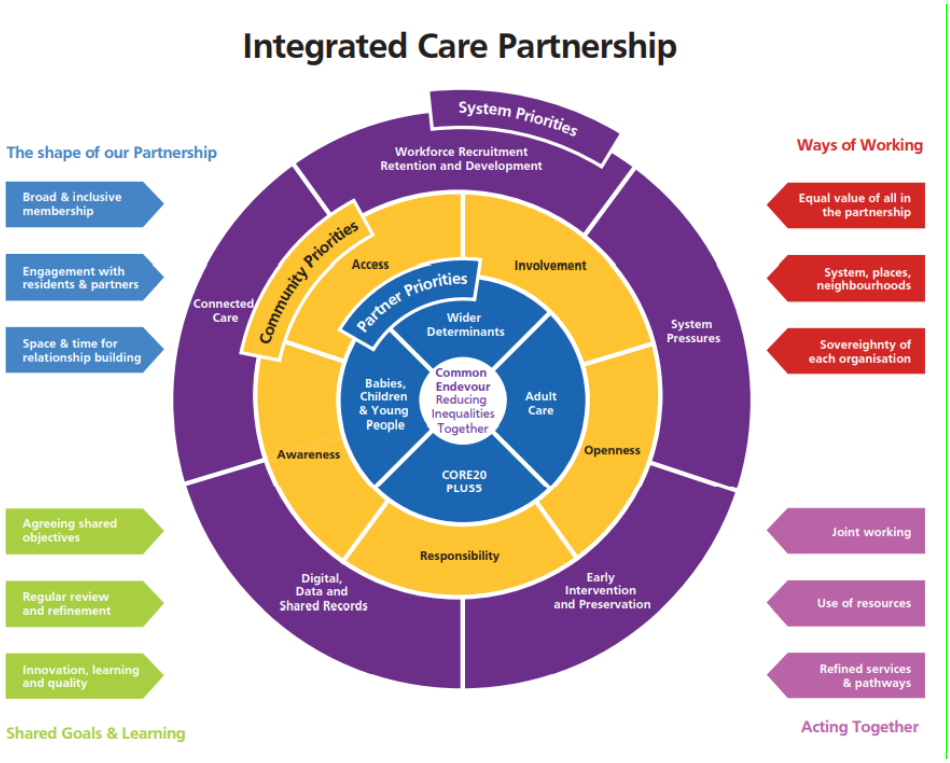
Let staff lead	Improve quality (access, experience and outcomes)	Supporting our workforce
Mobilising and supporting communities	Reduce health inequalities	Data, digital, technology
Further developing our system	Population health improvement	Financial sustainability
Improve oversight framework rating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

The April 2025 JFP refresh builds on the last 12 months efforts to recover the system in terms of quality, performance and financial sustainability. The NHS Medium-Term Plan (MTP), Operational Planning Guidance 2024/25 and the Reforming Elective Care Recovery Plan will be central in the delivery of our strategic ambitions listed above.

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. The delivery of the Joint Capital Plan is reported to the Mid and South Essex System Investment Group covering the ICB, EPUT and MSEFT Capital reporting and thus provides assurance that our duties regarding the plan are being discharged.

Our Common Endeavour

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



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

- 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 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.

Considering our strategic ambitions and the strategies and planning documents referred to above, the ICB set corporate objectives for 2024-25 as:

- To ensure that the MSE ICB and ICS deliver good quality health care and services within financial resource limits.
- To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.

- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement in staff survey results by March 2026.
- To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.
- To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.
- To be an exemplary partner and leader across mid and south Essex ICS, working with our public, patients and partners in the ICP to jointly meet the health and care needs of our people.

This annual report demonstrates the work undertaken by the ICB to achieve these objectives and manage their associated risks.

Review from 2024/25 and the year ahead

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

The sections below provide some examples of how we have redesigned care pathways to improve the way services work for our local communities, such as in emergency care and to reduce health inequality. We have invested in mental health, dentistry and general practice to deliver better access, recognising that there is more to be done. 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 a renegotiation during the year with NHS England. The outturn position for the system was a deficit of circa £16m.

During 2024/25 we appointed a joint Executive Director of System Recovery supporting our collective work to improve financial grip and control and to begin work on the fundamental changes to improve service efficiency.

The results of the ICB Staff Survey were a significant improvement on the previous year, with just under 80% of staff responding to the survey. There were increases in the percentage of staff who would recommend the ICB as a place to work, as well as high levels of satisfaction with flexible working arrangements, this is more fully described in the Staff Report section.

Recognising the further requirement for re-organisation, our focus for 2025/26 will be to deliver the ask of central government, while supporting our staff to continue their focus on delivery during these uncertain times. Undoubtedly this will further impact future staff survey results, but we are confident our staff feel supported by the senior leadership.

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.

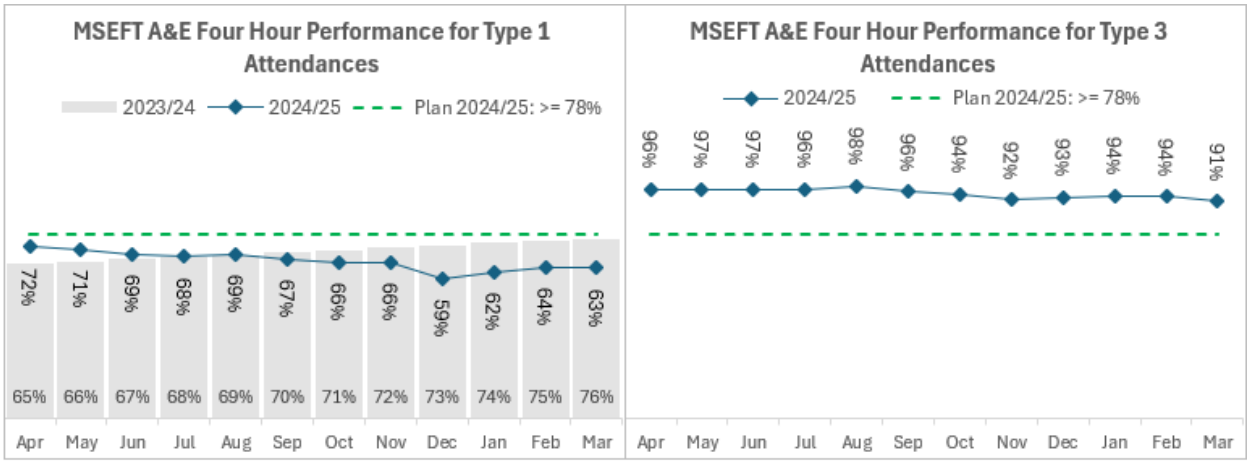
During 2024/25 the ICB, with partners, focused on recovery of performance. The section below outlines the 2024/25 achievement and delivery for MSE and incorporates case studies to demonstrate how the ICB has worked to improve performance and patient care.

Constitutional Standards

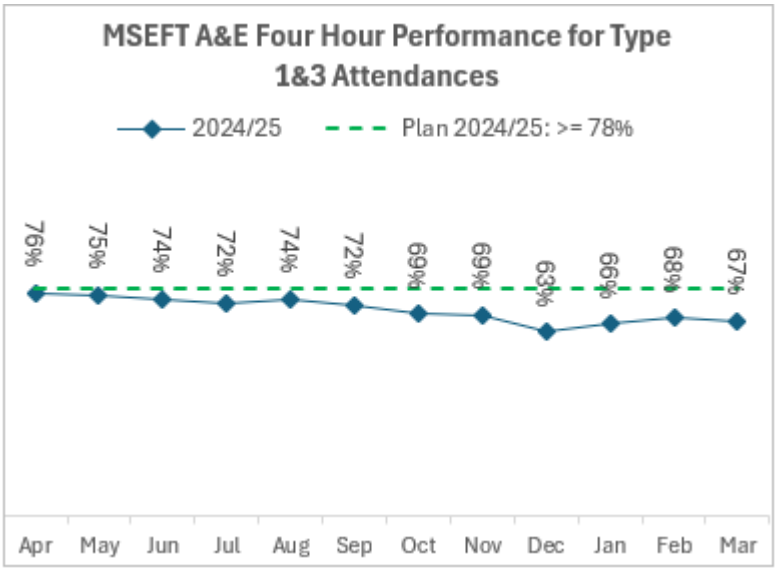
Urgent and Emergency Care (UEC)

In 2024/25, UEC planning for the accident and emergency (A&E) department four-hour standard (the proportion of patients who attend A&E departments who wait less than four hours from arrival to admission, transfer, or discharge) reflected the national operational planning ask to achieve 78% during March 2025. Recognising that the ICB uses other providers, the focus on Mid and South Essex NHS Foundation Trust (MSEFT) is because it is the main provider of accident and emergency services for our population.

The graph below shows the 2024/25 financial year performance for the A&E four-hour standard split between Type 1 (major) attendances and Type 3 (minor) attendances. Four-hour performance for Type 1 attendances did not achieve plan and below same period previous year from September 2024. Four-hour performance for Type 3 attendances remains circa 90% throughout 2024/25.



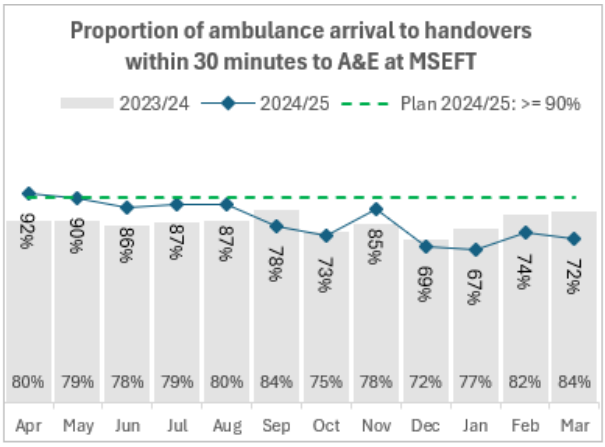
[1] NHS England » Priorities and operational planning guidance 2024/25

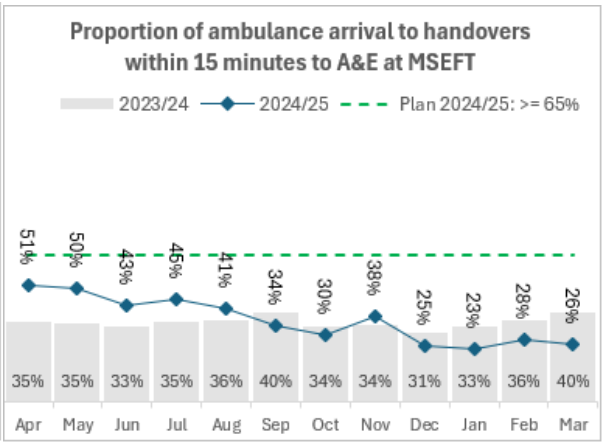


The UEC Improvement Programme is overseeing a number of schemes implemented specifically to impact the performance within A&E.

In addition, 89% of urgent community response calls were responded to within two hours during 2024/25 (above plan).

The ICB Urgent Emergency Care Board continues to work with partners, to further improve ambulance handover times. In 2024/25, 73% of ambulance handovers were completed in under 30 minutes (not meeting local system plan of >=90%) and 28% were completed within 15 minutes (not meeting local system plan of >=65%).



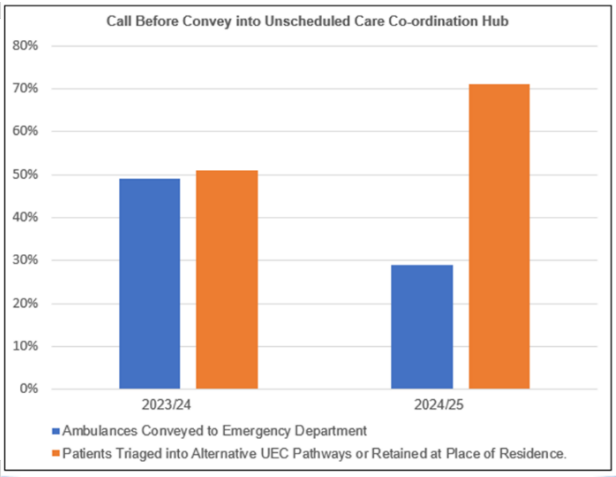


The Urgent Care Department for Mental Health and the Unscheduled Care Coordination Hub (UCCH) commenced in 2023/24; these have both supported the reduction in acute emergency admissions; with more patients receiving urgent care in their community. The continued impact of both schemes will be part of the 2025/26 programme of UEC work across the system.

Case study: Continued success of the Unscheduled Care Coordination Hub (UCCH)

2024/25: 29% of patients conveyed to the Emergency Department

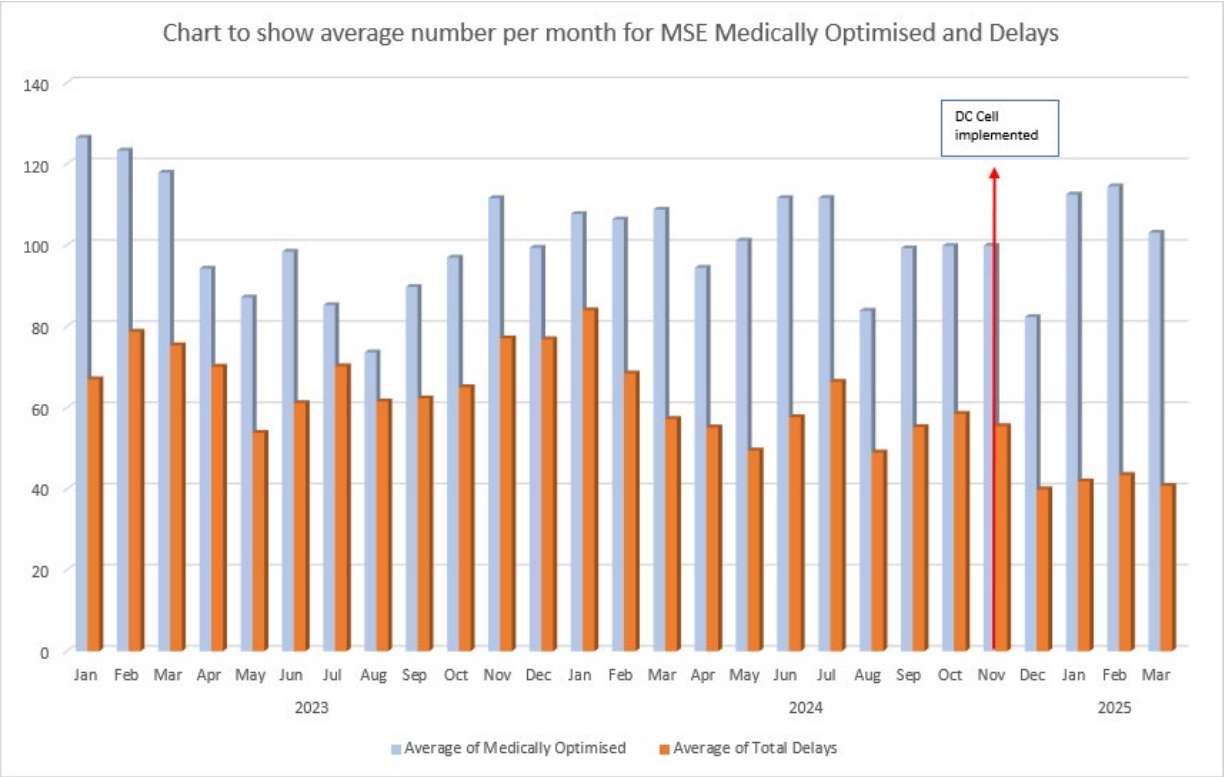
- Overall reduction in category 2, 3 & 5 ambulances conveyed to the Emergency Departments.
- Reduction in conveyances to the Emergency Department this winter due to **the enhanced** UCCH model and co-location with the ICB System Co-ordination Centre and ICS Discharge Cell.
- UCCH and EEAST collaboration to reduce conveyances from Care Homes commenced in January 2025.
- Further opportunities to increase referrals into the UCCH from 2025/26 with an enhanced MDT incorporating Urgent Community Response Nurse and NHS111 Clinician.



The System Co-ordination Centre (SCC) is a central point of co-ordination of all system partners to support the flow of patients through accident and emergency to discharge and to manage and co-ordinate incidents. It also includes the joining up of functions described herein to manage urgent and emergency care and is a conduit to the NHS England Regional Team. The SCC was established to oversee and coordinate responses to operational pressures across the MSE system, has been accredited by the NHS England national team. This accreditation recognises the SCC's exemplary collaboration and engagement with partners in managing surges in UEC activity. The SCC is frequently visited by partners and other regional and national organisations, highlighting its high-level operational standards.

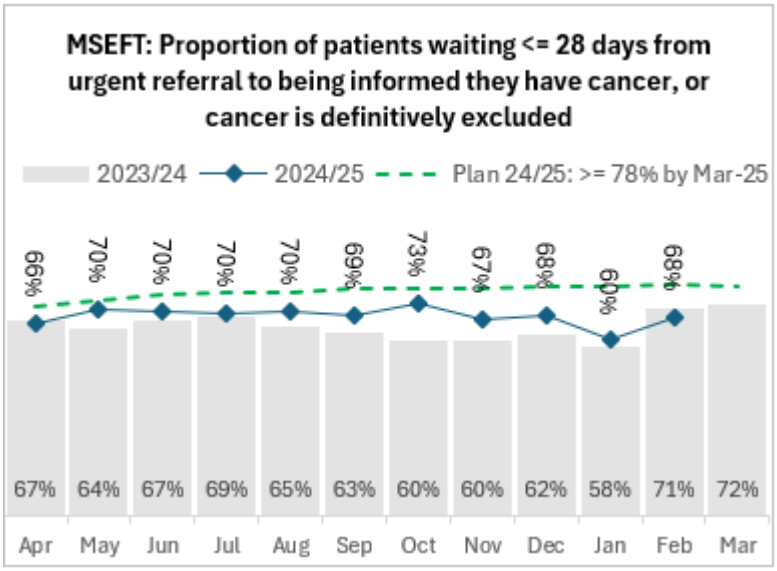
On 18 November 2024, the MSE system introduced a Discharge Cell, this brought together teams from across the local NHS to support discharge from hospital. The Discharge Cell has resulted in a significant reduction in hospital delayed discharges compared to 2023/24. The average discharge delays in 2023 and 2024 were 2072 and 1767 respectively compared to 1257 on average for the January to March 2025 period since the discharge cell was introduced.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Av.
2023	2075	2202	2334	2101	1666	1832	2174	1905	1867	2014	2310	2380	2072
2024	2601	1983	1772	1653	1532	1728	2056	1516	1655	1811	1662	1236	1767
2025	1296	1215	1261										1257



Cancer Care

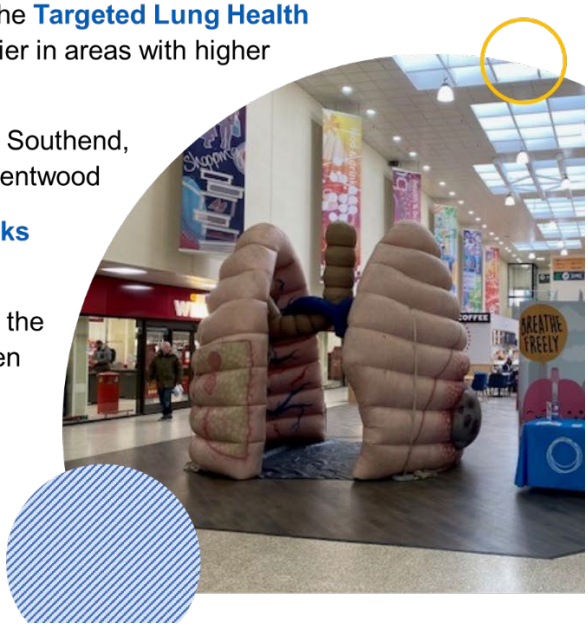
Performance against the 28 day faster diagnostic standard (patients waiting no more than 28 days from urgent referral to being informed they have cancer, or cancer is definitively excluded) reached 68% by February 2024, which is below plan.



Improving cancer care has been a priority of the ICB with new initiatives such as the targeted lung health checks project being expanded to cover Castlepoint and Rochford and Basildon and Brentwood, with plans to increase roll out to Mid Essex in 2025-26 so that the entire MSE population has access to this service in place to identify and treat lung cancer earlier.

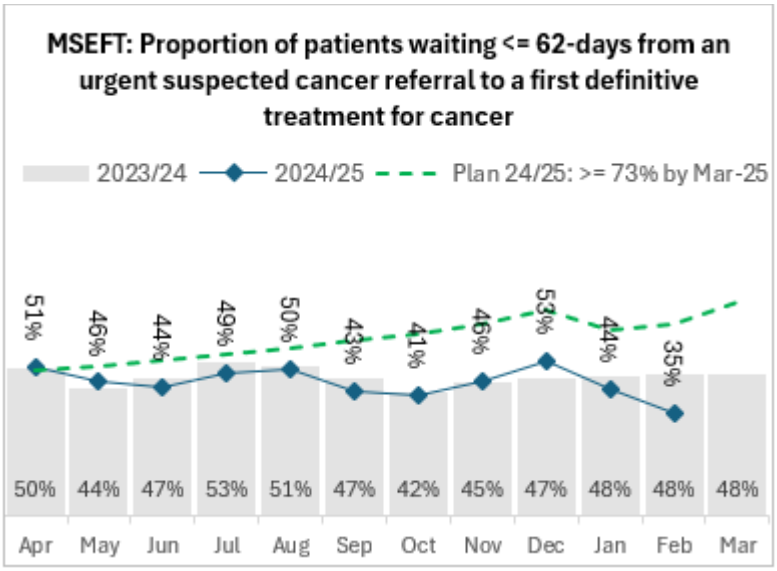
Case study: targeted lung health checks, improving patient care.

- As part of our work to address health inequalities, the **Targeted Lung Health Checks programme** is helping identify cancer earlier in areas with higher rates of smoking and incidences of lung cancer
- The checks began in Thurrock in 2020, followed by Southend, Rochford, Basildon and will be starting shortly in Brentwood
- As of October 2024, over **24,000 lung health checks** have taken place in the region.
- This has led to over **11,300 CT scans** for people at the highest risk. As a result, **163** lung cancers have been found of which **70% were stage 1 or 2.**
- https://www.midandsouthessex.ics.nhs.uk/news/saving-lives-by-finding-lung-cancer-early-targeted-lung-health-checks-programme/



We have also implemented a new teledermatology service, which has led to faster diagnosis and treatment of suspected skin cancer improving performance against the faster diagnostic standard for suspected skin cancer 74.5% (February 2025). 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.

Performance against the 62-day cancer treatment standard (patients waiting no more than 62 days from urgent suspected cancer referral to a first definitive treatment for cancer) decreased to 35% by February 2024, which is below plan.



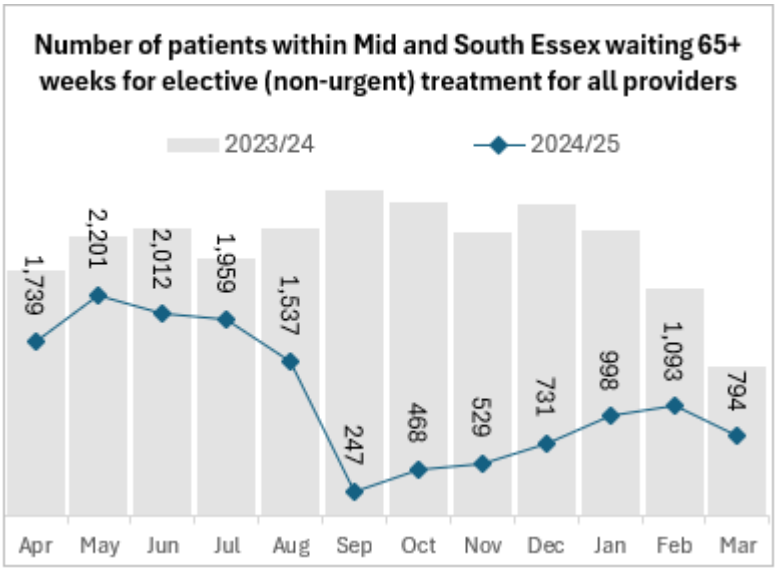
During 2024/25, the ICB and MSEFT met fortnightly with the national and regional NHSE teams to track delivery of the recovery of the System Cancer Backlog Plan. This will continue into 2025/26 to ensure sustained improvement of performance is achieved.

The ICB will continue to work with MSEFT to improve performance, acknowledging that there is significant further progress required to improve cancer access and achieve national expectations.

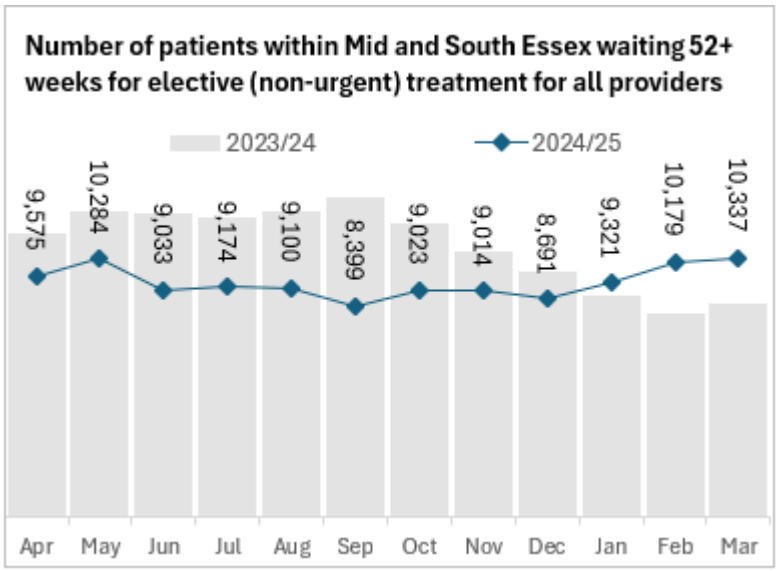
Mid and South Essex Cancer Board (including cancer alliance, patient representatives, specialised commissioning, and cancer stewards) has worked with MSEFT on a cancer improvement programme that supports clinical and service improvements, reduces waiting times, and improves patient experience across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

Elective Care Referral to Treatment (RTT)

In 2024/25, there were 945 fewer patients within MSE waiting over 65 weeks at all providers for their first definitive treatment and circa 4,000 more patients have completed their RTT admitted pathway compared to 2023/24.



The total number of patients waiting across providers has increased including the number of patients waiting over 52 weeks for their first definitive treatment.



During 2024/25 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.

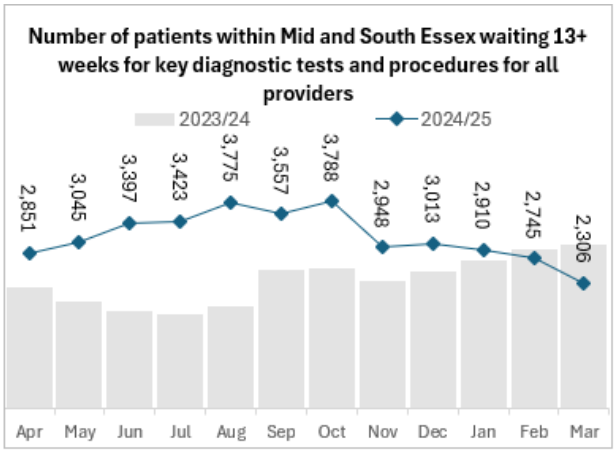
The ICB commissioned activity from both independent sector and community providers to support a reduction in referral growth at MSEFT.

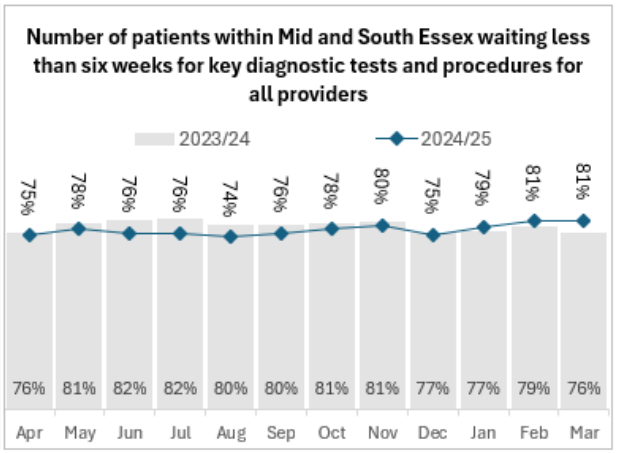
Diagnostics

During 2024/25, work continued via the ICS 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 95% of patients waiting less than six weeks for a diagnostic test and no patients waiting more than 13 weeks.

Identified risks to delivery were 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 26,900 more diagnostic tests were undertaken at MSEFT in 2024/25 compared to 2023/24.

There were 545 fewer patients within Mid and South Essex waiting over 13 weeks from referral to diagnostic imaging across all providers, and 81% of patients were waiting less than 6 weeks from referral to diagnostic test.





The MSE system has a programme to develop, implement and mobilise Community Diagnostic Centres (CDCs), as per the national expectation for systems. These CDCs 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 52,400 patients received their diagnostic test via the Mid and South Essex Community Diagnostic Hub.

Case study: Community Diagnostics – continuing our journey to improve diagnostic capacity

Continued progress in delivering plans for four **Community Diagnostics Centres** (CDCs) in Southend, Thurrock, Braintree, and Pitsea already in the building phases.

These centres will mean patients will receive **quicker diagnosis and treatment** from the NHS in line with the government's focus on reducing elective waiting lists.

We know people sometimes have to wait far longer for treatment than they should so in addition we are working hard to fix this, supporting the hospital trust to putt on **extra theatre sessions** and **improving our outpatient bookings** so fewer people miss their appointments.

Mental Health

The **Talking Therapy services** 6-week and 18-week waiting time standards for people referred to the Improving Access to Psychological Therapies (IAPT) programme had been sustainably achieved across MSE, exceeding the 95% target of people that should be seen within the waiting time standards. 53% of people achieved 'reliable recovery' through access to Talking Therapies. The Mental Health team continue to work closely with Alliances and PCNs to promote the uptake of access to Talking Therapies in the coming year.

The ICB continued to see an improvement in the number of patients with dementia who were diagnosed and added to the Dementia Register, with performance at 68% (February 2025). Alliances will support the continued growth of the Register size in the coming year, enabling the right support in place for more people living with dementia.

Across MSE, the Early Intervention in Psychosis (EIP) standard of people receiving a recommended package of care within 2 weeks of referral continues to be sustained during 2024/25, with MSE performance of 94% against the national target of 60% (as at February 2025).

The number of patients placed in an inappropriate bed (taken as a point in time at the end of each month) ranged between 20 and 46 average of 30 patients. Significant work has been undertaken to reduce the length of stay, therefore supporting better patient experience. This is to ensure more patients with serious mental illness receiving care closer to home.

People with severe mental illness (SMI) face a higher risk of developing physical health issues than the general population. Recognising this and the difficulties in improving the take-up of health checks over recent years, the ICB developed an improvement plan that was overseen by the Physical Health Improvement Group (PHIG). Working with community providers and general practice, a standard operating model was developed with a step-by-step guide to encourage a consistent approach to identifying patients and delivering the health checks. Co-production of leaflets and posters to promote the service and incorporating lived experience of patients has increased patient support and consequently overall delivery of health checks achieving 59% (as of December 2024) against the minimum national target of 60%. The Mental Health team

continues to work closely with alliances and PCNs to improve uptake and together have ensured that all practices have signed up to the new General Practice Extraction Service (GPES) (national data collection system) and continue to carry out home visits and expand outreach projects.

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

Case study: Mobilising Communities: Specialist Bereavement Service

During September 2024 a free Specialist Bereavement Service was launched, delivered by Amparo for residents in mid and south Essex, provides emotional and practical support for anyone who has felt the impact of suicide at any time (recent or historical).

The service is completely confidential and can provide short-term or longer-term support. It is also available to bereaved children (Aged between 4 and 11 with agreed appropriate adult) and young adults (Age 11 upwards).

Suicide has a far-reaching impact, leaving questions and concerns on many levels. Those directly affected are left with bereavement and loss, so it is important that help is on hand.

Experienced Liaison Workers, aim to make initial contact within 24 hours of a referral being received, offer residents:
Support in their homes or wherever is most comfortable to the resident.

- One to one individual support
- Help with any media enquiries
- Practical support when liaising with the Police or Coroners including preparing for and attending inquest
- Help overcoming feelings of isolation
- Appropriate contact with other local services that can help

All ICBs were required to plan to achieve the Mental Health Investment Standard in 2024/25 and were required to spend greater than or equal to the 2024/25 target spend number provided by NHS England.

The 2024/25 target spend was £229,720k and actual spend was £229,737k.

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**	**2024/25 £000's**
Mental health spend	£214,979*	£229,737
ICB programme allocation	£2,682,786	£3,148,202
Mental health spend as a proportion of ICB programme allocation	8%	7.3%

* the target spend was £215,008k.

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

Following delegation from NHS England, the ICB is responsible for the commissioning of general medical, pharmacy, optometry and dental services for the population of Mid and South Essex. This section of the report outlines the key focus of the ICB in the operation and development of those services.

Primary Care Strategy Review

During 2024/25, the Primary Care Commissioning Committee (sub-committee of the ICB Board) has been overseeing the development of a new Primary Care Strategy. In principle, the new Strategy will:

- Replace the strategy original developed in 2018 (and refreshed thereafter), to incorporate all primary care disciplines (medical, pharmacy, optometry and dental services).
- Seek to reinforce existing ICB plans for Integrated Neighbourhood Teams (INTs).
- Provide the local response to the Primary Care Access Recovery programme (PCARP), endorsed by the ICB Board in November 2023.

The Strategy will be finalised in 2025/26 and will aim to underpin the 'left shift' of services to be delivered (where appropriate) in the community and closer to home.

Improving access to Primary Care services

Consultation numbers in Primary Care continued to increase year-on-year. For the period April 2024 to February 2025 (most recently reported period) there were 6.4million consultations undertaken in Primary Care across MSE. This was an increase of over 230,000 t consultations compared to the same period in 2023/24. Face-to-Face consultations accounted for 3.9million of these (again, a year-on-year increase of nearly 43,000 consultations).

Timeliness of consultation was also an area of focus. Across MSE, 2.7million consultations were held on the same day the patient contacted a practice.

General Practice Estate

The Premises Cost Directions 2024, issued by the Department of Health and Social Care (DHSC) outlined the responsibilities of the ICB for supporting premises developments for General Practice. This can take different forms and be for proposals of varying scale from minor refurbishment through to full new builds/rebuilds. Whilst these projects are 'practice' led, the Alliance teams, along with the Primary Care and the Estates teams play a vital role in the development, quality assurance and approval of business cases, that ultimately progress through ICB governance and, where required, NHS England.

During 2024/25 £233k of Section 106 (S106) 'planning obligations' funding has been allocated to live projects, with a further £290k drawn down and spent on projects, a total of 9% of the overall S106 funding available across mid and south Essex.

This year has seen a number of achievements in the development of General Practice Estate through the joint working outlined above. Some examples of this are:

General Practice Estate	Project
Sutherland Lodge, Chelmsford	To refurbish and reconfigure the premises to provide additional clinical space, improve infection control, disability access and compliance. ICB Primary Care Estates funding also supported this project.
Sidney House & The Laurels Doctor's Surgery, Chelmsford	Support approved for additional clinical workforce, as well as funding for reconfiguration and adaptation of existing space creating additional clinical space.
Church Lane Surgery, Braintree	Approval to refurbish part of the practices first floor, allowing additional rooms for clinical consultation.
Chelmer Medical Partnership & Rivermead Gate Medical Centre, Chelmsford	Funding split across both practices to support refurbishment of existing space, to create additional clinical consultation rooms, and administrative support.
Coggeshall Surgery, Coggeshall	Creation of new rooms to support clinical consultations.
South Ockenden Health Centre & Stifford Clays Health Centre, Grays	Local Alliance funding has been deployed to update and refurbish formerly 'void' (unused) space in the health centres to create additional consulting rooms and offices for the extended practice, and PCN primary care workforce.

Connected Pathways

As part of our Primary Care Access Recovery Programme, practices and PCNs have continued to implement several initiatives to support patients better. All practices are now using cloud-based telephony, with many practices having upgraded to include a call back function so patients don't have to wait in a queue.

Over half of practices have implemented a 'total triage' system of appointment booking, encouraging use of digital contact to message their practice with their symptoms. This frees up telephone lines for those who cannot or choose not to use digital methods. All requests, whether online, via phone or walk-in, are reviewed by a clinician, ensuring each person is seen by the right clinician for their needs. Practice staff workload is consequently spread more evenly across the day rather than dealing with an 8am rush.

Self-referral services (for example for eye problems, mental health issues including suicide bereavement, pregnancy and maternity, lifestyle services and physiotherapy etc.) are available so patients do not need to contact their practice for a referral. Additionally, patients can also self-refer to services provided by community and

voluntary groups in Essex that can support people with more social concerns, via Essex Frontline (https://essexfrontline.org.uk/).

Expanding upon the work undertaken with GP practices, the Connected Pathways team are also working with Pharmacy and Optometry to improve access for our population.

Case study: Communications campaign supporting primary care access recovery

We launched our **"Get the Care You Need Quicker"** campaign in support of NHS England's delivery plan to recover access to primary care and to help drive behaviour change in how residents access local services.

The campaign **promotes different themes that are central to access recovery**, and which are helping patients access primary care services locally: self-referral pathways, pharmacy support, the NHS App (and other digital tools), the wider GP team, and the Modern General Practice Access model.

Through **news-led editorial, case studies, video, print and digital advertising**, the campaign is helping local audiences understand how general practice is evolving – with a focus on the tools and services that are helping patients access the care they need more quickly than traditional routes through their GP.

With a local GP as campaign spokesperson, we developed a video that through exclusive media partnership has generated further **significant free coverage in print and online**.

With over 40 editorial placements reaching over 1.5 million residents to date, the campaign leverages both print and digital communications to improve patients' access to primary care services and **build understanding about modern general practice**.

Pharmacy

The ICB continues to work closely with community pharmacies and the Local Pharmaceutical Committee as part of the wider Primary Care Access Recovery Programme.

The Pharmacy First Service (a national initiative) commenced on 31 January 2024; delivered by all pharmacies with a consultation room. From April to December 2024, a total of 17,296 electronic referrals were made to pharmacies and a significant number of patients were also signposted to pharmacies (data is not captured to monitor signposting). The Service offers diagnosis and medication for common conditions such as otitis media, impetigo, infected insect bites, shingles, sinusitis, sore throat and uncomplicated urinary tract infections. Raising awareness and training is increasing use of this Service and thereby freeing up capacity in general practice.

Alongside this, community pharmacies have delivered additional services such as blood pressure checks and contraception services, accessed through the Essex Sexual Health Service, as well as providing flu and COVID vaccinations.

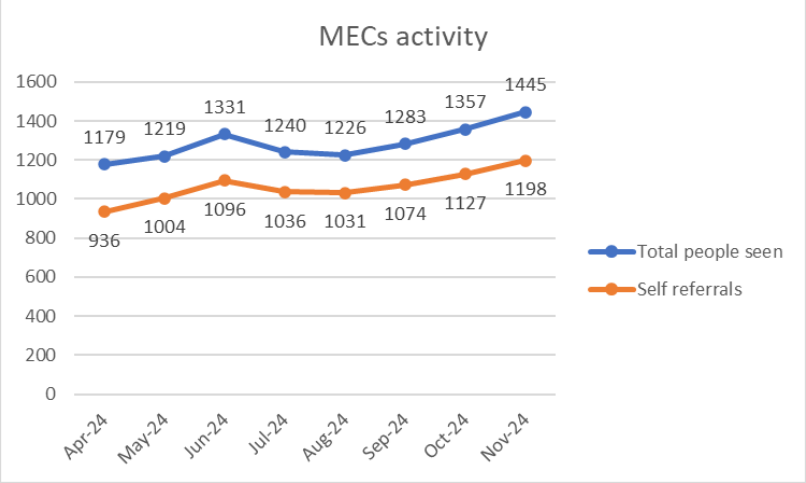
Mid and south Essex is one of the ICBs taking part in the Community Pharmacy Independent Prescribing Pathfinder Programme. The four pathfinder sites started their services from May 2024 and are based in Braintree, Benfleet, Westcliff and Tilbury. All four sites are now prescribing using paper prescriptions, supporting patients with immediate care needs who are not eligible for the Pharmacy First Service.

Consultation numbers to date are shown below:

Number of consultations completed 2024	Cross Chemist	Christchurch Pharmacy	Essex Pharmacy	Kalsons Chemist	Total
May	288	14			302
June	192	21			213
July	284	46			330
August	199	30		30	259
September	211	40		39	290
October	159	106		35	300
November	241	120	15	40	416
December	248	132	100	43	523
Total	1822	509	115	187	2633

Optometry

Optometrists are highly skilled (community based) primary care providers. Commissioned to provide the Minor Eye Conditions Services (MECS), they provide assessment and treatment for recently occurring minor eye problems through self-referral. This has recently been promoted as part of the 'Get the care you need quicker' campaign. Activity is steadily increasing as the chart below shows.



Dental Services

Following delegation for Dental Services in April 2023, the ICB has implemented several initiatives to improve access to dental services.

Urgent Access Pilot and additional Units of Dental Activity

Over 22,600 additional half hour appointments have been delivered during evenings, weekends and bank holidays to improve access to urgent dental care. 11 practices

offer evening (Monday to Friday) 3.5-hour sessions, several of these practices offer 5-hour sessions on Saturday, Sundays and bank holidays. Patients access the service by contacting NHS 111, who directly book an appointment at the nearest practice.

Additional investment has funded practices to deliver up to 110% of their contracted activity in 2024/25 allowing for a 10% increase of both mandatory dental services and Orthodontic treatment.

Care Home Pilot

Initially commissioned in November 2023, the Care Home Dental pilot uses Dentists, supported by Dental Care Professionals to visit care homes providing oral health advice, undertaking basic assessments and where intervention is required, it is delivered in situ by the Dental team and has significantly improved the wellbeing of residents.

As of April 2024, the pilot covers all 8,424 care home beds within MSE. Over 4,500 courses of treatment have been delivered to residents to date resulting in waiting list reductions from over 100 weeks to under 12 weeks.

Children and Young People Dental Pilot

A further dental pilot aimed at children and young people commenced in October 2024. This pilot focusses dental practice at the heart of both oral health instruction and prevention, delivering dental treatment, as clinically required.

Dental team members will ‘lift the lip’ referring children who need further intervention to a dental practice. Oral health instruction sessions will also be delivered in the practice to family groups.

This pilot also includes access for Looked After Children. To date 265 of the 325 schools within MSE have been linked with a dental practice, allowing greater access to dental services for children and young people.

Case Study: Dental in Care Homes

Sheila’s Story

Sheila a care home resident had not slept for 2 days and had been trying to pull her own tooth out in desperation. Sheila is 89 years old and is a lovely lady who just needed to access dental care. The dental team delivering the Care Home Pilot were able to treat Shela who is now pain free and able to eat and rest.

Case Study: Health Inequalities Child Oral Health

We launched the Thurrock Early Year Oral Health (EYOH) Improvement program at the end of January 2024.

Tooth decay is almost entirely preventable yet, it is the **number one cause of admission to hospital** for five to nine-year-old children. The ICB is working in partnership with local partners across Thurrock to deliver targeted interventions to promote and embed positive oral health of children and young people within Thurrock.

The Thurrock EYOH programme aims to address the **causes of poor child oral health**, which has resulted in children and young people in Thurrock experiencing:

- **High prevalence of dental decay in five-year-olds, with the highest prevalence seen in areas of less affluence.**
- **High incidence of admissions to hospital for dental extractions under general anaesthetic.**
- **Low rates of accessing dental services.**

Mid and South Essex Primary Care Training Hub

Funded by NHS England, the Training Hub is embedded within the ICB and supports recruitment, retention, and development of staff across primary care. It also supports wider strategic initiatives such as the Primary Care Strategy and the Access Recovery Plan.

Working with the newly established GP Provider Collaborative the Hub assists the delivery of our wider system ambition of reducing inequality, supporting the left shift from secondary to primary care and supporting new ways of working in primary care.

Some of our key highlights this year include:

- *Career Conversations Project:* Gathered insights from senior GPs to improve retention.
- *GP Training & Fellowships:* Including the Thurrock GP Enhanced Fellowship and MSE Thrive Fellowship for early-career GPs.
- *Portfolio Development:* Supports mid-to-late-career GPs in developing specialist skills, including palliative care roles with local hospices.
- *Nursing Career Pathway:* Clear training routes from Healthcare Assistant to Advanced Practice, supported by mentorship and fellowships.
- *Peer Group Support:* Funding of up to £500 to help GPs create supportive networks.
- *Student Placements:* Expanding opportunities to attract new nurses and improve training experiences.
- *Admin & Clerical Development:* New apprenticeship resources and training tailored to Primary Care teams.
- *Advanced Clinical Practitioner Support:* Strengthening supervision and development of Advanced Practitioners.

Lloyd George Record Digitisation Programme

In 2020 the ICB secured one-off funding of £1.6m from NHS England to digitise the "Lloyd George Records"; the formal legal patient records held in brown envelopes - in all GP practices across Mid and South Essex. Implementation was delayed due to Covid restrictions, but the digitisation programme has now been completed across all practices in MSE, with a final "mop up" phase underway to collect 20,000 non-digitised notes being held due to patients moving from non-digitised practices to digitised ones.

This programme enabled improved working areas and space for practices to deliver services in new ways, with better access to records for patients and staff. On current prices, the Programme has saved an estimated £15.7million capital with associated annual revenue costs between £804,000 and £1.14million, by using the freed-up space, which still provides further opportunity for expanded productivity in 2025/26.

Place based alliances

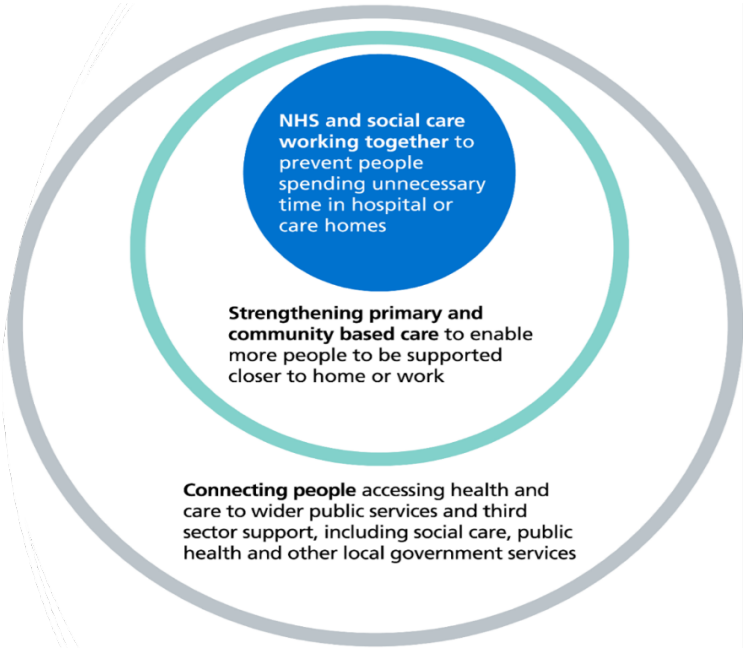
Alliances operate as the place-based delivery structures within ICBs, providing a framework for local health and care partners to collaboratively plan, commission, and deliver services that reflect the needs of their communities. Positioned at the heart of the ICS, Alliances are central to driving population health improvement, reducing health inequalities, and embedding prevention at scale. Through strong strategic relationships with system partners, voluntary sector organisations, and communities, Alliances enable tailored, data-driven, and neighbourhood-focused approaches to health and care transformation, ensuring national priorities are delivered through locally led, sustainable solutions.

Integrated Neighbourhood Teams

During 2024, the number of Integrated Neighbourhood Teams (INTs) increased from 9 to 23, with the final INT on target to be live by April 2025. Through the INTs, strong foundations and relationships with local partners have been created which aligns to the graphic below recently published by NHS England. This way of working looks to use the existing strengths in our communities and helps them to grow, providing opportunities for residents to improve their health and wellbeing and reduce health inequalities and social isolation.

What is an Integrated Neighbourhood Team

			
A multidisciplinary group of professionals from primary, community, secondary care, social care, third sector and local government organisations	The aim is to deliver more joined up, preventative care at a local neighbourhood level putting the resident at the centre of all decisions	Based on available impact data and an aging population across MSE the decision has been made for each INT to start with a frailty focus.	A key priority is to focus on high frequency users of health appointments including hospital admissions, emergency department attendances with a view to freeing up vital capacity.



Following results from several small-scale pilots, it was proposed that INTs work focuses on frailty and end of life for the next 12 months, areas where health and social care colleagues already work closely together. Our Ageing Well stewards have developed tools to support and further enhance this work, which also supports our priorities of prevention of ill health and reducing health inequalities. There are already examples of partnership working that has resulted in increased access to GP practices, reductions in Accident and Emergency attendances, reductions in readmissions to hospital and positive patient outcomes. During 2025/26, this work will be replicated across all Alliances.

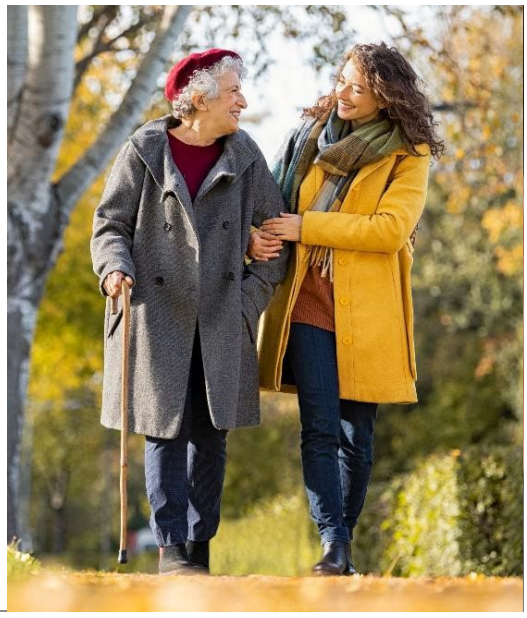
The case study below shows how 6 different organisations worked together through care co-ordinators to achieve a positive outcome for an individual in crisis.

Case Study: Coordinated care for a Patient in need of support

Teams involved: BERT, TOCH , Discharge Team, Rehab facility, OT, Nurses.

Prior to a patient's hip operation, the BERT social prescriber and care co-ordinator recognised that the patient required support at home but was embarrassed to accept help because of hoarding tendencies. Following the hospital procedure, it was agreed that it would not be safe for the patient to recover at home and arrangements were made for transfer to a community hospital where rehabilitation could take place safely. The BERT social prescriber had built a trusting relationship with the patient and relatives and led the co-ordination of support with partners including health, social care, local Council and voluntary sector. With consent the home was cleared, and a package of care and equipment were put in place to enable a safe return to home and follow up to ensure continued improvement.

The patient, relatives and staff involved were all pleased with the outcome which highlighted the benefits of working in such a co-ordinated way.



Transfer of Care Hubs (TOCHs)

MSE has 4 TOCHs, one per locality, working across Health and Social Care teams to support residents with complex care needs from the point of admission to ensuring that the person leaving hospital or being supported at home via virtual ward and the Urgent Community Response Team (UCRT) is on the correct pathway. Ultimately ensuring residents have a shorter length of stay and are discharged safely either to home or to an appropriate placement.

Our work to develop wider networks for our TOCHs across MSE has progressed over the last year to support our core objectives:

- It coordinates care/input during and following discharge and to prevent acute hospital admissions. For example, onward assessment or supervision post-discharge and reablement support; linking in with voluntary sector organisations.
- It is responsible for developing timely, person-centred 'step-down' or 'step-up' plans for people based on the principle of 'no place like home'
- It supports residents needing support on admission avoidance pathways, such as UCRT and virtual wards.
- It links community services and INTs.
- It makes the most of partnership working to link not duplicate teams through a multi-disciplinary team approach.
- It understands the user experience outcomes linked to services and uses the learning from this to improve.

Use of the 'Discharge Fund' has enabled a community run service; a collaboration between Provide Community Interest Company and MSEFT to support patients in addition to the TOCH service whereby 'welfare calls' are made to those discharged with no formal care requirements. The impact of the service can be seen in the case study below.

Case Study: The impact of welfare calls linked to discharge flow and TOCHs

A 65 year old man was admitted to hospital, staying less than 5 days, having minor investigations. At the time of discharge, he advised hospital staff that he was very keen to get home, he declined further support at home and consequently, following his wishes, he left without a care package.

A welfare call revealed that the gentleman lived alone, he advised he found the hospital quite overwhelming, noisy and busy which was why he declined further investigations and support. He was struggling to cope with both physical health decline and emotional challenges, including low mood.

Through the Provide Welfare call he was supported with practical help (food and shopping) and onward referral to support services for him to remain at home and was followed up with a call a week later to check his progress.

Without the service the gentleman may have declined further and felt isolated.

The service helps to reduce avoidable re-admissions, provides wrap-around support, gives advice/guidance and onward refers and has an improvement culture based on feedback from service users.

Health Inequalities – Working at Place

Through Alliance led delivery, the ICB is prioritizing its commitment to effectively utilise specific health inequality funding at local level to address disparities in health outcomes.

As part of a collaborative approach, Alliances have commissioned Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations to lead a *Trusted Partner* process. Under this model, VCFSE organisations are responsible for coordinating the application, assessment, and engagement process, ensuring it is inclusive, transparent, and responsive to local needs. Governance and decision-making for the allocation of funds remain the responsibility of NHS commissioners, maintaining accountability and compliance with statutory and financial frameworks.

In the 2024/25 funding round, 7 projects were approved in South East Essex (SEE) through a multi-agency panel-based approach. A total of 30 expressions of interest (EOI) were received with 14 going on to submit a full bid, 80% of the EOI were from the VCSFE sector. The 7 approved projects span both adult and children and young people (CYP) initiatives including CYP mental health, sensory hearing aid support, cancer screening for people with learning disabilities and autism, physical activity and family support services.

Digital, data, technology, and business intelligence

In our journey of delivering the strategic ambitions for digital, data and business intelligence, we have continued progress across our four strategic programmes of work to support innovative solutions to improving patient care both in and out of hospital:

- Data and business intelligence.
- Patient Knows Best.
- Shared Care Record.
- Unified Electronic Patient Record.

For **data and business intelligence**, the strategic data platform allows partner organisations within local authority, primary and secondary care to access systemwide, linked data. This enables data-driven decision making, ensuring impactful interventions that can change lives.

Since launching **Patient Knows Best** (PKB) in February 2023, over 211,538 people have registered for accounts and we have uploaded c.412k appointments, 121k radiology results and 40k documents, all available for the patient to view directly in the app. The digital patient interface integrates with the NHS App, providing our patients with a digital front door to access their records. Further enhancements in 2025/26 aim to create bespoke spaces within PKB that can offer patients access to a library of information relevant to care, the ability to receive questionnaires, develop care plans jointly or send and receive messages with their clinician.

The successful procurement of our **Shared Care Record** (SCR) last year is reducing the need for patients to repeat information to different care professionals, enhancing care with readily available information, supporting our staff wellbeing with up-to-date information that aids effective and efficient decision making about a person's care. It also supports efficiencies for our system by minimising wasted community visits. It contains data from 145 GP practices, our acute trust, mental health and community services, adult social care, our 111 provider and links out to neighbouring shared care records, providing partners with access to data previously unavailable to them. With over 7,000 users, the system has supported nearly 300,000 moments of care by enabling access to centralised patient records from our partners. This has been extended to facilitate the retrieval of additional information from organisations across the East of England and Greater London. Clinical leads have used this capability over

48,000 times so far. Clinical and operational teams are feeding back examples of improvements in care provision and efficiency helping to demonstrate its growing impact across the ICS.

We are progressing well in our journey to a **Unified Electronic Patient Record** (UEPR), having selected Oracle Health as our supplier (after a comprehensive procurement process involving over 300 colleagues across our ICS). The UEPR will span acute, mental health and community health services in MSEFT and EPUT. The new UEPR will build on the work of current digital transformation programmes like the SCR and will improve service delivery through safer, smarter and more connected care. Over the next year the programme will concentrate on its initiation and EPR design in preparation for our intended 2026/27 'go live'.

The case study below demonstrates how we have implemented the principles we are seeking in our PKB, UEPR and SCR in making that step change improvement in care.

Case study: Digital, Data and Technology: Electronic Care Coordination System

At their core, the main purpose of EPaCCS is to **improve the quality of care for people near the end of life**. The registers achieve this by making sure that the person's needs, wishes, and preferences are properly recorded and easily accessed by professionals involved in their care.

As data sharing platforms, EPaCCS increase the visibility of people with palliative and end of life care (PEoLC) needs. They allow for valuable information about a person's care needs and wishes to be **shared across multiple organisations**, whether it is a care home, primary care, a community service, or emergency services.

People that benefit most from EPaCCS are those within their last year(s) of life. As they are living with a severe, life-limiting condition, they are likely to have contact with multiple care providers. Having their **personal choices, priorities and goals for care** recorded and easily accessible means they can get the most appropriate care in line with their wishes. The information recorded might include details like current palliative medication being taken, preferred place for care and personal decisions on resuscitation.

Having access to this information helps professionals improve the end-of-life experiences of people in their care. It can help **prevent delays** in care or **avoid unplanned and unwanted urgent care or hospital admission,** and it helps ensure patients' wishes are respected.

Improve quality

The ICB has a statutory duty to continuously improve the quality of healthcare services, ensuring better prevention, diagnosis, and treatment of illnesses for residents. This includes the effectiveness and safety of healthcare services, and the overall experience of patients and families. The Nursing and Quality Directorate plays a vital role in delivering these responsibilities by working closely with healthcare providers, system partners, and local communities to improve care and patient experience through collaboration, oversight, and assurance.

Throughout 2024/25, we have strengthened our approach to quality monitoring and improvement. The MSE System Quality Group and Quality Committee have played a key role in ensuring that the voices of residents and patients remain at the heart of decision-making. By listening to patient feedback and working with healthcare partners, we continue to shape services that meet the needs of our communities.

To enhance oversight and accountability, we are developing robust quality data dashboards. These dashboards enable us to identify trends, monitor service effectiveness, and make informed decisions to drive improvements.

In response to urgent concerns regarding the safety and quality of a service, we commission Rapid Quality Reviews; a focused approach that enables us to quickly assess and address areas of concern. This proactive measure ensures that issues are identified early, and actions are taken to improve patient safety, care standards, and overall patient experience.

Our commitment remains firm, to work collaboratively with patients, families, and healthcare providers to create a safe, effective, and compassionate healthcare system for all in MSE.

Areas of ongoing focus include:

All Age Continuing Care

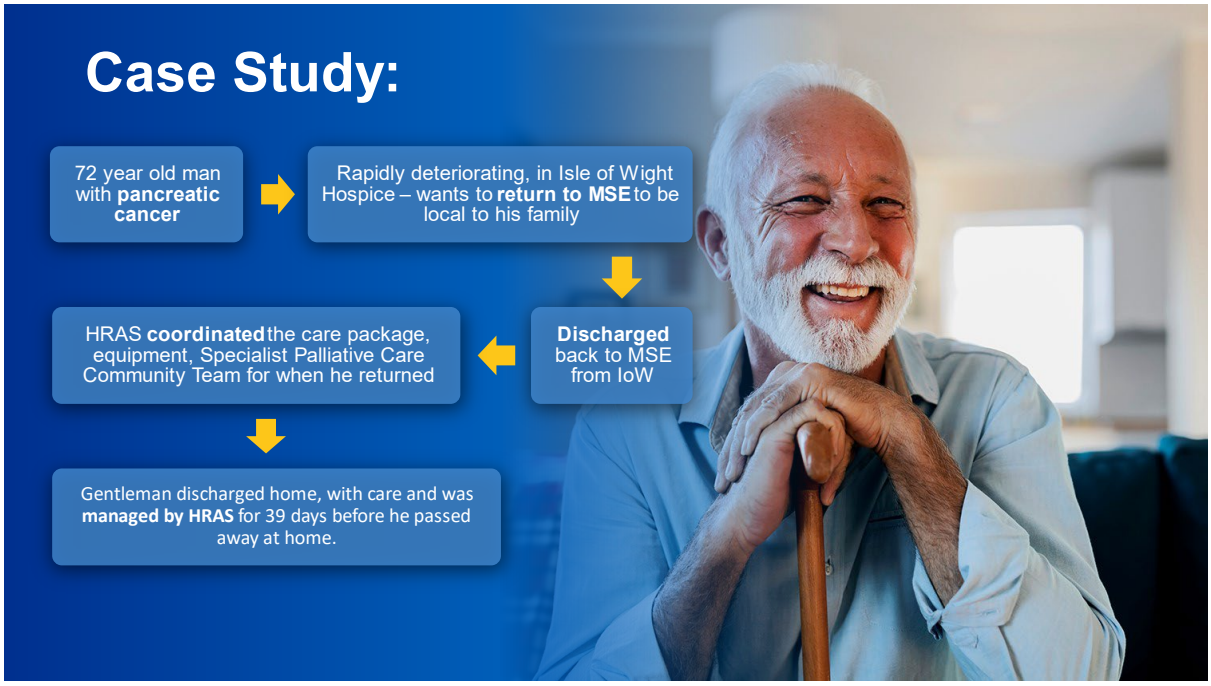
Throughout 2024/25 the All Age Continuing Care (AACC) team has focused resources on ensuring that people are assessed for eligibility for NHS Continuing Healthcare, Funded Nursing Care and Children and Young People's Continuing Care funding in a timely manner.

A key element of this is the assessment of adults who are discharged from hospital on a health 'Discharge to Assess Pathway' (DTA). This Pathway offers an opportunity for an adult to continue with their care outside of a hospital environment where they can be assessed for their longer-term needs. In MSE we recognised that adults could reach their optimum health by offering care and support differently and in late 2024 we commenced a pilot focusing on the impact of providing therapy whilst supported on a DTA pathway. Early evaluation of this pilot is due in Spring 2025.

Hospice Rapid Access Service

The ICB continues to provide the Hospice Rapid Access Service (HRAS) for adults with a deteriorating condition and a primary health need. The three MSE hospices: Farleigh, Havens, and St Luke's, assess the individual to enable them and their families to receive person-centred care. The hospices lead and co-ordinate the adult's/family's access to holistic care and support through networks that include hospices and other services. This enables people to be cared for and supported at home, in a care home or within the hospice inpatient unit (dependent on their wishes and clinical need). This service continues to grow with 11% more bed nights in April 2025 than in April 2024 and 9% more domiciliary care hours provided in April 2025 than the same time in 2024 (latest data). The HRAS service continues to work closely with the AACC team to ensure adults receive the right support at the right time.

Case study: The benefits of a hospice rapid access service



Special Educational Needs and Disabilities (SEND)

During 2024 the ICB strengthened its strategic collaboration with local authorities, Community Health Providers and other key partners across the MSE SEND system. New forums for joint commissioning across Southend, Essex and Thurrock were established, shared objectives were agreed with the ICB to reduce variation, leading to the development of an integrated health and education SEND Data Dashboard.

The ICB Designated Clinical Officer (DCO) continues to engage with health professionals across Community Health Providers, through audit and quality assurance activities to improve the quality of health advice provided for Education, Health and Care Needs Assessments. This work ensures that all decision-making is considered from a multi-disciplinary approach. The DCO supports Education teams to identify challenges and barriers to ensuring that Education, Health and Care Plans (EHCP) accurately capture the health needs of children and young people.

It is recognised that further work is necessary to improve the delivery of EHCPs within statutory timeframes across MSE. The ICB's decision to recruit additional DCO capacity will support collaborative working with partners across Southend, Essex, and Thurrock, to implement the agreed SEND Strategies that will improve the timely support provided to our most vulnerable children, young people, and their families.

Patient Safety

Over the past year, we have made considerable progress in enhancing patient safety. All our healthcare providers now follow the Patient Safety Incident Response Framework (PSIRF), a unified approach to managing and learning from safety incidents. This Framework helps us learn from incidents and implement changes to prevent them in the future.

In October 2024, we hosted a Patient Safety Summit with over one hundred participants from various health and care sectors. The event was supported by national and local organisations. The insights inspired attendees and reinforced our shared commitment to patient safety.

We have taken several steps to strengthen patient safety, collaboration and learning across organisations. Meetings to discuss learning from safety incidents increased from three to six times a year, an ICS Learning from Deaths Forum has been established, where organisations come together to share insights and lessons learned from patient deaths. Two new patient safety improvement programmes have commenced; one focussing on improving communication with end-of-life patients who have pressure ulcers, ensuring compassionate and effective care and one setting out ways to improve pathways of care for patients at risk of acute physical deterioration or who are deteriorating, through better Prevention, Identification, Escalation, and Response (PIER).

Through these initiatives, we continue to demonstrate our strong commitment to patient safety. By collaborating, sharing knowledge, and continually seeking improvements, we are making healthcare safer for everyone in MSE.

Infection Prevention and Control

The Infection Prevention and Control (IPC) team have continued with supportive oversight, assurance and collaboration with system partners relating to all relevant IPC guidance. Healthcare associated infections such as Meticillin Resistant Staphylococcus Aureus Bacteraemia (MRSAB) have remained consistent with last year's reporting and Clostridioides Difficile infection cases have reduced in the acute setting. 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.

The IPC team continue to work collaboratively with regional and national colleagues and particularity during times of managing incidents and outbreaks.

Quality Oversight and Assurance

All members of the Quality team have continued to work closely with providers to support them in preparedness for Care Quality Commission (CQC) inspections. Current CQC ratings of main providers are outlined below:

Provider	**Rating**
Mid and South Essex NHS Foundation Trust (MSEFT)	Requires Improvement
Essex Partnership University NHS Foundation Trust (EPUT) Mental Health Services	Requires Improvement

Provider	Rating
Essex Partnership University NHS Foundation Trust (EPUT) Learning Disability Services	Requires Improvement
Essex Partnership University NHS Foundation Trust (EPUT) Community Services	Good
East of England Ambulance Service NHS Trust	Requires Improvement
Provide Community Interest Company	Outstanding
North East London NHS Foundation Trust Community Services	Good

Mid and South Essex Foundation Trust (MSEFT)

The Quality team regularly visits all clinical areas within MSEFT to assess the quality-of-care provision. These planned quality assurance visits enable us to observe what is working well and where improvements are required. If concerns are noted, we take quick action through our 'emerging concerns protocol', ensuring that any risks to patient care are addressed as soon as possible. The team continues to remain responsive to concerns that are raised through other channels, such as the CQC, Healthwatch and nationally published reports and inquiries. As an example, we have undertaken quality visits to the mortuaries within MSEFT, to ensure that the recommendations from the Fuller Inquiry have been actioned. This is a crucial step in making sure that dignity, respect, and high standards of care are maintained for patients after they have died.

In addition, the monthly ICB Quality, Contracting and Performance Review (QCPR) meeting supports the triangulation of information relating to quality and patient safety with the ICB Commissioning and Contracting teams.

The team and wider ICB continues to support MSEFT with initiatives that improve patient experience, highlighted in the following case study.

Case study: Improving Patient Care – emergency department expansion

In August 2024 an £8.5 million **expansion of Southend Hospital's Emergency Department** commenced.

Improvements will include a **dedicated paediatrics area**, linking it to the existing children's ward and creating a better experience and calmer environment for children coming into hospital.

Treatment areas, waiting rooms and resuscitation areas will be redesigned to improve flow through the hospital, meaning those coming to ED get the **urgent care they need faster** and allowing ambulances to handover patients as quickly as possible.

Local Maternity and Neonatal System

The Local Maternity and Neonatal System (LMNS) continues to work closely with MSEFT and local partners to improve maternity and neonatal care, ensuring it is safer, more personalised and with equal access and outcomes for all. Our smoke-free pregnancy services have helped 94% of women and pregnant people stay smoke-free in five of the last six months, improving health outcomes for both parent and baby.

The Maternity and Neonatal Voices Partnership (MNVP) has expanded, and their participation and voice has ensured that women, birthing people, and their families are at the centre of service development and improvement. The recruitment of midwives and doctors has been ongoing, and this will actively support the work to achieve the national ambition of reducing preterm births. Health inequalities remain as a focus within our Equity and Equality Programme. A Maternity and Neonatal Independent Senior Advocate (MNISA) is in place to support families affected by serious adverse outcomes, as part of an NHS England pilot running until March 2026.

There remain challenges, with Broomfield Maternity Services receiving a CQC Section 31 notice following the last inspection. Basildon Maternity Services has demonstrated improvement, leading to the removal of their Section 31 notice; however, work continues to deliver the requirements set out within the legal undertakings. To support delivery of these requirements, MSEFT has a Perinatal Improvement Programme with participation from NHS England, the LMNS, and the ICB.

Whilst a governance framework is in place, it is subject to a local consultation and review. Regular monitoring by the LMNS Steering Board and MSEFT Perinatal Assurance Group continues. The ICB Executive Chief Nursing Officer provides oversight of the legal undertakings reporting to NHS England and the ICB's Strategic Oversight Assurance Group.

The LMNS remains committed to improving maternity and neonatal care, ensuring better experiences and outcomes for women, birthing people and their families across MSE.

Community Collaborative

The Community Collaborative continues to work for the population of MSE as three separate providers following an agreed accountability framework.

The Quality team continues with annual quality assurance visits to sites covered by all 3 providers. Recommendations are followed up at the Quality, Contracting and Performance Meeting (QCPM). The emerging concerns protocols are initiated following any issues raised and shared with the Community Collaborative as required.

The Community Collaborative invites the ICB Quality Team to attend various quality fora to provide assurance to the ICB on quality and patient safety.

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

The Quality team continue to provide rigorous oversight of service delivery in EPUT using various methods. Quality Assurance visits in partnership with EPUT remain a key mechanism to assess service delivery, identify areas for improvement, and ensure that high standards of patient care are maintained.

The team places great emphasis on triangulating information and analysing data from multiple sources to gain a comprehensive understanding of the issues that may arise within the services. This approach helps to identify potential risks, enabling them to be addressed swiftly and effectively. By maintaining a thorough and systematic process for monitoring care, enables proactive steps to resolve any concerns, ensuring continuous improvement in the quality of care provided to patients.

This ongoing effort is a direct response to significant concerns that have been raised through various channels. The team's efforts reflect a strong commitment to improving the standard of care for individuals accessing mental health services, ensuring their safety, and fostering a culture of continuous improvement.

Learning Disability and Autism (LDA)

The scrutiny of LDA services has seen a significant increase over the past year, with a stronger focus on the quality and accessibility of services. Commissioning of LDA services is delegated to Essex County Council (ECC), with the ICB's role evolving to enable greater oversight of these services. The ICB collaborates with Commissioners from Herts and West Essex, and Suffolk and North East Essex ICBs, and ECC to understand the provision of services, identify gaps, and address areas where service delivery can be improved.

In the ongoing oversight of LDA services, the ICB has placed a strong emphasis on quality assurance through regular monitoring and evaluation. Quality Assurance visits are undertaken to assess service delivery, ensuring that the services provided adhere to the agreed-upon standards and continue to meet the needs of service users. The ICB team works closely with ECC Commissioners to gain a deeper understanding of challenges and opportunities within services. By performing thorough assessments and engaging in dialogue with Commissioners, the ICB can ensure that service provision remains effective and responsive, particularly as it pertains to the quality of care provided to individuals within Essex and those placed outside of the county.

Primary Care

The Primary Care Quality team provides quality assurance for General Practice and Dentistry. Pharmacy and Optometry remain hosted by Hertfordshire and West Essex ICB. As a team we collaborate with all providers to support them in providing excellent care to our patient population.

Working closely with our providers we support improvements, for example, in 2024/25 there were two General Practice providers who had been rated inadequate following inspection by the Care Quality Commission (CQC). Through a collaborative and supportive approach, the practices were able to deliver against the required actions and both subsequently achieved 'Good' ratings following re-inspection.

This year has also seen a progression with commencing quality assurance within dentistry, since the delegation from NHSE in 2023.

All-age safeguarding, including children and young people (CYP) safeguarding

MSE ICB is responsible for the statutory duties set out in the Children Act 2004 and Care Act 2014 and the statutory guidance documents that underpin our approach. In

addition, NHS England *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, whereas the Working Together to safeguard children 2023, provides the statutory guidance for partners in how agencies collectively work together.

Throughout 2024-25 the team have continued to work closely with our partners and the six Safeguarding Boards/ Partnerships across Southend, Essex and Thurrock on a wide range of priorities. This collaborative approach has strengthened our efforts to safeguard vulnerable residents and drove improvements across all-age safeguarding practices.

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 Multi Agency Safeguarding Arrangements (MASA), demonstrating the ICB's delivery against safeguarding statutory duties for 2023/24.

Essex Safeguarding

- Essex Safeguarding Children Board Annual Report 2023-24 [hyperlinks]

- Essex Safeguarding Children Board Arrangements [hyperlinks]

- Essex Safeguarding Adults Board Annual Report 2023-24 [hyperlinks]

Thurrock Safeguarding

- Thurrock Local Safeguarding Children Partnership Annual Report 2023-24 [hyperlinks]

- Thurrock Safeguarding Adults Board Annual Report 2023-24 [hyperlinks]

- Thurrock Local Safeguarding Children Partnership MASA Arrangements [hyperlinks]

- **Southend Safeguarding**

- Southend Safeguarding Partnership - Annual Report 2023/24 [hyperlinks]

- SSAB Multi-Agency Safeguarding Arrangements (Jan 2025) [hyperlinks]
- SSCP Multi-Agency Safeguarding Arrangements (Jan 2025) [hyperlinks]

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' with a Deputy Director of Nursing for Safeguarding having oversight of the Safeguarding team and delivery.

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.

The All-age Safeguarding team have also put in place an Assurance Framework to make sure that there is sufficient oversight and scrutiny of safeguarding practice in all sectors of NHS healthcare. This team provides clinical, professional, and strategic leadership to support safeguarding adults, children, and children in care.

The Framework 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.

Safeguarding in Primary Care (General Practices)

The team has also continued to implement an audit strategy for GP practices. Following the receipt of completed responses from 95% of practices across MSE in November 2023, the team has provided support to improve practice in the identified areas. The

Primary Care Safeguarding Audit for 2025 has recently been distributed to all GP practices across MSE.

In addition, the team has facilitated bi-monthly GP safeguarding forums, which have been attended by over 400 practitioners to date. Furthermore, we have participated in the delivery of the Time-to-Learn Programme, which included a three-hour, all-age safeguarding session delivered to the four Alliances (Mid Essex: 245 attendees; Basildon: 218 attendees; Thurrock: 121 attendees; South East: 200 attendees). Due to the highly positive feedback, we have now expanded the safeguarding presentation by adding an additional one-hour session per Alliance. The first of these was delivered in February 2025, with over 200 attendees from Mid Essex.

The team has dedicated significant capacity in learning from serious safeguarding serious incidents, ensuring a structured approach to reviewing incidents, embedding learning, and implementing system-wide improvements that enhance safety and improve the quality of care. At present, the team are supporting the completion of 46 Safeguarding Reviews, including 13 Child Safeguarding Practice Reviews: 21 Safeguarding Adult Reviews and 12 Domestic Abuse Related Death Reviews. The main themes from these Reviews include the management of neglect (including self-neglect); mental ill health, fatal self-harm and harm to others; domestic abuse and coercive control, and the impact of substance misuse on individuals and their ability to care for others.

Designing Pathways (Children Asthma Pathway and Safeguarding in Dentistry Pathway)

We have developed pathways for the safeguarding management of asthma in children, which have been widely distributed, alongside training. Additionally, we have initiated an approach to safeguarding within dental practices through the development of a dedicated Dental and Safeguarding Pathway, which has been well received by MSE-wide practices.

Both Pathways support the recognition of neglect, helping to reduce avoidable illness and improve overall health outcomes.

We have led a project to explore how the ICB and local Health providers can improve compliance with the Mental Capacity Act 2005 so that all patients aged over 16 years are protected if they lack capacity to decide for themselves.

By embedding learning, strengthening partnerships, and improving frontline safeguarding processes, the ICB remains committed to protecting vulnerable residents and ensuring high-quality safeguarding practices across MSE.

Reducing health inequalities

ICBs have a statutory responsibility to have regard to reducing inequalities between patients with respect to their ability to access health services and the outcomes achieved for them. This means that health inequalities must be properly considered when we make commissioning decisions for our population.

Reducing health inequalities is central to our delivery within MSE. The Mid and South Essex **Equality, Diversity, Inclusion and Belonging Strategy** published in November 2024 sets an overarching objective to:

'Ensure equitable access, excellent experience, and optimal outcomes for all by addressing unwarranted variations in our services and moving towards an integrated health and care system.'

The Strategy sets out our population needs highlighting the gap in life expectancy across MSE which 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 Population Health Improvement Board (PHIB) ensures that these 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. This Board reports to both the MSE ICP, reflecting the work from partners across the system around wider determinants of health, and the ICB to deliver improvements around specific healthcare priorities.

MSE ICB ensures that the consideration of inequalities is firmly embedded within our strategic plans and key business activities, examples of which include:

- Ensuring our plans and strategies are in line with the needs of the local population.
- Ensuring appropriate oversight and scrutiny of our arrangements to tackle health inequalities and improve health outcomes through the ICB's Board and committee structures.
- Decision making throughout the ICB's governance structure considers the impact on health inequalities.
- Establishment of Equality and Health Inequalities Assessment Panel to review impact assessments to ensure that proposals to change or remove a service, policy or function clearly demonstrate the impact on reducing health inequalities and actions are identified to mitigate wherever possible.
- Ensuring our framework for generating citizen engagement and insight is fully inclusive; by working with local communities, through our Research and Engagement Network Champions and the Virtual Views digital platform to enable us to hear from those who are experiencing the greatest health inequalities.

We recognise that good quality, robust data enables the NHS and wider system partners to understand more about the populations we serve. During 2024/25, the ICB utilised its population segmentation tool, that integrates data sets across the health and care system, to establish where health inequalities exist and develop interventions to support the needs of the population. A Health Inequalities dashboard has been developed to monitor progress in reducing health inequalities.

The ICB Health Inequalities Information Statement for 2024/25, 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. The metrics within this Statement align with the national five strategic health inequality priorities alongside the clinical areas of the Core20PLUS5 approach.

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. The ‘Narrowing the gap’ report outlines how partners are working collectively across MSE to tackle health inequalities Narrowing the gap - Mid and South Essex Integrated Care System [hyperlinks]

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

- Invested in PCN clinical leadership development to utilise a health creation approach to addressing health inequalities.
- Working with Pathway the Homeless and Inclusion health charity to undertake engagement across the system including with those with lived experience to develop a MSE Homeless Needs assessment.
- Delivering one stop clinics for the homeless and vulnerable in Chelmsford providing health and wellbeing support including cancer screening, health checks and flu and covid vaccinations.
- Taking a holistic approach to residents’ wellbeing to prevent more severe conditions in the future. Benfleet PCN led an initiative focusing on 63 residents aged 60–74 with multiple complex health issues such as depression, hypertension and diabetes.
- Targeted Lung Health Checks Programme is helping identify cancer earlier in areas with higher rates of smoking and incidences of lung cancer. As of October 2024, over 24,000 lung health checks have been taken in MSE with over 160 local people with previously undiscovered lung cancer, found and treated.
- Improving the proportion of patients whose cholesterol levels are optimised, by use of higher intensity statins and ensuring adherence to medication, to reduce the risk for over 2,500 patients of future heart attacks and strokes.
- Bright smiles campaign worked with early years workforce and community groups in deprived areas to provide leaflets, videos and reward charts to support improved child oral health. Oral health - Mid and South Essex Integrated Care System [hyperlinks]
- Introduction of the Smoke Free pathway in maternity with provision of in-house smoking cessation behaviour support has resulted in a reduction in the number smoking at time of delivery to be in line with the national target of 6%. (see case study below)
- Weight management support provided to over 1,000 individuals via the national Digital Weight Management services, which was double that of the previous year.
- Utilisation of an outreach vehicle to deliver a holistic health and wellbeing service in community settings engaging with over 500 users from our most deprived areas to offers services including health checks, smoking cessation, long covid, sexual health and weight management support.
- Collaboration with local authorities, the Department for Work and Pensions (DWP), and the voluntary sector to support individuals with physical and mental health conditions, including neurodiverse individuals, in their journey back into employment. At our latest event in Southend, over 250 people received specialist employment support and information, advice and guidance from Wellbeing and Health services and the opportunity to engage with prospective employers.

Case study: Population Health: Smoking Cessation

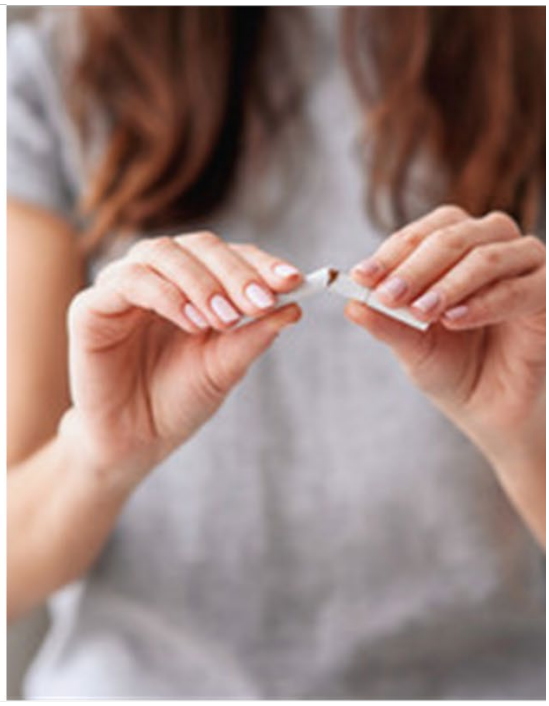
Specialist teams across our local hospitals have **successfully reduced the percentage of women and birthing people smoking** at the time of delivery from **7.5% to 5.8%.**

Since February 2024, the smokefree pregnancy service has been **providing free support**, including telephone and face-to-face counselling, behaviour change advice, and nicotine replacement therapy, to help combat smoking during pregnancy.

While the initiative, funded by NHS Mid and South Essex, operates across Southend, Basildon, and Broomfield hospitals, **Thurrock has been identified as a greater challenge**, with 11.2%* of those giving birth being smokers.

In mid and south Essex, **11.1% of adults are smokers**, with nearly 150,000 residents at increased risk of diseases such as lung cancer, chronic obstructive pulmonary disease (COPD), and coronary heart disease.

Smoking remains the leading cause of preventable illness and death, with 64,000 deaths annually. We encourage staff to promote Stoptober to local smokers, as research shows that quitting for 28 days increases the chances of quitting for good by five times.



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

- **Priority 1: Restore NHS services inclusively.** Implementation of the ICB's Primary Care Access Recovery Programme in 2024/25 has demonstrated improved access, measured via the GP survey. Focused work has been undertaken by the MSE Community Collaborative to increase diabetes checks in localities of highest needs and work is underway in partnership with Healthwatch to engage with seldom heard groups around design of respiratory services. MSEFT completed an annual impact report and evaluation of access on the waiting list and patient experience that was presented to their public Board in June 2024.
- **Priority 2: Mitigate against digital exclusion.** The ICB continues to work with health and local authority partners to implement the MSE Digital Inclusion Framework. Alliances via their social prescribers offer support in the use of health apps to improve digital and health literacy, and signpost to free digital support including further help with free data vouchers and SIM cards.
- **Priority 3: Ensure datasets are complete and timely.** Ethnicity data completeness continues to be tracked and remains at more than 92% of records having a recorded ethnicity. Areas of further improvement have been identified by the PHM team with further insight provided on the identification and recording of PLUS groups, those groups that are greater risk of health inequalities.
- **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, and highlights of delivery are included across this report with detailed progress reported bi-annually to the ICB Board.
- **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 are embedded across ICB.

Alongside the reduction in health inequalities being a core element of all commissioning decisions, in 2024/25, the ICB continued to support investment of £2.2million into health inequalities transformation schemes. The funding was utilised to support innovative partnership solutions to reduce health inequalities at an Alliance level based on their local population needs. The funding also contributed towards resourcing the ICB capacity to address health inequalities including the PHM function, alongside system delivery against Core20PLUS5 priorities such as improved Hypertension case management. The ICB continues to evaluate the outcomes from this investment and learn lessons for future scale and spread of the work.

The Information Statement on health inequalities provides a more extensive overview of the programme of work and outcomes about the Core20PLUS5 Framework, the five planning priorities and health inequalities funding investments and outcomes.

Public Sector Equality Duty

The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires us to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations. These are often referred to as the three general aims of the PSED. Having due regard requires the ICB to consider removing or minimising disadvantages, take steps to meet people's needs, tackling prejudice, and promoting understanding.

The ICB recognises and meets the requirements of the PSED, which applies to both workforce and service delivery. The ICB published its Equality**, Diversity, Inclusion and Belonging Strategy** that set out its commitment to taking equality, diversity and human rights into account in everything we do whether commissioning services, employing people, developing policies, community with, or engaging local people in our work.

Equality, diversity, inclusion and belonging - Mid and South Essex Integrated Care System [hyperlinks]

The Equality and Human Rights Commission, which oversees compliance with the Equality Act, confirmed the ICB is compliant in meeting the PSED specific duty obligations.

Equality Delivery System (EDS) 2022

Within the system, the ICB and NHS providers have been working together to implement the EDS 2022 on an ICS footprint. The EDS is an improvement tool that supports health organisations to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. For Domain 1: Commissioned or provided services, the services selected for review in 2024/25 were:

- Diabetes.
- Heart Failure.
- Paediatrics.

All 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, EPUT and the Community Collaborative 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. Equality Delivery System - Mid and South Essex Integrated Care System [hyperlinks]

EDS action plans have been developed for these services and along with actions from prior year reviews, they are monitored via the Health Inequalities Delivery Group and through the individual NHS organisational governance.

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 Wellbeing 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 a lead Executive or Alliance Director within the ICB supports agenda setting for the Health and Wellbeing Boards, maintaining a close working relationship with the three chairs.

The themes discussed within this annual report were reflected at the Health and Wellbeing Boards in early 2025 and written report outlining the work of the ICB was provided to the Boards in March 2025. There was no specific feedback received from the Boards and the updates were noted. The final version of the annual report will be shared with the Boards, once published.

This 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 (JSNAs) 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 ICB supports the implementation of the Health and Wellbeing Strategies by being involved in the workshops to update and develop the strategies; through contributions at Board meetings as well as ensuring the Joint Forward Plan and other priorities of the ICB are aligned to and consequently contribute to the achievement of the strategies.

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

The ICB has undertaken extensive and meaningful engagement with local communities throughout 2024/2025, fulfilling its statutory duty to involve the public in the planning, design, decision-making, and proposals for changes that impact health services. This has been achieved through various channels and initiatives to obtain diverse insights from individuals, groups, and underserved communities across our geography.

The ICB has engaged with residents, Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations, and stakeholders, ensuring that all perspectives are considered in shaping the future of health services.

Community Beds Public Consultation

In line with our duty to involve the public, the ICB launched a public consultation from 25 January to 11 April 2024, regarding community hospital services provided by MSEFT, EPUT, Provide Community Interest Company, and North East London NHS Foundation Trust. This includes services such as stroke rehabilitation inpatient care, intermediate inpatient care, a standalone midwifery unit and community services provided from St Peter's Hospital in Maldon.

This consultation received an unprecedented level of feedback, with more 5,000 survey responses alone from a wide range of individuals and organisations. These responses were gathered from residents, VCFSEs, partners, stakeholders, and staff.

In response to the strength of feedback, decision making on the final configuration was paused for six months and a working group was formed to carefully review and consider the proposals. This group included diverse community representatives and stakeholders, ensuring that the decision-making process would be as inclusive as possible. The final decisions are now due to be made in Summer 2025.

Virtual Views Engagement Platform

The ICB launched the Virtual Views Engagement Platform [hyperlinks] in November 2023, which has since developed into a vibrant online space for local people with common interests or lived experiences to come together and work collaboratively to improve healthcare services. The Platform enables participants to share their experiences, feedback, and thoughts with decision-makers in healthcare, ensuring that local perspectives are heard and acted upon.

As of March 2025, Virtual Views has attracted 42,275 visits, with 3,440 contributions from 840 registered participants. The Platform has been crucial in gathering insights on various healthcare topics, including breast screening, mental health, Talking Therapies, hospital discharge processes, and oral health, thereby contributing significantly to service improvement efforts.

Engage News

In May 2024, the ICB introduced 'Engage News,' a monthly electronic newsletter aimed at keeping local audiences informed about engagement activities and opportunities for involvement. The newsletter is distributed to a wide range of stakeholders, including individual residents, VCFSE partners, parish councils, and community groups, ensuring

broad dissemination of key information and engagement opportunities. More details on how to subscribe can be found on our website [hyperlinks].

NHS 10-Year Plan Engagement

As part of the national 'Change NHS - help build a health service fit for the future' nationwide consultation, the ICB seized the opportunity to engage local communities and gather feedback for both the national NHS 10-Year Plan and the ICB's future planning. Through a successful funding bid, the ICB supported nine community groups, predominantly from underserved populations, to hold focus groups in their local areas. These sessions provided a platform for residents to share their views on the future of healthcare services.

In addition, several online sessions were held to ensure wider participation. The feedback was collated into a comprehensive report, which has been published on the ICB Insight Bank [hyperlinks] The national NHS 10-Year Plan is expected to be published in Spring 2025, and the ICB's engagement efforts will continue to play a crucial role in shaping our response locally.

Research Engagement Network Project

The Research Engagement Network (REN) Project, launched in November 2023 with funding from NHS England and the Department of Health and Social Care, focused on increasing inclusivity in health and care research. REN fosters partnerships between VCFSE organisations, the National Institute for Health Research (NIHR), and local communities to engage underserved populations in meaningful research opportunities.

Since its inception, REN has made significant progress, including mapping the local research landscape and conducting a baseline survey to assess community awareness of research opportunities.

A key milestone this year has been the training of 20 community organisations and 19 community champions, who are now leading engagement efforts in their communities. REN has also facilitated events, such as a learning session with over 30 attendees, to showcase the real-world impact of community-led research initiatives.

Furthermore, REN has formed partnerships with other organisations ensuring that research reflects the needs of diverse communities.

This year the REN Programme received additional funding from the NIHR to focus on mental health research in coastal and rural communities, further enhancing the network's ability to engage hard-to-reach populations.

Looking ahead, our REN will continue to strengthen these partnerships, gather feedback from ongoing activities, and ensure that research opportunities remain aligned with the needs of the communities served.

VCFSE Strategic Engagement

The VCFSE sector plays a crucial role in improving population health and reducing inequalities within the MSE ICS.

The ICB is strengthening its engagement with the sector through a strategic approach that ensures VCFSE voices are embedded in decision-making and service planning.

In 2024/25, the ICB appointed Dr Geoffrey Ocen, Associate Non-Executive Member of the ICB Board, to lead VCFSE strategic engagement efforts. Key activities so far have included structured interviews with VCFSE leaders to identify opportunities for enhancing collaboration and forming a new strategic VCFSE Assembly. This Assembly will provide a system-wide platform for the sector to contribute to strategic planning, policy influence, and sustainable funding for health services.

VCFSE engagement and delivery is integrated across multiple areas of the ICS, with VCFSE-led social prescribing services, peer support programs, and community listening initiatives as examples. The sector has also been involved in key working groups addressing health inequalities and population health management, ensuring that local communities have a voice in shaping services and policies.

Developing a strategic approach aligns with NHS England's guidance on working with communities and aims to create long-term partnerships to improve health outcomes across the region.

Case study: Research Engagement Network (REN) Promoting Inclusive Health and Social Care Research

The REN project continues to make significant progress in promoting diversity and inclusivity in health and social care research. REN secured funding, with 70-80% allocated to local VCFSE groups. This supported initiatives addressing health inequalities and amplified unrepresented community voices.

In the first phase, REN engaged with 20 community groups and have trained 18 community champions from diverse groups in June 2024. Insights were gathered through surveys and feedback reported to NHS England.

In November 2024, REN hosted a learning event with community champions, researchers, and stakeholders. The event focused on sharing success stories and strategies to address health inequalities through inclusive research.

In December 2024, an Inclusive Research Event was held at Anglia Ruskin University where local researchers and attendees discussed barriers to participation and co-developed solutions for more inclusive research design.

Supporting our workforce and social value

ICB workforce

During 2024/25, the ICB organisational development plan moved into a period of 'reset and rebuild' as well as 're-focus and re-energise'. This followed a significant re-organisation in 2023/24. The People Management Strategy was published in May 2024 to provide a guiding structure to organisational development to best support ICB staff and how the ICB becomes an employer of choice.

The NHS Staff survey results for 2024 demonstrated a marked improvement upon previous years, demonstrating the hard work undertaken across the organisation to rebuild staff morale and improve working conditions within the ICB.

Embarking on a new journey of organisational change will continue to challenge the ICB, however, lessons from previous re-organisations are being used to manage the impact upon and support staff in the most appropriate way.

System workforce planning

Echoed in our NHS provider colleagues, plans to rebase workforce numbers continued in 2024/25. The People Board continued to bring together partners across the ICB both in health, social care and the hospice sector to work together developing:

- Clinical capacity and expansion / education and innovation.
- Workforce re-alignment.
- Colleague experience, wellbeing and retention.
- Equality, Diversity and Inclusion.

Each workstream had the underlying principle of supporting the workforce across MSE. The case study below showcases just one of the initiatives demonstrating how the ICS support staff development as part of the four workstreams.

Case study: Supporting our workforce: Health Care Assistant Academy

- July 2024 saw the first group of newly hired **Health Care Assistants (HCAs)** attend their induction with the HCA Academy. The induction built on a foundation of great work from Mid and South Essex Foundation Trust (MSEFT) to bring industry-leading training to HCAs who are set to join services across Essex.
- Newly hired HCAs from both Essex Partnership University NHS Foundation Trust (EPUT) and MSEFT are **automatically enrolled** to the HCA Academy upon successful appointment.
- They will receive **additional support** from the Academy during their onboarding process and continued guidance throughout their first few months with their Trust. The centralised induction across the two Trusts prepares them for roles in both mental and physical health, offering a **comprehensive understanding** of the various patient and healthcare scenarios they may encounter.

Clinical and professional leadership (stewardship)

MSE ICS's Stewardship Programme is now established as an award-winning, nationally recognised exemplar, with a track record of delivering value improvement in MSE. In 2024/25, our stewards continued leading and supporting system work to deliver on the Triple Aim, particularly financial sustainability.

Based on Elinor Ostrom's Noble Prize-winning work on stewardship, we have now brought frontline staff from across our system together into Stewardship groups in 10 out of 25 care areas to lead and support our system in stewarding resources better.

The ICB has developed 10 Stewardship groups including ageing well, babies, children and young people, cancer, dermatology, diabetes, eyes, mental health, musculoskeletal, stroke and urgent and emergency care. These include 75 stewards

from at least 14 health and care organisations including primary, secondary and community care, voluntary sector, ICB and residents. We have built interactive dashboards on Athena, our strategic data platform, to provide insights and support action lead interventions that underpin service transformation across our stewardship groups. We also have a central stewardship programme team to support the efforts and outputs from the programme.

Following the national recognition during 2023/24, the programme has since featured:

- **On the '*Leading Improvement in Health and Care*'** podcast from the NHS Confederation and Health Foundation - www.nhsconfed.org/podcast/productivity
- **In a number of publications including**
    - *How ICBs are tackling delayed hospital discharge and improving patient flow* - Healthcare Leader

      https://healthcareleadernews.com/insight-and-analysis/how-icbs-are-tackling-delayed-hospital-discharge-and-improving-patient-flow/
    - How to create a system-wide data tool - Healthcare Leader

      https://healthcareleadernews.com/insight/how-to-create-a-system-wide-data-tool/
- **East of England Cancer Summit, September 2024** - with a focus on the work of the Cancer Stewards on the Skin Cancer pathway.

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

Area	**Achievement**
Cancer case 1:	Prostate case-finding pilot **Problem:** Too many men have a late diagnosis of prostate cancer resulting in difficulty of successful treatment of the cancer. There was a phased approach of 11 PCNs participating in the programme. **Intervention:** 1841 patients were offered the chance to participate in the pilot. 865 patients were seen in prostate initial clinics, 287 seen in follow-up clinics. **Impact:** 768 patients had normal results; 32 were fast-tracked into the Trust. Outcomes to date noted 10 serious cancers found, 1 treatment started, 1 death and 10 with no cancer.
Cancer case 2:	Colorectal cancer referrals **Problem**: In people with possible colorectal cancer, there was significant variation in referral practice from primary and secondary care, and confusion about best practice. For example, referrals were rejected from the hospital because an initial test had not been carried out and in some cases, referrals were still

Area	Achievement
	sent and diagnostics carried out where the initial test showed this was not necessary. **Intervention**: The Cancer Stewards organised a number of educational webinars including at the MSE Cancer Summit to facilitate discussions around the patient pathway. **Impact**: By 2024, 73% of all colorectal referrals had an initial test result attached, compared to only 33% in 2022.
MSK case 1:	Fracture Liaison Service (see case study below)**.**
MSK case 2:	Community appointment day **Problem:** People waiting for community physiotherapy in South West Essex were facing long waiting times, and disjointed care (i.e. having to go to different providers for different services). **Intervention:** The MSK stewards held a 'Community Appointment Day' at Basildon sporting village, with more than 20 different providers (e.g. physiotherapists, employment advisors, local charities, Active Essex, Smoking cessation etc). **Impact:** Over 100 local people from Basildon and Brentwood were invited; 99 were seen on the day. 60% were discharged on the day and did not need further support. For those who couldn't make it, the waiting list was reduced by 3.5 weeks. 85% of people stated that attending the CAD helped them to manage their condition. 100% of service providers stated they enjoyed the day and agree to being part of another CAD.
UEC:	See UEC section on page 11.
Diabetes Case:	Diabetes Checks **Problem:** Patients with diabetes need to have annual diabetes health checks each year to check for early signs of complications. Uptake of these tests are low in areas of high deprivation. **Intervention:** The stewards developed a focussed project to improve completion rates of annual diabetes checks, the ICB allocated £200k of NHS England funding to the Community Collaborative specifically to support PCNs in improving diabetes care for the most deprived residents of the population. The stewards worked with the Community Collaborative and the PCNs to share learning and ideas about how to use the funding and raise awareness about the project. **Impact:** This initiative resulted in 1,200 people receiving their diabetes checks, many of whom had not had any checks in the last two years. Without the initiative many of the patients would not have come forward for their checks.
Ageing Well:	FrEDA and e-FraCCS

Area	Achievement
	Problem: Incorrect data and limited tools available for staff to ensure patients were receiving best practice care within Frailty services. **Intervention**: The Ageing Well Stewards co-designed a common assessment tool to deliver and capture best practice within Frailty focusing on the use of 7 high impact pro-active personalised actions, known as the Frailty End of Life Dementia Assessment (FrEDA). FrEDA launched across PCNs, Community Teams, Hospices, Dementia Teams, Virtual Wards and more. **Impact**: • 12,000 new people with frailty, dementia or EOL needs identified in 1st year • 50% reduction in older people with more than 3 unplanned hospital admissions in their last 90 days of life • 5% reduction in 30-day hospital readmission rates, • 70% reduction in 30-day readmission rates in Integrated Neighbourhood Teams with highest FrEDA usage • uniting colleagues under a whole-person culture, using integrated tools so partners seamlessly collaborate for better patient outcomes, as opposed to siloed organisational practice.
Stroke:	<u>Stroke ambulatory pathway</u> **Problem:** There were challenges to patients receiving timely access to the stroke unit and opportunities to improve pathways or community pathways to help discharge patients as soon as possible. **Intervention:** The stewards helped introduced a fast-track pathway at Broomfield Hospital for non-disabling stroke patients, allowing them to receive same-day access without being admitted. This has freed up beds previously occupied by patients with conditions that cause neurological symptoms similar to a stroke but are not caused by a stroke. **Impact**: This helped prevent unnecessary hospital admissions while simultaneously freeing up valuable bed space for patients who need more intensive care. It had a positive knock-on effect on reducing A&E waiting times for people with stroke. Additionally, it released more therapy time, enhancing patient experience. This is the first pathway of its kind in the UK.
Dermatology:	<u>Dermatology – Dermoscopy Club</u> **Problem:** A survey showed that while all primary care clinicians that responded saw patients with dermatological conditions, 30%

Area	Achievement
	did not have access to a dermatoscope (device used to examine skin to better show skin lesions), and only 27% were "somewhat confident" in interpreting dermatoscope images. **Intervention:** Stewards supported the provider to set up a Dermoscopy Club. Hosted by a Consultant Dermatologist, the Club delivered a course of 9 training sessions and a learning platform that supports clinicians in MSE. **Impact:** Since commencing in October 2024, more than 150 primary care colleagues have enrolled and are developing their skills and confidence in using dermatoscopes.
Eye Care Case:	**Ophthalmology – Cataracts** Cataracts are a loss of transparency of the lens within the eye, resulting in reduced vision, which can be reversed through noncomplex surgery. **Problem:** Cataract activity has grown significantly since the pandemic. Over 1,000 procedures are carried out each month (at both NHS and independent provider hospitals); a cost pressure to the system and wider demand on ophthalmology services. Referral routes are complicated, there is uncertainty if patient choice is consistently offered or whether the local service restriction policy criteria are applied. **Intervention:** The single point of access (SPoA) cataracts pathway commenced in December 2024. The SPoA will allow better understanding and management of patient flow, data capture, and importantly will offer choice for MSE patients. **Impact:** All referrals for cataract surgery for all providers are now routed through the SPoA, which will: • streamline the referral process making it more straightforward • offer informed patient choice • provide assurance all patients are meeting our local criteria • provide clear data to allow us to plan well for the future.

Case study: Population Health Improvement: Fracture Liaison Service

In May 2024 mid and south Essex ICS became the **first Fracture Liaison Service in the country** to operate across a large geographical area, where it can provide consistent care for patients across GP, hospital and community services. The new service aims to strengthen bones in those aged over 50, **reduce fractures and free up hospital beds**.

There are **70,000** residents over the age of 50 with osteoporosis in mid and south Essex, leading to **8-10,000 fractures** each year. Across the UK it is estimated that there are 3.5 million living with the condition.

The service identifies eligible residents who have suffered a fracture and offers them **checks by nurses in hospital** for osteoporosis (fragile bones). Patients are then treated with bone medication or referred to services such as physiotherapy to **reduce their risk of falling again**.

Environmental matters (Sustainability)

The DHSC Group Accounting Manual has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following ‘pillars’: Governance, Risk management, and Metrics and targets. These disclosures are provided below.

Sustainability Governance

Mid and South Essex ICS Greener Plan Programme Board provides oversight and assurance that the ICB and system providers are delivering against the ICS Green Plan and key priority areas outlined below. Responsibility for day-to-day implementation sits with the Basildon and Brentwood Alliance Director, who ensures progress is monitored and reported internally.

Sustainability Risk Management

Climate-related risks are integrated into the ICB's overall risk management framework. These risks include both physical risks (e.g. extreme weather events impacting estates or service delivery) and transition risks (e.g. policy changes, supply chain disruptions). The Corporate Risk Register has been updated to reflect these emerging risks, and mitigations are developed in line with NHS England's Net Zero and climate adaptation guidance.

The ICB also uses a sustainability impact assessment tool to aid the management of associated risks within programmes and projects.

Metrics and Targets

MSE ICB and the ICS are dedicated to achieving the Greener NHS target of net carbon zero by 2040 (scopes 1 and 2) and 2045 (scope 3), as outlined in our ICS Green Plan (hyperlinks). Our strategy centres on building sustainable health and social care systems that deliver high-quality services and improve population health and wellbeing.

The ICB reports on its greenhouse gas emissions using the NHS Carbon Footprint categories. Progress is measured against NHS targets, including delivering Net Zero emissions and the ICB works with providers and suppliers to align reporting and reduction efforts across the system.

Our Five Key Priorities:

We are focused on five core areas to drive our sustainability efforts:

1. **Reduce Carbon Emissions:**

    - Decreasing energy and water consumption.
    - Transitioning to 100% green electricity.
    - Promoting sustainable travel options.
    - Ensuring supplier alignment with net-zero targets through sustainable procurement.
    - Implementing contract monitoring, sustainability impact assessments, electric/hybrid car leasing, and a cycle to work scheme.

2. **Decrease Pollution:**

    - Minimising waste and eliminating single-use plastics.
    - Reducing air pollution across the system.
    - Prioritising low/no-carbon product procurement.
    - Implementation of electric car charging points, sustainable office supplies, reusable cup schemes, enhanced recycling, solar panels and energy-efficient lighting at headquarters.

The case study below is just one example of an ICB initiative to reduce carbon emissions and decrease pollution.

Case study: Working towards Net Zero: E-bike

Basildon and Brentwood Alliance received an e-bike donated from Ford Motor Company as part of the Electric Bike Loan Workplace Pilot organised by the Find Your Active Basildon partnership. The partnership aims to improve the health and mobility of our frontline primary care support staff. This significant contribution will support their team in delivering essential one-to-one care across the community.

Kelly Herring, a dedicated Social Prescriber from the West Basildon Primary Care Network, was the first recipient of an e-bike. As a non-driver, Kelly faces unique challenges in her role, and this new addition has greatly improved her ability to efficiently reach patients and community projects.

3. **Improve Health and Wellbeing:**

- Supporting on-site health and wellbeing initiatives.
- Investing in green spaces and site enhancements.
- Encouraging active travel.
- Fostering a motivated and engaged workforce.
- Supporting a Green Staff Network, Net Zero training for board members, and sustainability inclusion in staff inductions.

4. **Increase Financial Efficiency:**

- Reducing energy and water consumption to cut costs.
- Minimising waste to achieve financial savings.
- Integrating sustainability considerations into all financial decision-making and board/committee templates.
- Implementation of campaigns such as the "Gloves Off" campaign (to reduce the number of gloves worn by clinicians, which has been implemented in the acute hospital and community settings, now being rolled out in primary care).

5. **Enhance Reputation:**

- Promoting transparency and action across the ICS and partner organisations.
- Empowering Green Champions and cultivating a culture of compassion and inclusivity.
- Ensuring staff are informed and empowered to make sustainable choices.
- Strengthening collaborative partnerships.

MSE recognises the interconnectedness of social, economic, and environmental sustainability. We are committed to a unified approach that aligns our Green Plan with efforts to reduce health inequalities. Our governance structure, with representation from across the ICS, ensures coordinated action, maximises opportunities, and avoids duplication. This long-term program is dedicated to achieving our sustainability objectives, supporting our people, and protecting our planet.

Progress against the MSE ICB Green Plan 2024-25

The following key deliverables were delivered by MSE ICB during 2024-25:

- MSE ICS NHS Greener Programme Board established, chaired by the ICB Executive Lead for Sustainability.
- ICB Greener NHSE Staff Network established, and green champions identified.
- Staff induction sessions held with a dedicated section relating to the Greener NHS agenda.
- Greener NHS intranet page developed for ICB staff.
- Cycle to work and lease car schemes introduced, supported by showers and electric car charging points available on site within the ICB headquarters site.
- Windows and lighting replaced, and solar panels installed at ICB headquarters, to support the reduction of emissions and move towards Net Zero.
- Sustainability Impact Assessment introduced into ICB commissioning processes.
- Gloves off campaign introduced by secondary care and community providers launched within primary care.
- Greener prescribing programme established which includes:
    - Inhaler disposal scheme
    - Reduction of medicines waste.
    - Prescribing of lower carbon inhalers.
    - Optimisation of medical gases, including the reduction of nitrous oxide waste.
- Sustainability statement included in all job descriptions.
- MSE ICB Commissioning Intentions include sustainability compliance measures.

Financial review

Our full statutory financial accounts are included from page 104. This section provides a summary of our 2024/25 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 83. 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 27 of the Annual Accounts section for their full audit opinion).

ICB funding

The MSE ICB in-year total healthcare funding was £3,148.20m and funding for running the ICB (called "running cost expenditure") was £22.37m, resulting in total overall funding of £3,170.58m. ICB expenditure was £3,170.51m, resulting in £0.07m surplus for the financial year.

The ICB had an agreed plan to breakeven as its contribution towards the broader system position.

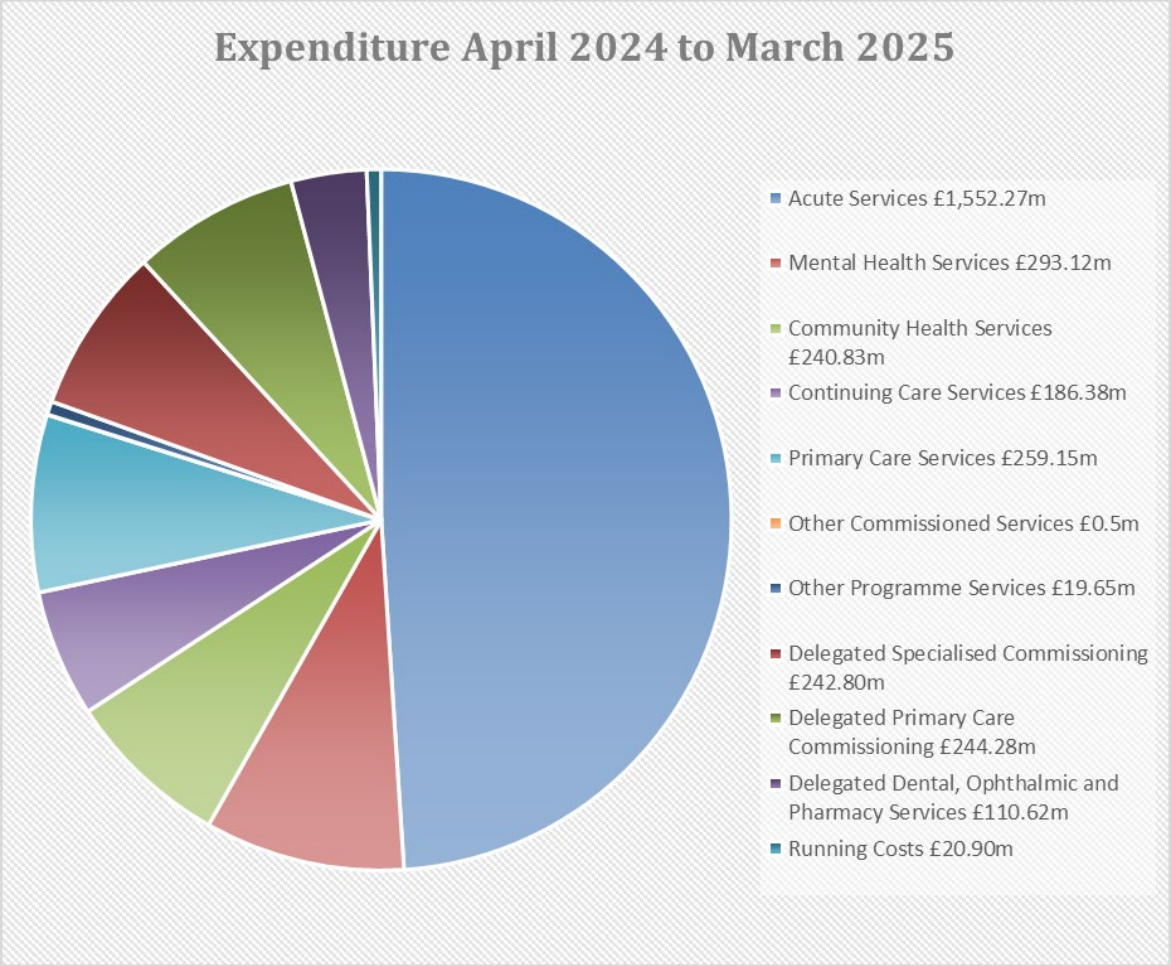
There was additional income received relating to the elective recovery fund (ERF). The ICB has a delegated primary medical services budget of £239.7m which included additional funding for Additional Roles Reimbursements for PCNs (ARRS) for commissioning general practice and a delegated budget for commissioning pharmacy, optometry and dentistry of £113.5m. In 2024/25 the ICB took on full delegated commissioning responsibility for suitable specialised services with a budget of £249m.

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 2024/25 the ICB has achieved the MHIS by increasing all mental health related expenditure by 6.84%.

How your money was spent

In 2024/25 we spent £3,149.6m on healthcare services and a further £20.9m on running costs, totalling £3,171m.

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 2024/25, but accessed primary care capital held by NHSE on behalf of the ICB towards primary care estates projects and GP IT.

It did receive a capital allocation of £2.3m in year to enable it to enter a lease for a system training hub in line with the accounting treatment required under International Financial Reporting Standards (IFRS)16.

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 2024/25 the ICB met all four targets (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.

2025/26 financial plans and looking to the future

In line with the NHSE planning process, the 2025/26 Financial Plan was submitted on 30 April 2025 with a breakeven position for the ICB. Allocations for 2025/26 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 NHS England. 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 with the aim of improving the sustainability of our services.

On 13 March 2025, the government announced changes to the NHS that included merging functions between NHS England and the Department for Health and Social Care as well as tasking ICBs with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. The ICB continues to support its staff through the coming change process that ICBs are currently being asked to implement during quarter 3 of the 2025/26 financial year.

ACCOUNTABILITY REPORT

Tom Abell
Chief Executive of Mid and South Essex Integrated Care Board

19 June 2025

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 2024 to 31 March 2025, 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 2025, the composition of the ICB Board was as follows:

- Professor Michael Thorne CBE, Chair
- Tom Abell, Chief Executive Officer
- Dr Giles Thorpe, Executive Chief Nursing Officer
- Dr Matthew Sweeting, System Medical Director
- Kathy Bonney, Interim 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
- Robert Persey, 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
- Prof. Sanjiv Ahluwalia, 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
- Jo Cripps, Executive Director of System Recovery

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 ICB 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].

A register of interest pertaining to each individual sub-committee of the Board is also maintained and presented at each meeting of those committees in order to facilitate the management of any potential conflicts of interest.

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 2024/25.

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 2025 is published on the website at Modern Slavery Act statement — Mid and South Essex Integrated Care System (ics.nhs.uk) [hyperlinks]

Statement of Accountable Officer's responsibilities

Under the National Health Service Act 2006 (as amended), NHS England 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 NHS England, 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 NHS England.

NHS England 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.

Tom Abell
Chief Executive of Mid and South Essex Integrated Care Board

19 June 2025

Governance Statement

Introduction and context

The MSE ICB is a body corporate established by NHS England 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 2024 and 31 March 2025, the ICB was not subject to any directions from NHS England 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 NHS England 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 60, within the Members Report.

The Board met in public on six occasions during 2024/25 at different venues across MSE. Attendance at meetings is recorded. Each meeting was well attended and was quorate.

The Board also held one extraordinary meeting in private in August 2024 to consider the procurement of Tier 3 Weight Management services, and the Community Beds Decision Making 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 delivery of the ICP Strategy.

One urgent decision required between scheduled Board meetings was 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 the Board's risk appetite, financial recovery, the ICB's strategic objectives, 2024/25 planning, health inequalities, the Lampard Inquiry, community services, all age continuing care, new care models, equality diversity and inclusion, Medium Term Plan, and an ICB Board self-assessment.

The Board considered the outcome of the annual review of its effectiveness in January 2025. A detailed desktop review of effectiveness was provided to the Board; reviewing attendance at meetings, decisions made and how meetings were conducted generally. Two surveys were conducted with Board members to review the skill-mix of the Board and how members felt the Board had performed: identifying improvements for the future. During the session, members considered how the Board receives and relies on assurance, the approach to Board development, how the Board demonstrated its values and preparing for future challenges.

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), health and safety, sustainability and the ICB's responsibility to act effectively, efficiently, and economically.

As of 31 March 2025, 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 2024/25, the committee met on six occasions. Decisions were quorate in line with the committee's terms of reference (minimum of two members) on all occasions. There were no urgent decisions taken between meetings.

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 reporting to the Audit Committee were also received to provide the 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 2024/25 on behalf of the Board.

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

In line with NHS England 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 NHS England mandatory guidance on the management of conflicts of interest was received via the annual internal audit of conflicts of interest for 2024/25 which supported the previous year audit opinion of 'substantial' assurance.

The committee undertook a review of its effectiveness during 2024/25. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference.

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 2025, the committee comprised of three members. The committee was chaired by Joe Fielder, Non-Executive Member of the Board.

During 2024/25 the committee met on seven 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 new staffing structure, oversight of delivery of the ICB's Organisational Development Plan, approval of new and revised policies, approval of very senior managers' remuneration, review of ICB workforce key performance indicators, off-payroll contracts, review of NHS Staff Survey and Pulse Survey outcomes, the ICB's Workforce Race Equality

Standard report and Gender Pay Gap report, and ratification of any urgent decisions taken between meetings.

The committee undertook a review of its effectiveness during 2024/25. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to further 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; quality and patient safety policies and procedures, review of the provider Quality Accounts 2023/24; serious incidents and never events; updates on special educational needs and disabilities (SEND) services; learning disabilities; infection prevention and control strategy; safeguarding escalations; all age continuing care; review of patient safety and quality risks; medicines optimisation; mental health services; community services; maternity services; and complaints. No virtual decisions were taken outside of formal committee meetings during 2024/25.

Deep-dive reviews into specific areas, which included lived experience stories, including catheter care, special educational needs and disabilities (SEND), inpatient peer support, Patient Safety Incident Response Framework (PSIRF) and community dental services initiatives, 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 2025, the committee comprised of sixteen members, including representation from main provider organisations and the ICB's Patient Safety Partner. The committee was 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 2024/25. 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 2024/25. 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 further enhance how the committee operates going forward.

Finance and Performance Committee

The scope of the ICB's former Finance and Investment Committee was changed in August 2024 to include scrutiny of all aspects of performance and was renamed as the Finance and Performance Committee.

The committee 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 undertakes quarterly 'deep dive' sessions where the Executive Chief Finance Officers from MSEFT and EPUT attend regarding financial sustainability and performance.

The committee approved any new or updated finance policies prior to their adoption by the Board.

As of 31 March 2025, the committee comprised of ten members. The committee was 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 12 occasions during 2024/25. Decisions were quorate in line with the committee's terms of reference (minimum of four members) on all occasions. There were no urgent decisions taken between meetings.

The committee undertook a review of its effectiveness during 2024/25. 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 role and membership of the System Oversight and Assurance Committee was revised in July 2024/25 to avoid potential duplication between other sub-committees of the Board. Its primary purpose was to bring partners together for mutual accountability of system overall performance according to the requirements of relevant legislation, the NHS Constitution and NHS England (assessed through the NHS England Oversight Framework). To support this, deep dives of significant system risks are undertaken. During 2024/25 these related to: outpatients; community waiting lists; and clinical diagnostic centres.

The committee also receives escalations of issues not being resolved via other ICB sub-committees of the Board to collectively agree on action required and agrees on matters for escalation to the Chief Executives Forum and sovereign Boards of the ICB or partner organisations.

As of 31 March 2025, the committee had 13 members. The committee was co-chaired by Tom Abell, Chief Executive of the ICB, and Simon Wood, Regional Director for Strategy and Transformation, NHS England.

The committee met on six occasions during 2024/25. 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 also holds separate confidential meetings, chaired by the Regional Director of Finance, NHS England, specifically to provide oversight of MSEFT's progress with delivery of its agreed National Oversight Framework Level 4 (NOF4) exit criteria. From August 2024, seven confidential meetings were held.

The committee undertook a review of its effectiveness during 2024/25. This assessment identified that the committee had contributed to collaborative working across the system, holding partners to account and escalating issues to appropriate forums.

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, proposed branch closures and mergers, 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 premises and information and technology were also considered by the committee.

Virtual approval of three urgent decisions between meetings was also sought regarding: securing primary care services for the Special Allocation Service; non-recurrent commissioning of additional orthodontic activity to support a waiting list reduction; and support for the establishment of a Local Dispute Resolution Panel.

As of 31 March 2025, the committee had eleven members. The committee was chaired by Professor 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 2024/25. Decisions were quorate in line with the committee's terms of reference (minimum of four members) on all occasions, including virtual decisions which were ratified at subsequent meetings.

The committee undertook a review of its effectiveness during 2024/25. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to further 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 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 2024/25 the work of Congress included reviewing several service restriction policies and considering the options and feedback on the Neuromodulation service.

As of 31 March 2025, the committee's terms of reference state that its membership may comprise of up to 15 members. Congress was chaired by Dr Matt Sweeting, Executive Medical Director. Meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

Congress met on six occasions during 2024/25. Meetings were quorate in line with terms of reference (minimum of eight members) on all occasions. No urgent decisions were taken between meetings.

Congress undertook a review of its effectiveness during 2024/25. This assessment identified that it had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen effectiveness of the committee has been developed.

Executive Committee

The Executive Committee provides 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 2025 comprised 12 members.

The committee met weekly during 2024/25. Business conducted by the committee included consideration of business cases; review of performance; oversight of operational delivery; development of ICB strategy, oversight of financial sustainability within the ICB and wider system, review of draft agendas for meetings of the ICB Board and its sub-committees, and organisational development.

Following the announcement in March 2025 that ICBs are required to significantly reduce their running costs by Quarter 3 of 2025/26, the committee's focus will include developing arrangements to achieve the necessary savings.

Digital, Data and Technology Board

The Digital Data and Technology (DDaT) Board was formally established as a sub-committee of the Board in November 2024, with the purpose of providing oversight and assurance to the Board in the development and delivery of relevant services commissioned by the ICB, mitigating risk as appropriate in the context of system working.

The committee's key achievements included oversight and assurance on delivery of Patients Know Best for EPUT and MSEFT; oversight and assurance on delivery of the Shared Card Record; implementation of an ICS reporting dashboard; implementation of an oversight framework for the management of Information Standard Notices with partners; supporting the Unified Electronic Patient Record programme approvals through local governance; supporting the implementation of Digital Social Care Record solutions across our local authority partners; and maintaining established governance through sub committees to support assurance on key functions such as cyber, information governance and relevant standards.

As of 31 March 2025, the committee had 16 members. The committee was chaired by Paul Scott, Chief Executive Officer of EPUT. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

DDaT Board met on five occasions during 2024/25 (twice as a formal sub-committee of the Board). Decisions were quorate in line with the committee's terms of reference (minimum of five members). No urgent decisions were taken between meetings.

The committee undertook a review of its effectiveness during 2024/25. 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.

People Board

The People Board was established as a sub-committee of the Board in January 2024, with the first formal meeting occurring in 2024/25. Its purpose is to provide the ICB with assurance that it is delivering its functions and undertaking its responsibilities to deliver workforce related activities carried out by the ICB as an employer, and to collaborate with partner organisations to build and develop the system's workforce.

During 2024/25 the People Board focussed on reviewing bank and agency use by its main providers (MSEFT and EPUT) including action taken to reduce expenditure in these areas; progress against the equality, diversity and inclusion six high impact actions; updates from workstreams reporting to People Board; learning and development; the People Promise and retention; workforce data and key performance indicators; and risks within the remit of the committee.

As of 31 March 2025, the committee had 16 members. 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 five occasions during 2024/25. Decisions were quorate in line with the committee's terms of reference (minimum of four members) on all occasions. There were no urgent decisions taken between meetings.

The committee undertook a review of its effectiveness during 2024/25. This assessment identified (that as a new committee) there were several areas for improvement. An action plan to strengthen the effectiveness of the committee has therefore been developed.

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 (including discharge fund) 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 and was delivered both to the Alliance Committees within the ICB for internal governance and to the relevant Health and Wellbeing Board as required under the national BCF policy Framework.

Case study: Better Care Fund – shared working and supporting flow

- An Out patient antibiotic therapy service is in place at Southend Hospital and Basildon Hospitals funded by the Discharge fund within the BCF.
- The service is designed for and has demonstrated support to Assessment units / ED / inpatient wards / and allowing people to avoid admission by facilitating patients to be treated in an outpatient facility to have their therapy rather than remaining in hospital, thus supporting hospital flow and reducing LOS.
- The service is reviewing capacity at Broomfield to build on this learning.
- The service is popular with patients attending as it allows them to go home and have their care over seen by the hospital and has great patient feedback.

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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 2024/25 encompassed 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. 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.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

The ICB's Scheme of Reservation and Delegation was updated in November 2024 to take account of the establishment of the Digital, Data and Technology Board as a sub-committee of the ICB Board.

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, which encompasses clinical and non-clinical risks, 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.

The policy includes 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 in 2025/26 to take account of new operational arrangements to manage risks, including system risks (the ICB is part of an NHS England pilot to implement a new process for assessing risks in an integrated care system).

Risks recorded on the ICB's risk management database are mapped against the ICB's Strategic Objectives, approved by the ICB Board in July 2024, along with responsible directorates, risk leads and committees.

The ICB identified its top strategic areas of risk which are monitored via the ICB's Board Assurance Framework (BAF). During 2024/25, 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 might 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 or operational performance standards.

- **System financial performance** – the system is financially challenged. Failure to deliver the financial plan could 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 BAF is reviewed by the Audit Committee and by the ICB Board at its publicly held meetings. Committees also maintain oversight of risks on the BAF that link to their terms of reference.

The Board reviewed risks reported via the BAF in March 2025 and were agreeing revised BAF risks for 2025/26.

The ICB is participating in a pilot for assessing and managing risks across integrated care systems in line with guidance issued by NHS England. This will involve bringing partner organisations together in early 2025/26 to assess two specific service areas where the patient pathway cuts across different system partners.

Capacity to handle risk

During 2024/25 the ICB had the following arrangements in place:

- A risk management database (Datix) which records clear ownership of risks, with responsible directors and lead officers identified.

- Regular reporting to committees regarding risks within their remit.

- Escalation arrangements in place to the ICB Board and/or other appropriate forums.

- 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.

- Health & Safety 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.

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 Patient Safety Incident Response Framework (PSIRF) 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. The Quality Committee received a presentation on progress with PSIRF in December 2024.

Stakeholders, including staff, patients and the public are involved in the risk management process, for example by ensuring that relevant staff are identified to input into any risk assessments in their function or area of work. ICB staff and contractors are 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 is 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.

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, 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 substantial assurance that effective risk management, control and governance processes in place.

Annual audit of conflicts of interest management

The internal audit of conflicts of interest issued in February 2024 identified 'substantial' assurance that a robust system of control is in place to identify, manage and monitor conflicts of interest. A further audit by the counter fraud team in March 2025 confirmed that there had been no change to the measures and controls in place to manage conflicts.

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 and the People 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 the Cyber Assurance Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) 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 2025, the ICB will be submitting a partially compliant CAF aligned DSPT return at the end of June 2025. This has resulted from the change in assertions whereby nationally the DSPT has been aligned to the CAF. This is a similar position to other ICBs and ICS partners across the country. The Information Governance Steering Group has provided assurance to the Audit Committee that appropriate action plans are being developed to address the gaps and these will also be approved and monitored by NHS England.

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 2024 to March 2025, there was a total of 1727 new complaints, concerns and enquiries opened, and 1336 closed, excluding those carried forward from 2023/24.

<u>Current Trends</u>

The top five thematic subject areas for complaints, concerns and enquiries are listed below. It should also be noted that whilst there was a significant increase in concerns regarding Shared Care Arrangements for ADHD Medication following GP Collective Action, access to treatment or drugs would still have been the highest rated area of concern.

1. Access to treatment or drugs.

2. Patient care.
3. Appointments.
4. Communications.
5. Values and behaviours (staff).

Learning from complaints is shared with providers, primary care, alliances and internal stakeholders to inform pathways and services and improve patient experience. This includes where serious incidents or professional standards issues are identified as a result of a complaint investigation.

Complaints to Parliamentary and Health Service Ombudsman (PHSO) and Local Government and Social Care Ombudsman (LGSCO)

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 PHSO.

In 2024/25, five complaints were referred to the PHSO. Of these, two were stage 1 enquires; two were stage 2 primary investigations, and one was a stage 3 detailed investigation undertaken jointly by the PHSO and LGSCO.

The areas of concern raised to PHSO included continuing healthcare assessments and retrospective appeals, learning and disability care for babies and young children, adult mental health provision and ADHD assessment referrals for children.

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 2025/26 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). All service auditor reports summarised below were issued on the basis of providing assurance limited to the scope of their review according to the testing undertaken.

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 that controls were suitably designed and operated effectively to provide reasonable assurance that control objectives were achieved.

The ICB retains the services of *Attain* to ensure probity during procurement processes. The Finance and Performance 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.

PriceWaterhouseCoopers LLP undertook a review of the GP Extract Services (GPES) and the Capitation Feed, which is concerned with the processing of data used to inform payments; it was noted that processing of actual payments to General Practices was out of scope of the review. The service auditor report concluded that controls were suitably designed and operating effectively with two exceptions relating to the approval of new user access, the revocation of access for leavers and the quarterly review of access, alongside there being a lack of segregation of duty between the production and the development environments of the GP Data Controller.

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 approval, reporting and payments calculation system for General Practitioner (GP) Practices. The service auditor report concluded that controls were suitably designed and operated effectively to provide reasonable assurance that control objectives were achieved.

Forvis 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). The report provided a qualified opinion concluding that controls were suitably designed and operated effectively to provide reasonable assurance that control objectives were achieved with the exception of one control matter relating to logical access controls.

NHS Shared Business Services Limited (NHS SBS) provides finance and accounting services to the ICB. Ernst and Young LLP undertook the independent audit of the control environment within SBS and issued a qualified opinion concluding that controls were suitably designed and operated effectively to provide reasonable assurance that control objectives were achieved with the exception of three areas relating to samples of validation checks on bank details, checking credit limits prior to processing and user access controls. SBS have provided assurance that additional checks have been put in place to mitigate these issues.

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. The report concluded that controls were suitably designed and operated effectively to provide reasonable assurance that control objectives were achieved.

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 controls were suitably designed and operated effectively to provide reasonable assurance that control objectives were achieved.

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:

Performance against cancer constitutional standards – oversight of improving cancer performance was via the national fortnightly tier one meetings and the MSE Cancer Board, with escalations via the System Oversight and Assurance Committee (SOAC), with a focus on recovery of both the faster diagnosis standard and 62-day standards. The cancer alliance pathway analyser tool was used to identify actions to support recovery of cancer pathways to identify where actions can be taken to improve performance by reducing delays in the pathway. Immediate actions to support recovery of the skin pathway have included outsourcing skin pathology to streamline the approach, with the introduction of one stop clinics across MSEFT sites for a longer-term sustainable recovery of performance. In Quarter Four of 2024/25 four task groups were established to provide greater senior leadership and focus on the most challenged pathways: skin, treatments, urology and breast.

Elective recovery – a recovery plan was in place with oversight via the national fortnightly tier one meetings and the SOAC 'undertakings' meeting, which focussed on recovery of the waiting list standards. Procurements to improve services, pathway and performance are being undertaken for community dermatology, community MSK, community endoscopy and ultrasound services. The ICB working with MSEFT have been supporting patients to be transferred to other providers with shorter waiting times to support them to have their treatment, reduce overall waits. In Quarter Four of 2024/25 in response to the NHS England Elective Reform Letter a group has been established to ensure delivery of the asks within this including Choice, ensuring productivity, increased utilisation of advice and guidance and improving performance.

Diagnostics – the ICB worked closely with MSEFT on oversight of their recovery actions to improve performance and the time people were waiting from referral to diagnostic test. During Quarter Four of 2024/25 MSEFT were placed in Tier 1 for diagnostic performance due to the number of people waiting 13 weeks plus for their diagnostic test rather than the six-week standard. Performance is overseen via the Quality, Contract, Performance Meeting (QCPM) and the System Diagnostic Board, with escalation to SOAC if required. Community Diagnostic Programme and centre plans are overseen via the Community Diagnostic Programme Board who have oversight of the capacity constraints and delays in building CDC infrastructure.

Ambulance Services – handover delays have been overseen by the Urgent and Emergency Oversight and Assurance Board, with escalations to SOAC. Escalation processes were established within the System Control Centre (SCC) to ensure a clear plan was in place should handovers exceed 30 minutes. With twice daily SCC meetings and escalation processes in place in collaboration with the ambulance service and system partners to support improvement. Additionally, programmes of work such as the Unscheduled Care Coordination Hub (UCCH), handover and conveyancing protocols supported the recovery plan to improve ambulance waiting times.

Delivery of 4-hour A&E standard – a critical component supporting ambulance handovers, the quality improvement plan was overseen by the Urgent and Emergency Oversight and Assurance Board, with escalations to SOAC. SCC meetings supported the improvement plan, as well as specific actions on ward rounds, early discharge planning, same day emergency care services and use of the system discharge cell.

Continuing Health Care (CHC) – the CHC programme had a refreshed 3-pillar approach to address All Age Continuing Care (AACC), discharge to assess and market management process. Discharge to assess successfully moved into a recovered and sustainable position in quarter 3. Annual reviews of CHC patients and appeals backlogs had also significantly improved, with an increased focus on addressing outstanding court of protection/deprivation of liberty applications.

Maternity – Basildon maternity services received a 'notice of proposal' to remove their section 31 notice, whereas Broomfield maternity service was served a section 31 notice in April 2024. Southend and Basildon maternity services were rated by the CQC as 'requires improvement'. Oversight via the Local Maternity and Neonatal Steering Board with escalation to the Quality Committee or SOAC where appropriate.

Mental health and Dementia – remedial action place in place reporting to SOAC where appropriate. Current procurement processes in place and service improvement plans such as time to care are being initiated to address mental health and dementia service performance.

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 to increase financial scrutiny, which required certain financial decisions to be referred to and overseen by NHS England.

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

The ICB reported a £67K surplus for the year, whereas the system reported a deficit of £16.351million. The ICB's Finance and Performance 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 Performance Committee continued to monitor the ICB's procurement and planning arrangements to ensure value for money from commissioned services.

The ICB's 2024/25 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 2024/25 are included in their report immediately after the annual accounts (see page 27 onwards).

Commissioning of delegated specialised services

Mid and South Essex ICB signed a delegation agreement (DA) with NHS England and held full commissioning responsibilities for delegated services during the 2024/25 reporting period.

To the best of ICB leadership's knowledge, the commissioning of all delegated services has been compliant with the 10 core commissioning requirements – as set out in the 2024/25 Delegated Commissioning Assurance Guidance, published by NHS England – including the requirement that all conditions set out in the DA are being met.

The ICB leadership is able to provide the necessary evidence of core commissioning requirements compliance, should NHS England or a third party (e.g. external auditors) ask for such evidence.

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, for the contract management of the home oxygen service, and East of England Ambulance service contract.

The delegation of functions to the ICB from NHS England 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 2024 to 31 March 2025 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, for the areas reviewed during the year, the ICB had reasonable and effective risk management, control and governance processes in place:

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

Assignment	Assurance Opinion
Key Financial Controls	Substantial
Governance, Risk Management and Board Assurance Framework	Substantial
Cyber Security	Substantial
Primary Care Estates: Part 1 – Primary Care Directions Rents and Leases / Improvement Grants	Substantial
Primary Care Delegated Commissioning, Review of Self-Assessment for General Medical, Pharmacy, General Ophthalmic and Dental Services	Substantial
Addressing Health Inequalities and Population Health Management	Reasonable
Fit and proper persons test framework	Reasonable
Collaboration and Partnerships	Reasonable
Contract Management	Reasonable
Conflicts of Interest	No change from previous year assessment of substantial assurance.

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 Performance Committee.
- System Oversight and Assurance Committee.
- Primary Care Commissioning Committee.
- Clinical and Muti-professional Congress.
- Executive Committee
- People Board
- Digital, Data and Technology Board
- Alliance Committees
- Internal Audit.
- External Audit.

Conclusion

I concur with the Head of Internal Audit Opinion that during 2024/25 there were reasonable and effective risk management, control and governance processes in place, 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 2025/26 financial year.

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

Tom Abell
Chief Executive of Mid and South Essex Integrated Care Board

19 June 2025

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

For 2024/25 the membership of the remuneration committee was as follows:

- Joe Fielder, Non-Executive Member (Chair)
- Mark Harvey, Partner Member
- Dr Neha Issar-Brown, Non-Executive Member

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

HR and remuneration advice was provided by the Interim Executive Chief People Officer 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

2024-25	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5%	n/a*
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	5%	n/a*

The pay ratios have increase broadly in line with the NHS pay rise for 2024-25, during 2024-25.

	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.

* The ICB has not paid any performance pay or bonuses in 2024-25 or 2023-24. The percentages for salary and allowances were disclosed in 2023-24.

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 annualised remuneration of the highest paid director/member in Mid and South Essex ICB in the financial year 2024-25 was £220K - £225k (2023-24: £210K - £215k), and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay Ratio information table:

2024-25	25th percentile	Median	75th percentile
Total remuneration (£)	£33,940	£50,181	£64,669
*Salary component of total remuneration (£)	£33,940	£50,181	£64,669
Pay ratio information	6.6 : 1	4.4 : 1	3.4 : 1

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

*No Performance Pay and Bonus Payments are paid by the ICB, although Total remuneration does included benefits in kind relating to lease cars.

In 2024-25 0 employees received annualised remuneration in excess of the highest-paid director (2023-24: 0)

During the reporting period 2024-25, remuneration ranged from £2k to £223k (2023-24: £1k to £212k) 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 2024-25

This ICB remuneration report for 2024-25 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 2024-25

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

Notes	Name	Title	2024/25					Date served	
			Salary (bands of £5,000) £000	Taxable benefits / expenses (nearest £100) £	Other Remuneration (bands of £5,000) £000	All Pension Related Benefits [8] (bands of £2,500) £000	Total (bands of £5,000) £000	Commenced	Ceased
	Executive Directors								
1	Tom Abell	Chief Executive Officer	140-145	0	0	0	140-145	08-Aug-24	
1	Tracy Dowling	Interim Chief Executive Officer	75-80	0	0	7.5-10	80-85	20-Nov-23	07-Aug-24
2	Jennifer Kearton	Executive Chief Finance Officer	140-145	1100	0	0	140-145	10-Oct-22	
2	Dr Giles Thorpe	Executive Chief Nursing Officer	155-160	6400	0	0	160-165	14-Aug-23	
3	Dr Matt Sweeting	Executive Medical Director	145-150	0	0	72.5-75	220-225	14-Aug-23	
4	Dr Kathy Bonney	Interim Executive Chief People Officer	125-130	0	0	0	125-130	01-May-24	
4	Lisa Adams	Interim Executive Chief People Officer	5-10	0	0	0-2.5	5-10	28-Jun-23	21-Apr-24
	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	
5	**Partner Members**								
6	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	
	Matthew Hopkins	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Aug-23	
	Peter Fairley	Partner Member, Essex County Council	0	0	0	0	0	01-Jul-22	
7	Robert Persey	Partner Member, Thurrock Council	0	0	0	0	0	13-Jan-25	
7	Ian Wake	Partner Member, Thurrock Council	0	0	0	0	0	May 23	05-Jan-25
	Mark Harvey	Partner Member, Southend City Council	0	0	0	0	0	13-Mar-23	

Notes:

1 Tracy Dowling filled the role of Interim Chief Executive Officer until 7th August 2024. Tom Abell became the Chief Executive Officer on 8th August 2024.

2 Jeniffer Kearton & Dr Giles Thorpe, have salary sacrifice lease cars, which accrue a taxable benefit, which has been included above.

3 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 Executive Medical Director from 1st May 2024.

4 Lisa Adams filled the role of Executive Chief People Officer until 21st April 2024. Dr Kathy Bonney was appointed Interim Executive Chief People Officer on 1st May 2024.

5 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.

6 In addition to the Partner Member role, Dr Anna Davey filled a Clinical Lead role. Remuneration for this role was in the £45k-£50k band and is in addition to the figure quoted above.

7 Robert Persey became the Partner Member for Thurrock Council on 13th January 2025, with Ian Wake ceasing to be the Partner Member for Thurrock Council on 5th January 2025.

8 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.

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	Taxable benefits / expenses (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.

Pension entitlements of directors and senior managers 2024-25

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 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2025 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2024 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2025 £000	Employers contribution to stakeholder pension £000
Executive Directors									
Tracy Dowling	Interim Chief Executive Officer	0-2.5	0	5-10	0	122	0	158	158
Jennifer Kearton	Executive Chief Finance Officer	0-2.5	0	40-45	95-100	721	0	767	767
Dr Giles Thorpe	Executive Chief Nursing Officer	0	0	40-45	105-110	841	0	874	874
Dr Matt Sweeting	Executive Medical Director	2.5-5	2.5-5	35-40	90-95	631	60	752	752
Lisa Adams	Interim Executive Chief People Officer	0-2.5	0	0-5	0	12	0	16	16

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for their non-executive directors role.

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.

Public Service Pensions Remedy

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 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	122
Anthony McKeever	Chief Executive Officer	0	0	0	0	0	0	0	0
Jennifer Kearton	Chief Finance Officer	2.5-5	40-42.5	35-40	95-100	415	244	721	721
Dr Giles Thorpe	Executive Chief Nursing Officer	2.5-5	32.5-35	35-40	110-115	495	175	841	841
Frances Bolger	Interim Chief Nursing Officer	0	0	0	0	0	0	0	0
Dr Matt Sweeting	Interim Medical Director	2.5-5	7.5-10	30-35	80-85	451	85	631	631
Lisa Adams	Interim Executive Chief People Officer	0-2.5	0	0-5	0	0	7	12	12

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.

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.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former 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 applies.

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. 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. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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 2024/25 accounting period there were none.

Payments to past directors

For the 2024/25 accounting period there were none.

Staff Report

Number of senior managers

In 2024/25, the ICB had 92 senior managers.

Staff numbers and costs (subject to audit)

EMPLOYED STAFF		
Employee category	Headcount	WTE
Permanent	392	360.74
Fixed-term	46	35.80
TOTAL	438	396.54
AGENCY & INTERIM		
TOTAL	86	32.61
GRAND TOTAL	**524**	**413.13**

Staff composition

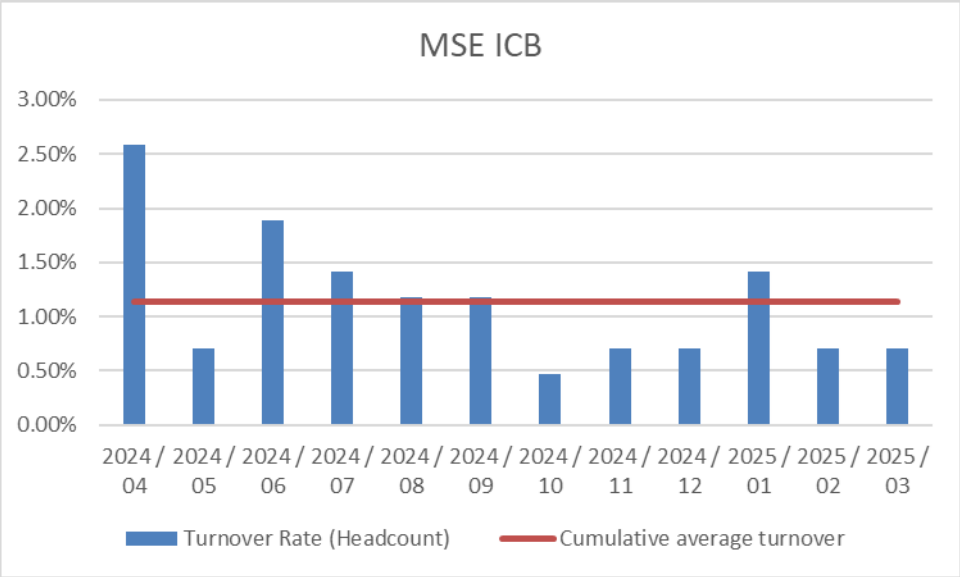
Pay Band	2	3	4	5	6	7	8a	8b	8c	8d	9	VSM	Other	Grand Total
									Senior Managers					
Female		4	51	35	70	57	54	36	20	17	7	13	29	393
Male	1		11	4	10	14	9	6	7	11	5	12	41	131
Grand Total	1	4	62	39	80	71	63	42	27	28	12	25	70	524

Sickness absence data

Average FTE	Average Sick Days per FTE	FTE-Days recorded Sickness Absence	FTE-Days Available
385.98	9.73	3754.90	140,883.53

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 again in 2024 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 13 March 2025.

The ICB had a significantly improved response rate of 79% compared with 62% the previous year.

Key themes were shared with the ICB executive team who commenced work with their directorates to write action plans in response to the staff survey results. In addition, the ICB has 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. In 2024/25 a new network was launched that celebrates and supports staff with neurodiversity. The ICB Inclusion and Belonging Steering Group co-ordinates the work of the networks and meets monthly to review progress.

86% of ICB staff, compared with 75% the previous year, said that they were satisfied with the opportunities for flexible working again above the national average of 80%.

The ICB was also a partner member in a system Staff Colleague Experience, Wellbeing and Retention Group, and a Culture and Diversity 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 2025/26 survey, supporting the development of organisational planning in response to the system survey results and giving the opportunity for staff to shape the plan.

The ICB continues to hold regular 'all-staff' briefings to communicate key messages, as well as operational updates and regular updates on system priorities. In 2024 the ICB also engaged with the NHS Staff Pulse Surveys to monitor progress throughout the year.

In 2024, 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.*

50% of staff, compared with 28% of staff in the previous year, would recommend the ICB as a place to work, which is a notable improvement and matching the national average of 50%. This is a direct result of the implementation of an effective organisational repair, recover and reset plan that has resulted in the ICB being the most improved ICB in the country (taking it out of the bottom position to the middle of national ICBs in just one year). In terms of attraction rates, the ICB has remained very popular in the recruitment market showing high levels of interest by high calibre applicants and retention has also improved showing a reduction in turnover of 9.5%.

The ICB continues to monitor and review its recruitment practices to ensure they keep pace with changing employment markets and remain values based and inclusive. This is part of an ongoing implementation ICB People Management Strategy (which looks at all elements of people management throughout the employees' journey from start to finish) and more recently the launch of an ICB Equality, Diversity, Inclusion and Belonging Strategy.

Staff policies

The ICB maintains a comprehensive set of HR policies to support managers and staff through this employment journey and has created and launched a manager's toolkit to

allow easy access to all policies and guidance notes. Both the People Management Strategy and the managers toolkit were promoted via monthly Managers Learning Networks.

All ICB policies have been reviewed and updated in the light of any legislative changes and recommendations and learning from employee relations work. and others have been reviewed bi-annually as required by the ICB. The ICB has recently launched a new Sexual Misconduct Policy and Procedure in line with National NHS Guidance and a new Fostering Policy as part of applying for Fostering Friendly Accreditation.

The ICB has a Freedom to Speak Up (FTSU) Guardian, 2 Senior FTSU Officers and FTSU Champions. The ICB adopted the national FTSU Policy in the previous year and has received 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

In 2024 the ICB worked with EPUT in a joint procurement for an Occupational Health Provider. As a result of this process a new provider was appointed: People Asset Management, who were successful based on cost and customer service. The ICB had previously commissioned Optima for several years, to provide both the Occupational Health Service and the Employee Assist Programme (EAP) service. The transition to the new service has been smooth and there was no reduction in the experience of staff using the service and has been some very positive reviews.

Equality, Diversity, and Inclusion (ED&I)

In November 2024, the ICB Board met to review the system position in relation to the national ED&I High Impact Actions which requires 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 successfully worked 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. The People Board has continued to receive highlight reports from the system Culture and Diversity subgroup and staff networks across the system have created space for us to understand the lived experience of those staff that have protected characteristics acknowledging the intersectionality of all staff. Network chairs from across the system met to share their experiences and both a Reciprocal mentoring programme and a Rise and Thrive Programme to support staff from the Global Workforce Majority to progress their careers.

In November 2024, the ICB was confirmed by the European Human Rights Group to be Public Sector Equality Duty compliant. The ICB also completed and submitted evidence against the Equality Delivery System domains 2 & 3.

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 2025. These will be regularly monitored to ensure progress against agreed objectives.

The ICB also prepared and published a Pay Gender Gap Report and created the first Ethnicity Pay Gap Report which showed that both the ICB and the NHS still had a bias in the totality of what men and women earned and similar disparities in earnings for staff form diverse ethnic backgrounds.

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 evaluated and depending on the results of that evaluation will be refreshed and relaunched in 2025/26 if it is seen to make an impact. A similar evaluation will take place of the system Rise and Thrive Programme with funding already ringfenced to invest in this group of staffing.

The ICB has made a solid commitment to try and turn the dial on this area of staff experience noting the particularly static nature of reporting in this area, both in the system and in the NHS as a whole, agreeing to a zero-tolerance approach to any form of discrimination, agreeing that any score is a poor score, regardless of where the score may fall in terms of national averages.

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 moving and handling were included in the mandatory training programme for all ICB staff, and conflict resolution training was mandated for specific groups of staff.

The ICB's Health and Safety Working Group (HSWG) chaired by the Executive Director of Digital and Business Intelligence, met eight times during 2024/25. A review of health and safety arrangements, including the group's terms of reference, membership and workplan was undertaken in the latter half of the financial year.

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. ICB staff continue to work in a hybrid way and are required to complete a display screen equipment and working from home risk assessment. Regular health and safety inspections, building system tests and maintenance of the ICB's headquarters continued throughout the year and are monitored via the HSWG workplan.

A review of the ICB's security arrangements was undertaken by its internal auditors. Implementation of action required to address recommendations was monitored by the HSWG and Audit Committee.

The ICB stress risk assessment has been updated, and a Wellness Recovery Action Plan introduced as stress anxiety and depression remains the highest cause of sickness absence in the ICB, the system and the NHS as a whole. 78% of staff compared with 70% the previous year reported that the ICB had made reasonable adjustments to enable them to carry out their work. New ICB Guidance was also launched to support managers in understanding the nature and process of making a reasonable adjustment.

Trade union facility time reporting requirements

For 2024/25 we had 2 union representatives who spent a total of 33.5 hours on paid facility time (trade union duties and activities).

One representative spent 29 hours, 1.48% of their working time on paid union duties and activities facility time.

One representative spent 4.5 hours, 0.02% of their working time on paid union duties and activities facility time.

The total cost of facility time was £1k.

Expenditure on consultancy

Administrative	£581k
Programme	£569k

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2025, for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2025	7
Of which, the number that have existed:	
for less than one year at the time of reporting	1
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 2024 to 31 March 2025, for more than £245(1) per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 to 31 March 2025	8
Of which:	
No. not subject to off-payroll legislation(2)	7

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]	1
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 2024 to 31 March 2025:

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during reporting period	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.	18

Losses and Special Payments

There was one loss in 2024/25 as follows:

Losses	**Total number of cases 2024-25 Number**		**Total value of cases 2024-25 £'000**
Fruitless payments	1		120
Total	**1**		**120**

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

Table 1: Exit Packages 2024/25

	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	-	-	-	-	-	-	-	-
£10,001 to £25,000	2	45,114	-	-	2	45,114	-	-
£25,001 to £50,000	-	-	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000	-	-
Over £200,001	-	-	-	-	-	-	-	-
Total	3	205,114	-	-	3	205,114	-	-

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 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 2: Analysis of Other Departures

There are none in 2024/25

Table 2: Analysis of Other Departures 2023/24

	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 23 of the Annual Accounts. An audit certificate and report is also included in this Annual Report.

ANNUAL ACCOUNTS

Tom Abell
Chief Executive of Mid and South Essex Integrated Care Board

19 June 2025

Entity name:	NHS Mid and South Essex Integrated Care Board
	Statutory Accounts
This year	**1-Apr-24 to 31-Mar-25**
Last year	1-Apr-23 to 31-Mar-24
This year ended	**31-Mar-25**
Last year ended	31-Mar-24
This year commencing:	**01-Apr-24**
Last year commencing:	01-Apr-23

Contents

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	**2024-25 £'000**	2023-24 £'000
Income from sale of goods and services	2	(40,125)	(47,564)
Other operating income	2	(228)	-
Total operating income		**(40,353)**	**(47,564)**
Staff costs	4	30,743	38,110
Purchase of goods and services	5	3,176,389	2,703,294
Depreciation and impairment charges	5	332	462
Provision expense	5	2,200	(8,931)
Other operating expenditure	5	1,171	557
Total operating expenditure		**3,210,835**	**2,733,492**
Net operating expenditure		**3,170,482**	**2,685,928**
Finance expense	7	27	21
Other gains & losses	8	-	6
Net expenditure for the year		**3,170,509**	**2,685,955**
Total net expenditure for the financial year		**3,170,509**	**2,685,955**

The notes on pages 7 to 26 form part of this statement.

Statement of Financial Position as at 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Right-of-use assets	9	4,115	2,195
Total non-current assets		**4,115**	2,195
Current assets:			
Trade and other receivables	10	15,679	17,736
Total current assets		**15,679**	**17,736**
Total assets		**19,794**	**19,931**
Current liabilities			
Trade and other payables	12	(131,821)	(143,315)
Lease liabilities	9	(469)	(285)
Borrowings	13	(3,626)	(2,523)
Provisions	14	(3,738)	(1,396)
Total current liabilities		**(139,654)**	**(147,519)**
Non-current assets less net current liabilities		**(119,860)**	**(127,588)**
Non-current liabilities			
Lease liabilities	9	(3,906)	(2,125)
Provisions	14	(5,687)	(7,385)
Total non-current liabilities		**(9,593)**	**(9,510)**
Assets less liabilities		**(129,453)**	**(137,098)**
Financed by taxpayers' Equity			
General fund		(129,453)	(137,098)
Total taxpayers' equity:		**(129,453)**	**(137,098)**

The notes on pages 7 to 26 form part of this statement.

The financial statements on pages 3 to 6 were approved by the Governing Body on 17th June 2025 and signed on its behalf by:

Chief Executive Officer
Tom Abell

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(137,098)	**(137,098)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(3,170,509)	**(3,170,509)**
Net recognised NHS Integrated Care Board expenditure for the financial year	**(3,170,509)**	**(3,170,509)**
Net funding	3,178,154	**3,178,154**
Balance at 31 March 2025	**(129,453)**	**(129,453)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2023-24		
Balance at 01 April 2023	(179,100)	**(179,100)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24		
Net operating costs for the financial year	(2,685,955)	**(2,685,955)**
Net recognised NHS Integrated Care Board expenditure for the financial year	**(2,685,955)**	**(2,685,955)**
Net funding	2,727,957	**2,727,957**
Balance at 31 March 2024	**(137,098)**	**(137,098)**

The notes on pages 7 to 26 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2025

	Note	**2024-25 £'000**	2023-24 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(3,170,509)	(2,685,955)
Depreciation and amortisation	5	332	462
Other gains & losses	8	-	6
Increase in trade & other receivables	10	2,057	(8,092)
Increase/(decrease) in trade & other payables	12	(11,494)	(22,986)
Provisions utilised	14	(1,555)	(1,793)
Increase/(decrease) in provisions	14	2,200	(8,932)
Net cash outflow from operating activities		**(3,178,969)**	**(2,727,290)**
Cash flows from investing activities			
Interest paid / received	7	27	21
Net cash Inflow from investing activities		**27**	**21**
Net cash outflow before financing		**(3,178,942)**	**(2,727,269)**
Cash flows from financing activities			
Grant in Aid funding received		3,178,154	2,727,957
Repayment of lease liabilities	9	(315)	(403)
Net cash inflow from financing activities		**3,177,839**	**2,727,554**
Net (decrease)/increase in cash & cash equivalents	11	**(1,103)**	**285**
Cash & cash equivalents at the beginning of the financial year		(2,523)	(2,808)
Cash & cash equivalents (including bank overdrafts) at the end of the financial year		**(3,626)**	**(2,523)**

The notes on pages 7 to 26 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 2024-25 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.
On 13 March 2025 the government announced NHS England, and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

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 Joint arrangements

The ICB has not been part of any pooled budget arrangements in 2024-25. The ICB has operated Better Care Funds during 2024-25 under Section 75 agreements with Essex County Council, Southend City Council and Thurrock Council. The arrangements under which the Better Care Funds operated in 2024-25 do not constitute pooled budgets as the risks of each scheme remained with the respective commissioners. See Note 20 for further information.

1.4 Operating Segments

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

1.5 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.

1.6 Employee Benefits

1.6.1 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.

1.6.2 **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.

1.7 **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.

1.8 **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.

1.9 **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.

1.9.1 **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 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.

1.10 **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 bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.11 **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. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
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.

1.12 **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.

1.13 **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.

1.14 **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.

1.14.1 **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.

1.15 **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.

1.16 **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.

1.17 **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 spot 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.

1.18 **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).

1.19 **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.

1.19.1 **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 2024-25, under section 75 agreements. These arrangements has 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 20 for further information.

1.19.2 **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 2024-25 that will be payable in 2025-26.

1.20 **New and Revised IFRS Standards in Issue but Not Yet Effective**
● 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.
● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet U.K. endorsed and not yet adopted by the FReM. Early adoption is not permitted
● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet U.K. endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2 Operating Income

	2024-25 Total £'000	2023-24 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	3,807	9,961
Prescription fees and charges	13,821	13,131
Dental fees and charges	20,691	19,978
Other contract income	1,806	4,494
Total income from sale of goods and services	**40,125**	**47,564**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	23	-
Other non-contract revenue	205	-
Total other operating income	**228**	**-**
Total operating Income	**40,353**	**47,564**

3 Disaggregation of Income - Income from Sale of Good 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	1,407	-	-	-
Non-NHS	2,400	13,821	20,691	1,806
Total	**3,807**	**13,821**	**20,691**	**1,806**
Timing of revenue				
Over time	3,807	13,821	20,691	1,806

4 Employee Benefits and Staff Numbers

4.1 Employee Benefits

	2024-25		
	Permanent employees £'000	**Other £'000**	**Total £'000**
Employee benefits			
Salaries and wages	22,659	654	**23,313**
Social security costs	2,532	-	**2,532**
Employer contributions to NHS pension scheme	4,646	-	**4,646**
Other pension costs	39	-	**39**
Apprenticeship levy	105	-	**105**
Termination benefits	108	-	**108**
Gross employee benefits expenditure	**30,089**	**654**	**30,743**
Net employee benefits	**30,089**	**654**	**30,743**

	2023-24		
	Permanent employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	24,624	1,023	**25,647**
Social security costs	3,074	(1)	**3,073**
Employer contributions to NHS pension scheme	4,450	(2)	**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**

4.2 Average Number of People Employed

	2024-25			2023-24		
	Permanently employed	**Other**	**Total**	Permanently employed	Other	Total
Total number of people employed (WTE)	**386.93**	**7.88**	**394.81**	**428.61**	**19.22**	**447.83**

4.3 Exit Packages Agreed in the Financial Year

	2024-25 Compulsory redundancies		**2024-25 Other agreed departures**		**2024-25 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	**-**
£10,001 to £25,000	2	45,114	-	-	2	**45,114**
£25,001 to £50,000	-	-	-	-	-	**-**
£50,001 to £100,000	-	-	-	-	-	**-**
£100,001 to £150,000	-	-	-	-	-	**-**
£150,001 to £200,000	1	160,000	-	-	1	**160,000**
Over £200,001	-	-	-	-	-	**-**
Total	**3**	**205,114**	**-**	**-**	**3**	**205,114**

	2023-24 Compulsory redundancies		2023-24 Other agreed departures		2023-24 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**

4.4 Analysis of Other Agreed Departures

	2024-25 Other agreed departures		2023-24 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	71	3,929,936
Total	**-**	**-**	**71**	**3,929,936**

4.5 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:

4.5.1 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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.

4.5.2 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 (considering recent demographic experience), and to recommend the contribution rate payable by 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.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

5 Operating Expenses

	2024-25	2023-24
	£'000	£'000
Purchase of goods and services		
Services from other ICBs and NHS England	6,001	6,702
Services from Foundation Trusts	1,831,719	1,481,685
Services from Other NHS Trusts	213,125	149,995
Services from Other WGA bodies	1,307	1
Purchase of healthcare from non-NHS bodies	490,210	457,335
Purchase of social care	146	590
General dental services and personal dental services	78,325	76,371
Prescribing costs	222,616	214,805
Pharmaceutical services	42,114	37,115
General ophthalmic services	12,224	11,759
GPMS/APMS and PCTMS	244,103	221,879
Supplies and services – clinical	489	68
Supplies and services – general	14,739	24,204
Consultancy services	1,150	782
Establishment	2,344	2,483
Transport	247	213
Premises	9,963	11,944
Audit fees	189	181
Other non-statutory audit expenditure		
Other services *[1]	55	91
Other professional fees	4,172	4,956
Legal fees	765	327
Education, training and conferences	386	(192)
Total purchase of goods and services	**3,176,389**	**2,703,294**
Depreciation charges		
Depreciation	332	462
Total depreciation charges	**332**	**462**
Provision expense		
Provisions	2,200	(8,931)
Total provision expense	**2,200**	**(8,931)**
Other operating expenditure		
Chair and non-executive members	201	170
Grants to other bodies	252	363
Expected credit loss on receivables	595	-
Other expenditure	123	24
Total other operating expenditure	**1,171**	**557**
Total operating expenditure	**3,180,092**	**2,695,382**

*[1] Other services includes the fee for the MHIS audit and £13k in relation to additional costs for 2023-24 year-end Audit.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	70,959	899,461	57,325	847,172
Total non-NHS trade Invoices paid within target	68,746	859,100	55,645	788,329
Percentage of non-NHS trade invoices paid within target	**96.88%**	**95.51%**	**97.07%**	**93.05%**
NHS Payables				
Total NHS trade invoices paid in the year	2,334	2,094,543	1,610	1,688,030
Total NHS trade invoices paid within target	2,253	2,089,507	1,541	1,683,761
Percentage of NHS trade invoices paid within target	**96.53%**	**99.76%**	**95.71%**	**99.75%**

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

	2024-25 £'000	2023-24 £'000
Amounts included in finance costs from claims made under this legislation	0	1
Total	**0**	**1**

7 Finance Costs

Interest	2024-25 £'000	2023-24 £'000
Interest on lease liabilities	26	20
Interest on late payment of commercial debt	1	1
Total interest	**27**	**21**
Total finance costs	**27**	**21**

8 Other Gains and Losses

	2024-25 £'000	2023-24 £'000
Gain on disposal of right-of-use assets other than by sale	-	6
Total	**-**	**6**

9 Leases

9.1 Right-Of-Use Assets

2024-25	Buildings excluding dwellings	Total	*Of which: leased from DHSC group bodies*
	£'000	**£'000**	**£000**
Cost or valuation at 01 April 24	3,204	**3,204**	3,204
Additions	2,253	**2,253**	2,253
Disposals on expiry of lease term	(419)	**(419)**	(419)
Cost/valuation at 31 March 25	**5,038**	**5,038**	**5,038**
Depreciation 01 April 24	1,010	**1,010**	1,010
Charged during the year	332	**332**	332
Disposals on expiry of lease term	(419)	**(419)**	(419)
Depreciation at 31 March 25	**923**	**923**	**923**
Net book value at 31 March 25	**4,115**	**4,115**	**4,115**

2023-24	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 24	**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**

9.2 Lease Liabilities

	2024-25	2023-24
	£'000	£'000
Lease liabilities at 01 April 24	(2,410)	(2,945)
Additions purchased	(2,254)	-
Interest expense relating to lease liabilities	(26)	(20)
Repayment of lease liabilities (including interest)	315	403
Disposals on expiry of lease term	-	177
Derecognition for early terminations	-	38
Lease liabilities at 31 March 25	**(4,375)**	**(2,347)**

9 Leases Continued

9.3 Lease Liabilities - Maturity Analysis of Undiscounted Future Lease Payments

	2024-25 £'000	Of which: leased from DHSC group bodies £000	2023-24 £'000	Of which: leased from DHSC group bodies £000
Within one year	589	589	308	308
Between one and five years	2,336	2,336	1,216	1,216
After five years	2,013	2,013	974	974
Balance at 31 March 25	**4,938**	**4,938**	**2,498**	**2,498**
Effect of discounting		(563)		(88)
Total		**4,375**		**2,410**
Included in:				
- Current lease liabilities		469		285
- Non-current lease liabilities		3,906		2,125
Total		**4,375**		**2,410**

9.4 Amounts Recognised in Statement of Comprehensive Net Expenditure

	2024-25 £'000	2023-24 £'000
Depreciation expense on right-of-use assets	332	462
Interest expense on lease liabilities	27	20

9.5 Amounts Recognised in Statement of Cash Flows

	2024-25 £'000	2023-24 £'000
Total cash outflow on leases under IFRS 16	315	403

9.6 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 budget statement from NHS Property
Services in relation to these costs.

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 budget statement from NHS Property
Services in relation to the costs.

Brentwood Community Hospital

The leasing activities falling under IFRS 16 relate to the 10 year lease which the ICB entered into in March 2025, for space on the 1st floor of Brentwood Community Hospital, for the mid and south Essex training hub.

The ICB receives an annual budget statement from NHS Property Services in relation to the costs.

10 Trade and Other Receivables

	31-Mar-25	31-Mar-24
	£'000	£'000
NHS receivables: revenue	3,630	3,626
NHS accrued income	377	-
Non-NHS and Other WGA receivables: revenue	4,671	7,927
Non-NHS and Other WGA prepayments	3,187	795
Non-NHS and Other WGA accrued income	333	629
Non-NHS and Other WGA contract receivable not yet invoiced/non-invoice	2,136	2,373
Expected credit loss allowance-receivables	(595)	-
VAT	1,940	2,384
Other receivables and accruals	-	2
Total trade & other receivables	**15,679**	**17,736**

10.1 Receivables Past Their Due Date but Not Impaired

	31-Mar-25	**2024-25**	31-Mar-24	2023-24
	DHSC group bodies	**Non DHSC group bodies**	DHSC group bodies	Non DHSC group bodies
	£'000	**£'000**	£'000	£'000
By up to three months	785	1,825	99	1,409
By three to six months	21	98	372	177
By more than six months	264	-	(13)	9
Total	**1,070**	**1,923**	**458**	**1,595**

10.2 Loss Allowance on Asset Classes

	Trade and other receivables - non DHSC group bodies	**Total**
	£'000	**£'000**
Balance at 01 April 2024	**-**	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(586)	**(586)**
Lifetime expected credit losses on trade and other receivables-Stage 3	(9)	**(9)**
Total	**(595)**	**(595)**

11 Cash and Cash Equivalents

	2024-25	2023-24
	£'000	£'000
Balance at 01 April 24	(2,523)	(2,808)
Net change in year	(1,103)	285
Balance at 31 March 25	**(3,626)**	**(2,523)**
Bank overdraft: Government Banking Service	(3,626)	(2,523)
Total bank overdrafts	**(3,626)**	**(2,523)**

The ICBs cash position is reported in the financial statements as a negative balance of £3,626k at 31 March 25 (£2,523k at 31 March 24), due to outstanding payments due to clear after year-end. As at 31 March 25, the ICB had a net positive balance deposited in its Government Banking Service bank account of £317k. (31 March 24 £915k).

12 Trade and Other Payables

	31-Mar-25	31-Mar-24
	£'000	£'000
NHS payables: revenue	5,457	16,385
NHS accruals	9,716	2,342
Non-NHS and Other WGA payables: revenue	16,438	23,895
Non-NHS and Other WGA accruals	96,674	92,799
Non-NHS and Other WGA deferred income	107	1,195
Social security costs	328	342
Tax	384	428
Payments received on account	0	-
Other payables and accruals	2,717	5,929
Total trade & other payables	**131,821**	**143,315**

Other payables include £1,495k outstanding pension contributions at 31 March 25 (31 March 24: £1,449k).

13 Borrowings

	31-Mar-25	31-Mar-24
Bank overdrafts:	£'000	£'000
· Government banking service	3,626	2,523
Total borrowings	**3,626**	**2,523**

13.1 Repayment of Principal Falling Due

	31-Mar-25	31-Mar-24
	£'000	£'000
Within one year	3,626	2,523
Total	**3,626**	**2,523**

14 Provisions

	Current 31-Mar-25 £'000	Non-current 31-Mar-25 £'000	Current 31-Mar-24 £'000	Non-current 31-Mar-24 £'000
Restructuring	293	-	(0)	469
Legal claims	1,254	-	-	-
Continuing care	1,292	3,594	1,057	4,824
Other	899	2,093	339	2,092
Total	**3,738**	**5,687**	**1,396**	**7,385**
Total current and non-current		**9,425**		**8,781**

	Restructuring £'000	Legal £'000	Continuing care £'000	Other £'000	Total £'000
Balance at 01 April 24	**469**	**-**	**5,881**	**2,431**	**8,781**
Arising during the year	-	1,254	561	900	**2,715**
Utilised during the year	-	-	(1,556)	-	**(1,556)**
Reversed unused	(176)	-	-	(339)	**(515)**
Balance at 31 March 25	**293**	**1,254**	**4,886**	**2,992**	**9,425**
Expected timing of cash flows:					
Within one year	293	1,254	1,292	899	**3,738**
Between one and five years	-	-	3,594	2,093	**5,687**
Balance at 31 March 25	**293**	**1,254**	**4,886**	**2,992**	**9,425**

Restructuring provisions
A restructuring provision was made as the ICB had a requirement to reduce costs by 30%. 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. The remaining provision related to staff on fixed term contracts, that will finish in the next year.

Legal provision
A provision had been made to cover the potential costs in relation to the Lampard Inquiry, which is a Statutory Inquiry investigating the deaths of mental health inpatients in Essex from 1st January 2000 to 31st December 2023.
Mid and South Essex ICB is a core participant in the Inquiry and is expected to receive requests for evidence and statements as a one of the commissioners of mental health services in Essex and has therefore created a provision to cover the below:

- Legal costs relating to preparation, response, and representation during the Inquiry.
- ICB staff costs, relating to project management of the Inquiry.
- Archiving costs, relating to the retrieval, storage and handling of archived data potentially relevant to the Inquiry.

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.

Other provisions
A provision has been created for dilapidation of rented buildings, 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 to cover the need to retest a cohort of patients who may have received an erroneous HbA1c result, following a field safety notice, where they were issuing a positive bias for patient results.

15 Contingencies

During 2024 a joint procurement was undertaken with 23 other ICBs for a Primary Care clinical waste collection and disposal contract, for a period of 5 years with the option to extend for a further 4 years. Each ICB procured an individual Lot. In December 2024, 9 of the ICBs, including Mid and South Essex ICB, published standstill letters with an intention to award a contract. During the subsequent standstill period, in December 2024 legal proceedings challenging the contract award decisions were commenced by one of the unsuccessful bidders, naming all 22 of the ICBs which remained involved in the Procurement (2 ICBs having decided not to proceed) as Defendants. At this early stage of the Claim, it is not possible to sensibly nor accurately determine the probability of success by the Claimant, nor is it possible to estimate the financial impact of a successful Claim with any level of certainty. Given this uncertainty of both of these key components, the ICB is therefore classifying this challenge as a contingent liability. Further to the discussions. An indication has been received that our liability (should we lose) will be circa £550k.

6 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 NHS Integrated Care Board 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 NHS Integrated Care Board 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 NHS Integrated Care Board in undertaking its activities.

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

16.1.1 Currency Risk

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

16.1.2 Interest Rate Risk

The NHS Integrated Care Board 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 NHS Integrated Care Board therefore has low exposure to interest rate fluctuations.

16.1.3 Credit Risk

Because the majority of the NHS Integrated Care Board revenue comes parliamentary funding, NHS Integrated Care Board 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

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

16.1.5 Financial Instruments

As the cash requirements of NHS Integrated Care Board 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 NHS integrated care board's expected purchase and usage requirements and NHS Integrated Care Board 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-25 £'000	Total 31-Mar-25 £'000
Trade and other receivables with NHSE bodies	1,929	**1,929**
Trade and other receivables with other DHSC group bodies	2,077	**2,077**
Trade and other receivables with external bodies	7,140	**7,140**
Total at 31 March 25	**11,146**	**11,146**

16.3 Financial Liabilities

	Financial liabilities measured at amortised cost 31-Mar-25 £'000	Total 31-Mar-25 £'000
Trade and other payables with NHSE bodies	2,814	**2,814**
Trade and other payables with other DHSC group bodies	12,734	**12,734**
Trade and other payables with external bodies	115,456	**115,456**
Private Finance Initiative and finance lease obligations	4,375	**4,375**
Total at 31 March 25	**135,379**	**135,379**

17 Operating Segments

The NHS Integrated Care Board has only one segment; commissioning of healthcare services.

18 Gifts

The NHS Integrated Care Board didn't have any Gifts, in the current year or prior period.

19 Fees and Charges

The NHS Integrated Care Board didn't have any fees and charges, in the current year or prior period.

20 Joint Arrangements - Interests in Joint Operations

Better Care Funds

Essex County Council
The ICB has operated a Better Care Fund of £71,768k during 2024-25, 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 £14,240k during 2024-25, 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 2024-25 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 £16,882k during 2024-25, 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.

21 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 NHS Integrated Care Board

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 2024-25.

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

		Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
Mid & South Essex NHS FT	Matthew Hopkins, ICB Board Partner Member (MSE FT)	1,332,158	(1,037)	3,719	(985)
Essex Partnership University NHS FT	Paul Scott, Partner Member, Essex Partnership University NHS FT	275,787	(66)	2,552	(66)
Essex County Council	Peter Fairley, Partner Member, Essex County Council	98,797	(25,144)	1,574	(1,436)
North East London NHS FT	Joseph Fielder, Non-Executive Member	47,868	-	590	-
Southend City Council	Mark Harvey, Partner Member, Southend City Council	19,082	(9,891)	10	-
Thurrock Council	Ian Wake, Partner Member, Thurrock Council (left 05-Jan-25) Robert Persey, Partner Member, Thurrock Council	18,712	(4,206)	128	-
Colne Valley Primary Care Network	Anna Davey, Primary Care Services Partner Member	2,552	-	25	-
Princess Alexandra Hospital	George Wood, Non-Executive Member	2,472	-	6	-
Essex Cares	Peter Fairley, Partner Member, Essex County Council	433	-	2	-
Health Innovation East	Tracy Dowling, Interim Chief Executive Officer (left 07-Aug-24)	4	-	4	-

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

		Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
Coggeshall Surgery	Anna Davey, Primary Care Services Partner Member	1,070	-	2	-

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 NHS Integrated Care Board has had a significant number of material

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 Foundation Trust
Essex Partnership University NHS Foundation Trust
Guy's & St Thomas' NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
North East London NHS Foundation Trust
NHS Business Services Authority
NHS England and Improvement
NHS Property Services
University College London Hospitals NHS Foundation Trust

In addition, the NHS Integrated Care Board has had a number of material transactions with other government departments and other central and local

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
We have reviewed the list of entities and the NHS Integrated Care Board has transactions with the below entities.

	Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
ACCURX LTD	629	-	-	-
ALZHEIMERS SOCIETY	65	-	65	-
NHS CONFEDERATION	55	-	28	-

22 Events After the End of the Reporting Period

On 13 March 2025 the government announced NHS England, and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

23 Losses and Special Payments

The total number of NHS Integrated Care Board losses and special payments cases, and their total value, was as follows:

Losses	**Total number of cases 2024-25 Number**	**Total value of cases 2024-25 £'000**	Total number of cases 2023-24 Number	Total value of cases 2023-24 £'000
Fruitless payments	1	120	-	-
Total	**1**	**120**	**-**	**-**

24 Financial Performance Targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended). NHS Integrated Care Board performance against those duties was as follows:

	2024-25 Target £'000	**2024-25 Performance £'000**	**Duty achieved?**
Expenditure not to exceed income	3,213,231	3,213,164	Yes
Capital resource use does not exceed the amount specified in Directions	2,302	2,302	Yes
Revenue resource use does not exceed the amount specified in Directions	3,170,576	3,170,509	Yes
Revenue administration resource use does not exceed the amount specified in Directions	22,374	20,914	Yes

	2023-24 Target £'000	2023-24 Performance £'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

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 and South Essex Integrated Care Board ("the ICB") for the year ended 31 March 2025 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 2025 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 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2024/25; 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.

We did not identify any additional fraud risks.

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, and Expenditure.

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.

The potential effect of these laws and regulations on the financial statements varies considerably.

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.

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 2024/25.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 63, 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.

The Audit Committee is responsible for overseeing the ICB's financial reporting process.

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 63, 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 are also not required to satisfy ourselves that the ICB has achieved value for money during the year.

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 issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- 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 these respects.

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 and 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.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the ICB's accounts consolidation template for the year ended 31 March 2025because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Mid and South Essex Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Emma Larcombe
for and on behalf of KPMG LLP
Chartered Accountants
20 Station Road,
Cambridge,
CB1 2JD

19 June 2025