NHS
Mid and South Essex
Integrated Care Board

Mid and South Essex
Integrated Care Board

Annual Report:

July 2022 – March 2023

Contents

Chair's Foreword

Welcome to the first annual report of the Mid and South Essex Integrated Care Board (ICB).

We became a statutory body in July 2022, inheriting a lot of excellent work from our colleagues in the five Clinical Commissioning Groups which came together to form our ICB. Our key responsibilities are developing and overseeing a plan for delivering healthcare and wellbeing that meets the needs of our population, reflecting the inequalities that currently exist in both the provision and access for some people within our community.

Put simply, we want to up our game in health and care in Mid and South Essex.

The challenges are significant. We have areas here in Mid and South Essex of high deprivation and where health outcomes are well below the national average. An estimated 133,000 people live in the 20% most deprived areas nationally, this is 10.5% of the whole mid and south Essex population. Giving our children and young people the best possible start in life is one of our key priorities. For our population size, we have far fewer GPs than other Integrated Care Boards, so we need to support our excellent GPs to meet the ever-increasing demands upon them.

Our achievements as an ICB can only stem from continued collaboration and there is much to celebrate on that front. We already have many excellent examples of partnership working between ourselves, our councils, our hospital, our mental health providers, and the voluntary sector. These partnerships are focussed on our local delivery vehicles, our four Alliances. And it is by working with the Directors of Public Health in Essex County Council, Southend City Council and Thurrock Council and their teams, our Public Health Management Team based within Thurrock Council, and these Alliances that we shall identify and target support to those communities most in need.

We have a very ambitious agenda, and it won't be an easy journey to realise it. It is through the commitment, skill, and energy of our teams that we will deliver these plans for you so I would like to thank our dedicated staff for their hard work in the challenging post-Covid world. We are determined to make Mid and South Essex a place where all its people are supported to live longer, healthier lives and, should they become unwell, feel secure that they will be looked after really well.

I look forward to updating you regularly as we move through this next financial year.

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

26 June 2023

PERFORMANCE REPORT

Introduction with Anthony McKeever

Welcome to the first annual report and accounts for NHS Mid and South Essex Integrated Care Board (ICB), which I am privileged to lead as Chief Executive.

This year, the cost of living and household budgets have been a concern for many of our residents. These challenges affect the NHS family too – we operate as a financial system with our Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust partners. Every NHS organisation has a statutory duty to live within their means and as financial system we have a duty to cooperate with our system partners to support our collective financial position. Our providers have faced increased and sustained pressures during the year and the ICB has worked to support them as they too have supported each other. Whilst the ICB position on its own is a surplus, collectively our system incurred a deficit of £46.3m. A Financial Improvement Plan was therefore developed to improve financial control, which will also help us secure more robust plans in the year ahead.

But stewardship of public money is only one of the challenges we inherited from our predecessor organisations when the ICB was formed in July 2022. This report reflects a much wider range of responsibilities and ambitions that are now pursued alongside partners in our Integrated Care Partnership. They include tackling health inequalities, developing as anchor institutions, promoting clinical leadership, and strengthening the workforce required to deliver high quality health and social care.

So, ultimately, success will depend on everyone playing their part – and we have already seen evidence of this. In particular, NHS staff supported by Council colleagues and voluntary organisations continue to work hard to restore the levels of service and performance residents expect. For instance, over the last 12 months:

- Delays and backlogs which grew during the pandemic have been cut back, with hospital waiting times now down below 78 weeks (from more than 2 years).
- The number of patients waiting 62 days or more following referral for a suspected cancer were almost halved across the last six months of the year, after peaking beginning of October 2022.
- Staff in post across our two main providers has increased by more than a thousand to 22,433+.
- Overall, primary care consultations reached circa 6.2m 2022/23, compared to circa 6m the previous year and 5.3m during the pandemic year (with 77% being face-to-face by the end of this period).
- Approximately 613,000 Covid vaccinations were delivered within the financial year.
- A dedicated Urgent Care Department for mental health patients has been opened in Basildon, which helped 58 patients in its first two weeks of operation. By the end of the year 60% of all emergency mental health referrals were seen in the Department.

In short, Mid and South Essex has been working hard – as separate organisations and across our integrated care partnership – to respond to mounting pressures in a positive, proactive way. New approaches have proved helpful in this regard. Virtual wards have been established to provide care and treatment for thousands of people in their own homes, thereby freeing up beds for those with more serious conditions or requiring urgent care. Similarly, more than 60,000 residents now participate in our Blood Pressure at home programme, enabling them to keep track of their own wellbeing.

These and other results are recorded in the pages that follow. Yet there is still much to be done – in restoring standards of performance and productivity achieved previously; pursuing the goals and common endeavour set out in our Joint Forward Plan; and continuing to transform the NHS for the future.

Anthony McKeever
Chief Executive of NHS Mid and South Essex Integrated Care Board

26 June 2023

Performance Overview

The performance overview section is designed to provide an understanding of the organisation, its purpose, the outcomes we look to achieve as well as our objectives, performance against them and the impact and management of key risks.

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 and the passage of the Health and Care Act (2022), forty-two ICSs were established across England on a statutory basis on 1st July 2022. The ICS is made up of two main 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 Integrated Care System area. The establishment of ICBs resulted in Clinical Commissioning Groups being closed.

Integrated Care Partnership (ICP): A statutory committee jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICSs area (councils with responsibility for children's and adult social care and public health). The ICP will bring 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 Integrated Care System area.

In Mid and South Essex, our ICS is made up of a wide range of partners, supporting our population of 1.2m 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:

Neighbourhoods*:* The areas covered by our 27 Primary Care Networks, and local neighbourhood teams, etc.

Places: The areas covered by our four Alliances, covering Mid Essex, Basildon and Brentwood, Thurrock and South East Essex.

System: The whole of Mid and South Essex.

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).

Mid and South Essex Community Collaborative: *Bringing together NHS community services in mid and south Essex* - Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT) and Provide Community Interest Company (CIC).

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

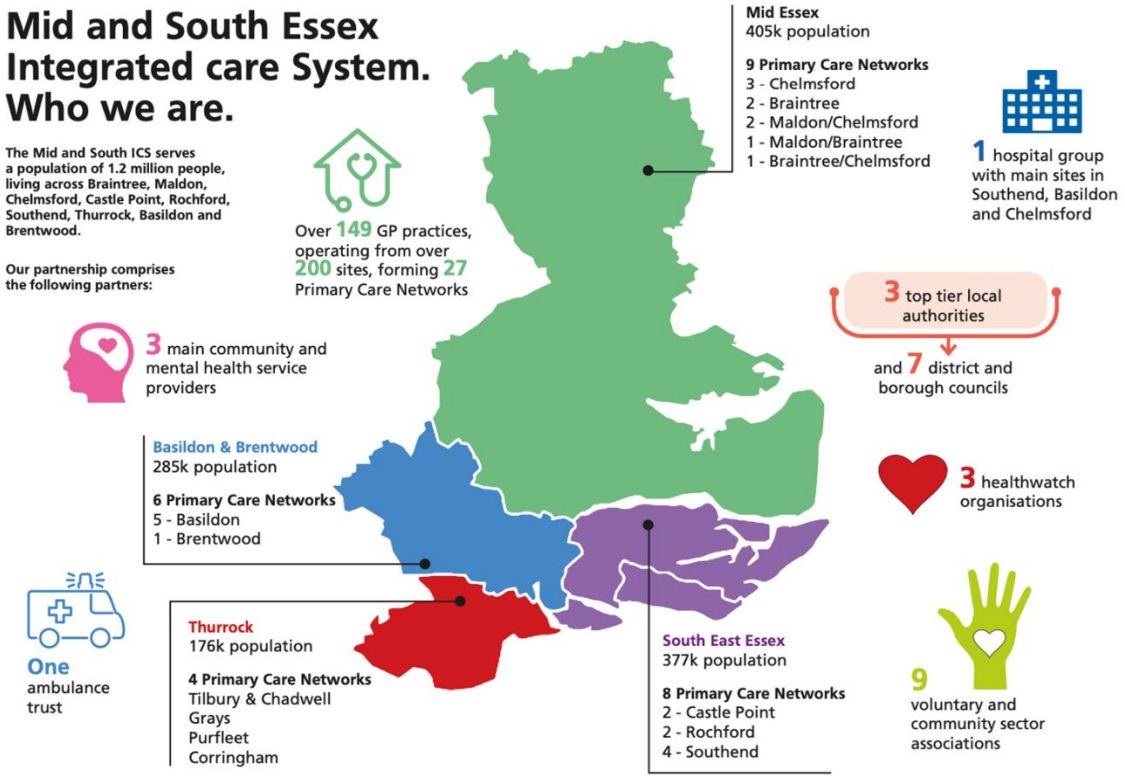
Primary care: 27 Primary Care Networks (PCN) covering 180 GP Practices.

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

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

The diagram below shows the shape of our Partnership:



"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 Partner made during the Integrated Care Partnership Strategy design

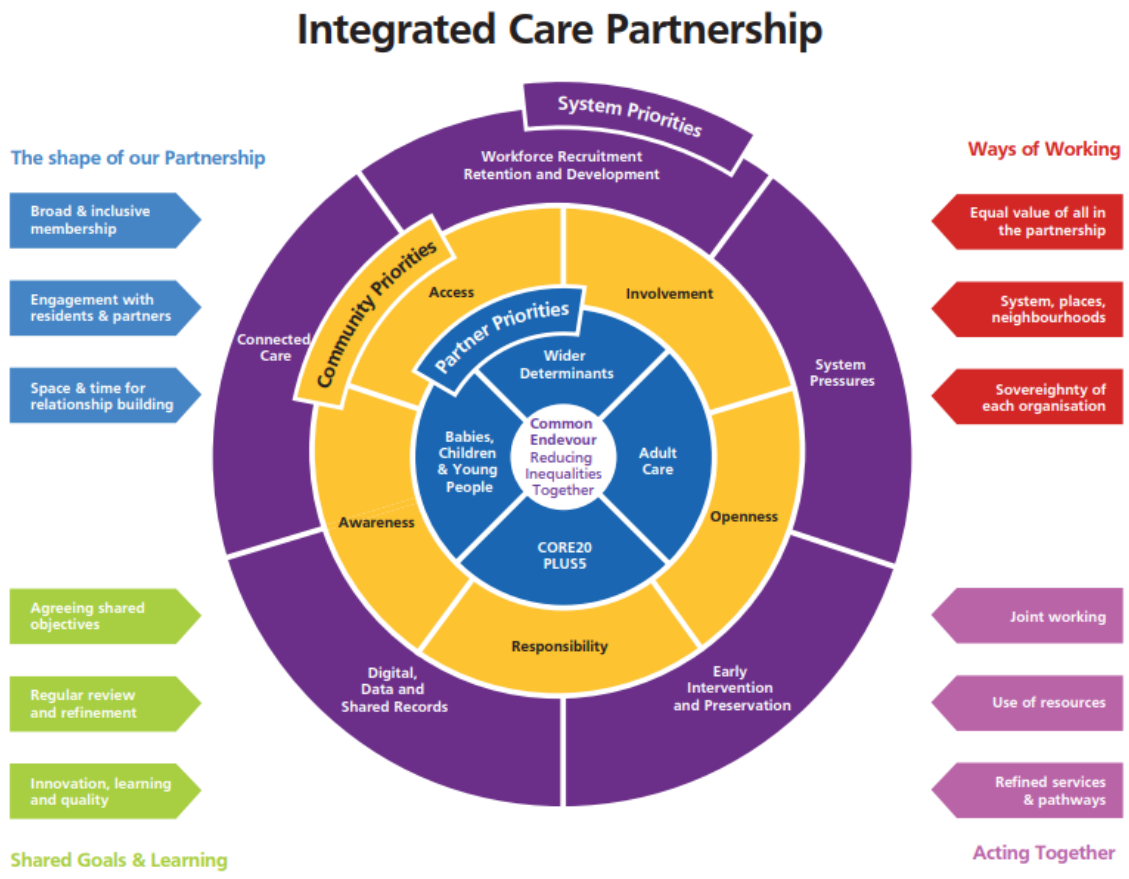
Our successes

In Mid and South Essex, we are building on firm foundations. The organisations and agencies working to improve health and social care outcomes for our residents have been working together positively for several years, starting with the formation of a Sustainability and Transformation Partnership in 2017, leading to the establishment of the Mid and South Essex Health and Care Partnership. In 2020 we agreed a Memorandum of Understanding, committing us to work together on a set of nine priorities:

1. Prevention.
2. Partnership.
3. Whole Systems Thinking.
4. Strengths and Asset Based Approach.
5. Subsidiarity.
6. Empowering Front-Line Staff to do the Right Thing.
7. Pragmatic Pluralism.
8. Health Intelligence and the Evidence Base.
9. Innovation.

Our Common Endeavour

In March 2023, our ICB led partners in the development of a 10-year Integrated Care Strategy, which describes our shared priorities across our ICS:



The full Strategy can be found at [MSE Integrated Care Strategy 2023-2033 (hyperlinks).]

In preparing the Integrated Care Strategy, we have also had regard for the regulatory and statutory requirements, particularly the four key aims established 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 have also had regard for the 'Triple Aim' established for NHS bodies that plan and commission services, which requires them to consider the effects of decisions on:

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

On 1 July 2023, the Integrated Care Board will publish its first **Joint Forward Plan** which describes how NHS partners across mid and south Essex will work together over the next five years to meet the needs of local people. The plan describes how the NHS will play a key part in delivering the objectives of the Integrated Care Strategy developed with our wider partners.

Mid and South Essex Integrated Care System publishes a joint capital resource plan (hyperlinks), which details what our plan for capital spend is for the next financial year, along with details of any risks and mitigations

Local Achievements

The Alliances within mid and south Essex have worked hard with the Local Authorities social care teams in the last year building strong and meaningful relationships from executive to operational staff levels.

There has been a relentless focus on "home first" discharge support with Local Authority district and borough colleagues.

Utilizing the intermediate care and reablement space to jointly support the residents of mid and south Essex and expedite any hospital stays they experienced. As part of this we have seen the successful implementation of the nationally recognised Connect Programme to drive improved outcomes for adults supported by the Mid and South Essex Health and Care System through closer collaboration of teams and better utilisation of data to:

- Support Independence: the alignment of adult social care teams to neighbourhoods resulting in 80% of adults who have engaged with the lived experience data capture are reporting that they are living as independently as possible.

- The Home First Approach – A focus on multi-disciplinary decision making around an adult's ideal pathway to continue to deliver the best outcomes for adults across MSE.

- Improving effectiveness of reablement – supporting adults with reablement potential to achieve their most independent outcomes.

In addition, we are implementing ward-led reablement to get frail and vulnerable patients moving earlier to enable them to get home sooner and have less complications. These initiatives impact on reducing the length of hospital stays and reducing harm to residents.

With the creation of senior joint roles with social care the focus will increase on admission avoidance in the intermediate care services in 2023/24.

Through the implementation of the Fuller Stocktake, which is the transformation of primary care; GP practices, will deliver integrated neighbourhood teams (teams that have a mix of very many roles reflecting wider determinants of health like housing, economic stability, and physical activity at place level) which all Local Authorities and voluntary sector partners have been designing with health colleagues.

Joint delivery roles between organisations in our Alliances will continue to support this focus on wider determinants and place-based projects with Alliance Delivery Leads in Basildon and Brentwood focussed on delivering priority projects aligned to the Live Well domains and Alliance Programme Managers in Mid Essex to progress delivery of the neighbourhood model.

The following four sections outline some of the examples of work within our Alliance Teams to support our 'common endeavour' and the overarching strategy of the ICP.

Mid Essex Alliance

The Dengie Neighbourhood Programme

We piloted a new approach to neighbourhood working in the Dengie between 1st April 2021 to 31st October 2022. The aim of the Pilot was to test a model of true integration with Community Nursing, Adult Social Care and Domiciliary Care working as a neighbourhood team with a network of other professionals wrapped around them.

The desire was to enable the team to work together without the barriers that come with working for individual organisations, to deliver holistic and personalised care and support to adults living in the Dengie.

The Pilot has shown the potential for integrated health and social care services on a local level. Through close working with organisations, relationships have been formed leading to closer working and better outcomes for adults. In addition, the pilot helped reduce levels of unsourced care and increase the pace at which packages of care were sourced.

Lessons learnt from the pilot will be carried forward through new PCN development roles (Better Care Fund (BCF) funded) to expand across Mid Essex for further improvements through integrated working on a local level.

Colne Valley Low Carb Programme

The Colne Valley PCN have continued to develop their successful Freshwell low carbohydrate diet programme. The programme provides advice about what to eat and why, as well as simple recipes and meal planners. The approach is designed to be

enjoyable, sustainable and has significant health benefits, including control of weight, management of a wide range of endocrine disorders, including diabetes, and increased energy levels. The programme has garnered huge community support with local shops signposting compliant ingredients and local cafes and restaurants joining in.

The service became freely available across Essex (delivered through Essex Wellbeing Service) and secured formal accreditation as a structured education programme in type 2 diabetes, pre-diabetes, and weight management (GPs can refer to it as a formally recognised programme).

To increase inclusivity, accessibility and reduce health inequalities, the ICB also commissioned the expansion of the service. Specifically, the app has been enhanced as more user-friendly and informative and has since been downloaded 9,821 times. Furthermore, two additional meal planners have been co-produced with residents (including families in receipt of free school meals) and a wide range of community partners, including Halstead Town Council, Active Essex, Braintree Foodbanks, United in Kind, Healthwatch Essex, Braintree District Council, Community 360, Eastlight community homes, local food caterers, and community pharmacies. These new meal planners focus on low-cost options (in recognition of cost-of-living increases) and vegetarian choices. Hard copies will be available from GP practices and community venues e.g., libraries, and within the free Freshwell low carb app and website. The PCN and ICB continues to work with local partners to increase uptake, including exploring cooking classes to trial and promote the manuals. A comprehensive evaluation and outcomes framework is due to be rolled out, with a view to assessing impact on weight loss, health improvement and health inequalities.

Chelmsford West PCN

Chelmsford West PCN progress with their Health Inequalities work, initially focussing on the prophylactic care of the younger adult (20-34yrs) population with Severe Mental Illness (SMI) & Personality Affective Disorders. Using a population health management approach, work has taken place to ensure robust process on the initial contact with targeted patients (letter and text messaging through SystmOne) as well as improving the Multi-disciplinary Team (MDT) approach to care. To date, the PCN have improved overall uptake of SMI health checks by 23%.

The PCN continue with successful recruitment under the Additional Roles Reimbursement Scheme (ARRS), with a heavy focus on embedding new staff into the primary care team and utilising staff effectively to make the most of their expertise.

The PCN Livewell Garden continues to be a successful space for social prescribing, with an expansion currently underway at the Writtle Surgery site.

The PCN are currently reviewing their longer term PCN Clinical Strategy, to ensure that the needs of the local PCN population drive forwards the direction of the PCN.

The PCN have formed and continue to form relationships with local partners and attend the Chelmsford Livewell Board to assist with this.

Basildon and Brentwood Alliance

Basildon and Brentwood Alliance have recently been re-established with a wide range of partner organisations committed to working together to tackle health inequalities and the wider determinants of health. To achieve this, partners have signed up to a Live

Well strategy (depicted below) that comprises of 6 domains (Start Well, Feel Well, Be Well, Stay Well, Age Well and Die Well) that cover the entire life course of our residents. This will be the key strategy over the next 5 years with a distributed leadership model supporting domain leads from all partner organisations.

The development of Integrated Neighbourhood Teams (INT) will be the foundation of our work, and these will enable health, social care, and voluntary sector organisations to work collaboratively at local level using an asset-based approach to deliver the strategy.

We will be outcomes driven and prioritise our combined efforts by using reliable population data, shared across all sectors as well as the local intelligence of our workforce and residents. We will develop, shared training and develop, joint posts across sectors and will also share estate to improve efficiency and further cement relationships and a collaborative culture with partners. Existing funding mechanisms such as the Better Care Fund (BCF) will be used effectively and strategically in areas where there is the greatest level of inequality, and we will build upon this to develop additional areas of pooled resource.

The Alliance will build upon the legacy of the 2012 London Olympics, funding through Sport England local delivery pilot via Active Essex and the subsequent Find Your Active Basildon and Brentwood, initiatives to give our residents and workforce multiple opportunities to increase the amount of physical activity they undertake. Sport is a non-judgemental medium and that has enabled communities to think differently about their wellbeing and embedded a culture change within the local system leadership that supports the wider Alliance ambitions. All our GP practices will be Active Practices and all our residents will be able to access an activity that suits their ability, preference, and circumstances.

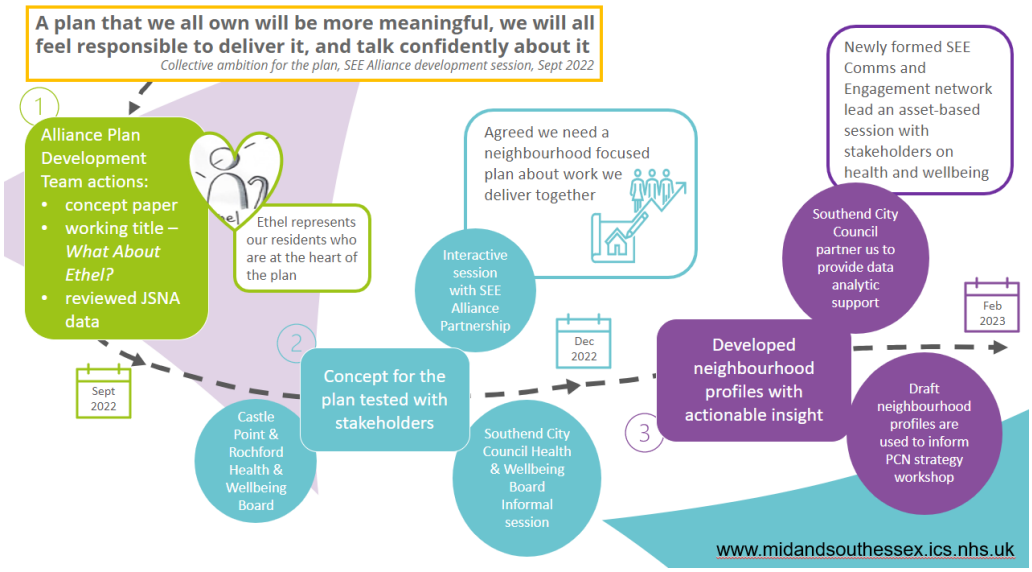
In the last 6 months, the following progress has been made:

- Roll out of GP Champion training and culture change project being delivered by Dr William Bird, GP and Chair of Active Essex. Working with and encouraging GP Practices and PCN's to sign up to the Royal College of General Practice – Active Practice Charter.

- TrailNet bike maintenance Health Bid application bid approved for 48 Basildon and Brentwood patients with Mental Health issues access free bikes.
- Application has been approved for Boxing in Brentwood for patients with Mental Health issues. Aiming to support 30 plus patients with referrals through Social Prescribers. Joint funded with Find Your Active (FYA) funding 50/50.
- Billericay Fire Station confirmed site for BAME cycling group in Spring 2023.
- Ongoing Population Health Management work with East Basildon; recently took part in a healthy lifestyle choice event for patients.
- Ongoing Workplace Wellbeing Work: have signed up as a Wellbeing Champion for MSE ICB and Basildon and Brentwood Alliance were awarded for this work at the Basildon Activity Awards.
- Successful Big Team Challenge across the Alliance.
- Working with Community Connector to hold Physical Activity Drop-in Sessions at GP Surgeries and other partnering organisations.

South East Essex Alliance

The South East Essex Alliance is committed to improving the lives of residents in the region. In 2022/23 we undertook a programme of development to strengthen our working relationships and develop our strategic direction. We identified tackling health inequalities as our core purpose and have begun gathering and analysing data to better understand areas of need. This will inform how and where we focus our energies and resources in the coming financial year, articulated in our Alliance Plan below.



The Alliance has been developing its plan since late Autumn 2022. The intention is to create a purposeful, dynamic document that delivers insight which will be used as a springboard for:

- Greater curiosity and understanding about our neighbourhoods and population.
- Priority setting.
- Targeting resources.

To this end we have created neighbourhood profiles, which will form the backbone of our plan.

Shoebury Health and Wellbeing Hub

Discussions to improve the healthcare estate in Shoebury have been ongoing since 2005. More recently, work in partnership with a local architect firm identified five possible sites for a new-build Health and Wellbeing Hub. In summer 2022 we engaged with local residents and stakeholders to identify a preferred site. We held a series of intercept interviews across Shoeburyness, working together with SAVS (Southend Association of Voluntary Services), the Shoebury Residents Association, local councillors, and the Patient Participation Group (PPG) Chair. This rich insight was used in combination with stakeholder evaluation, to assess each of the potential sites against a set of co-produced criteria. The preferred site is Shoebury House, a derelict NHS building on good transport routes. We are now procuring a human-centred design partner to support the development of an operating service model and schedule of accommodation. The strategic business case should be completed by December 2023.

Falls

Following a data deep dive between the acute trust and primary care, Canvey was highlighted as having a particular need around Frailty, and specifically Falls. This has resulted in a dedicated south east Essex Falls programme. Working in partnership with Active Essex, we have a developed a series of resources aimed at the general public, focused on building strength and balance in older people – Able Like Mabel. These will be shared through the Active Essex website, alongside targeted social media channels. With a booklet and prompt cards distributed through high street pharmacies and opticians, as well as primary care and community connectors.

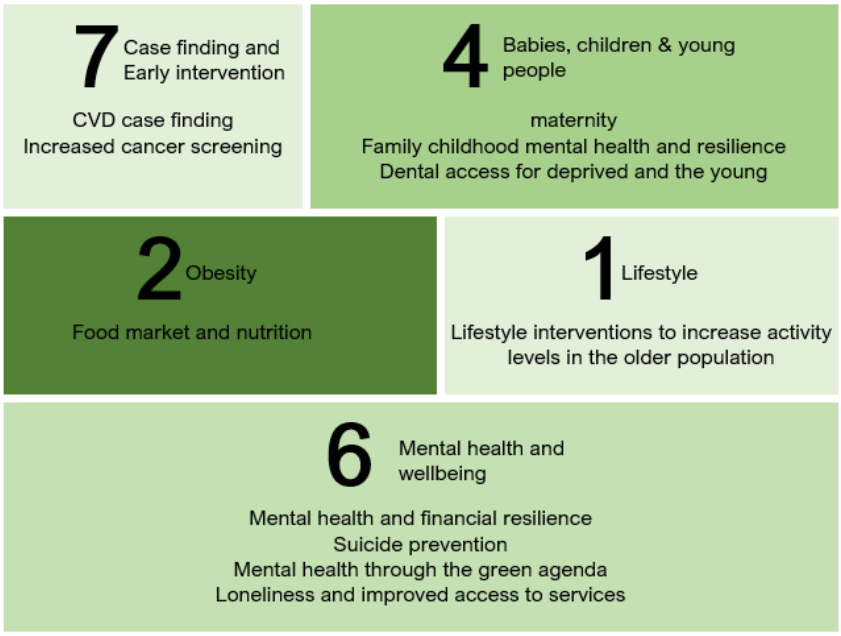
PCN Aligned Community Teams (PACT)

Our PACT model is a working example of Integrated Neighbourhood Teams, which are central to our ambitions of working closely with our communities and partners to deliver improving health and wellbeing for the people of south east Essex. PACT is well established in two of our neighbourhoods, Benfleet and SS9. Two more – Southend West Central and Canvey – are in the early stages of building the model. The aim is to scale this to six neighbourhoods by the end of the calendar year.

Health Inequalities

Through targeted work with partners and primary care we have added 1,200 people to our Carer's Register this year and are putting plans in place to continue this trajectory into 2023/24. Additionally, our PCNs and member practices have made concerted efforts to become Veteran Friendly with an increase of 20%. This means we now have at least one practice per PCN accredited as Veteran Friendly.

We held a robust bid process to identify twenty health inequality projects for south east Essex (depicted overleaf). All 20 will be live by April 2023, with nine already underway.



Thurrock Alliance

Thurrock Alliance has been focussing on recruitment to the Alliance Team since October 2022, due to significant vacancies. We have now recruited to the Primary Care Account Manager, the Transformation & Engagement Manager, and the Planning & Performance Lead roles. These roles will help to cement the good working relationship with all our partners and particularly Thurrock Council and will support the formalisation of the joint approach to supporting residents in the borough.

Thurrock Integrated Care Alliance has been in place since 2018. Thurrock Alliance has continued that engagement and is an active partner in delivering improvements to Health Inequalities, Leadership and Governance, better care closer to home, improvements in SMI Health Checks and LD Health Checks, reduction in obesity and diabetes rates, and increased lung health, all of which are driven by the shared commitment to the Better Care Together Thurrock (BCTT) Strategy. Work is underway currently, to align the ICS Strategy more closely, with the Thurrock Health & Wellbeing Strategy, and the BCTT Implementation Plan and the Joint Forward Plan/Alliance Delivery Plan.

The development of Integrated Medical and Wellbeing Centres (IMWCs) has begun with the opening of the Corringham IMWC in November 2022.

The IMWC provides access to a range of health and care services including access to the Acute Respiratory Hub for Thurrock, which has seen and treated more than 1,000 people since 16th January 2023 (a mean average of 75 people per day) and with 3 more IMWCs planned over the next 3-4 years. The IMWCs also offer shared office space for health and care staff to work together.

The PCN Accelerator Programme has delivered the draft clinical strategies for the 4 PCNs in Thurrock, which accords well with the Integrated Neighbourhood Teams developments.

The PCNs have adopted an approach to the management of long-term conditions that fits with prevention, and the reduction in health inequalities. Tilbury and Chadwell PCN has used this approach to better support people with low-level mental health needs.

All PCNs are reviewing the ARRS roles to improve the balance of these and ensure the remit of various roles complements the wider primary care model.

Thurrock Alliance is fully engaged in the review of the Social Prescribing service and is a partner in reviewing the arrangements around joint commissioning with Thurrock Council.

Working across mid and south Essex

Education, training, research

MSE have developed a partnership with Anglia Ruskin University, backed by Health Education England, to support education, training, and workforce development outcomes for Integrated Care Systems.

As part of this, three Action Learning Projects have been identified.

- Community Academy
- Innovation & Esteem
- Innovation of Information Sharing

The Action Learning process is being used to build shared learning across system partners, develop new skills for MSE ICS staff to support ongoing identification and development of new ideas for innovation supported by evidence and evaluation undertaken by ARU academics.

At the end of the Action Learning project delivery phase, we will have collaboratively responded to the needs of the MSE ICS system, increased awareness for opportunities to work in new ways across the system, identified opportunities to raise the esteem and profile of the new and emerging community health and care models, and developed a shared agenda for ongoing collaborative working.

The ICB has led a process over the last year to bring research partners together from across MSE ICS to map active research work and to develop a system research agenda.

Innovation

An innovative game-changing approach that places multi-professional clinical leadership at the helm called ‘stewardship’ has begun across mid and south Essex, starting with six key areas of healthcare:

- Ageing Well
- Cancer Care
- Cardiac Care
- Respiratory Care
- Stroke Care
- Urgent and Emergency Care

It brings together people ‘stewards,’ from the coalface of services with people with lived experience related to their own specialty care area, who have access to data, knowledge, resources, and skilled workforce. This ensure that we can focus our collaborative efforts to better understand our populations and identify and target inequalities causing poorer health within our local priority areas. The approach also talks to people from communities, to help provide insight and advice, so we can effectively re-prioritise how resources are used.

The overall aim is that stewardship will:

- Close the gaps between health and care services for our patients and residents
- Empower health and care staff from all organisations to be at the heart of service planning
- Enable our Integrated Care System to deliver on the promise of Integrated Care.

The teams across mid and south Essex have also been working with our residents, community, and voluntary sector partners to explore innovative ways to support our patients to avoid or reduce hospital admissions and stays. For example a multi-agency community hub pathway model that uses digital solutions to support effective discharge; a global partnership brokered and established to support our volunteer programme to create a recruitment platform using WhatsApp; a community campaign model ‘Essex is Ageing Well’ that supports the stewardship approach and communities to live well; and a pilot that supports the delivery of a voluntary and community sector referral tool to support clinician’s and the community obtain the community help they need.

Working with our residents and partners in this way is enabling the ICB to create innovative solutions to both tackle health inequalities as well as the challenges we have within the system to meet the performance expected of us.

Performance Analysis

Introduction

Mid and South Essex Integrated Care Board Constitutional Standards performance across all standards is below expected delivery. For many standards there is national recognition that following the Covid-19 pandemic that recovery isn't achievable. Nationally, expectations have shifted for some to agreed national deliverables.

Elective Care:

- Diagnostics

The constitutional standard of no more than 1% of patients waiting 6+ weeks for a diagnostic test and no patients waiting 13+ weeks has not been met across Mid and South Essex during 2022/23. Several Community Providers are meeting the standard, however unfortunately due to demand exceeding capacity, the performance and waiting times is 13+ weeks across most diagnostic modalities. The following table shows the year end percentage of patients on the waiting list, waiting 6+ and 13+ weeks (March 2023).

Test		Mar-23				
		13+ Weeks		6+ Weeks		Total WL size
		No.	%	No.	%	
Imaging	Magnetic Resonance Imaging	65	1%	1,491	27%	5,439
	Non-Obstetric Ultrasound	1,209	17%	3,235	44%	7,309
	Computed Tomography	37	1%	300	8%	3,663
	Barium Enema	0		0		0
	DEXA Scan	83	7%	335	27%	1,224
Endoscopy	Colonoscopy	8	1%	29	4%	652
	Cystoscopy	87	35%	151	60%	251
	Flexi Sigmoidoscopy	1	1%	9	5%	200
	Gastroscopy	49	8%	93	15%	634
Physiological Measurement	Audiology - Audiology Assessments	449	29%	645	42%	1,545
	Cardiology - Echocardiography	258	6%	1,309	32%	4,096
	Cardiology - Electrophysiology	0		0		0
	Neurophysiology	172	49%	180	52%	349
	Respiratory Physiology - Sleep Studies	119	28%	183	43%	425
	Urodynamics - Pressures & Flows	0	0%	2	5%	41
Total Diagnostic Tests		**2,537**	**10%**	**7,962**	**31%**	**25,828**

- Cancer

The waiting times for patients on a cancer pathway remain below the NHS constitutional standards during 2022/23. The following table shows the year end Mid and South Essex NHS Foundation Trust (MSEFT) position (March 2023) for each of the waiting time standards.

Two week wait	Two week wait breast symptomatic	28 Day Faster Diagnosis Standard	31 day first treatment	31 day subsequent treatment Drug Treatments	31 day subsequent treatment Radiotherapy Treatments	31 day subsequent treatment Surgery	62 day standard	62 day standard (Screening)	62 day standard (Upgrade)
Standard (>=93%)	Standard (>=93%)	Standard (>=75%)	Standard (>=96%)	Standard (>=98%)	Standard (>=94%)	Standard (>=94%)	Standard (>=85%)	Standard (>=90%)	
65.7%	28.1%	63.9%	86.6%	94.2%	92.5%	57.1%	54.6%	57.1%	56.5%

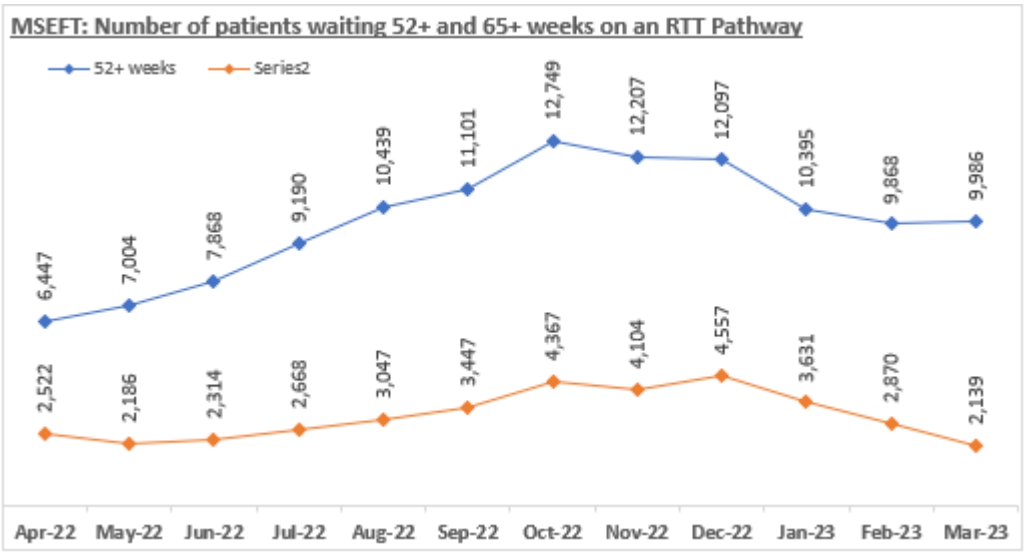
In terms of the number of people waiting 62+ days on a cancer 62-day pathway, this has decreased back down to the March 2022 level with MSEFT narrowly missing their nationally set trajectory for 31 March 2023.

- Referral to Treatment (RTT) Waiting Times

For 2022/23, systems were required to achieve zero people waiting 104+ weeks. Mid and South Essex NHS Foundation Trust (MSEFT) achieved this in February 2023.

Systems are required to have zero patients waiting 78+ weeks by 31 March 2023 which MSEFT have narrowly missed, however have decreased to 20 patients, and expected to reduce to zero patients within quarter 1 of 2023/24.

The number of patients waiting 52+ weeks increased through the first half of 2022/23 but has been decreasing from October 2022 as per following graph as patients will receive their elective procedure at the earliest opportunity with work ongoing to reduce the waiting list to below 65 weeks by 31 March 2024.



Community Elective performance for some services has been significantly challenged. During 2022/23 focus on community RTT has commenced with providers to ensure the same level of challenge and oversight as to the acute RTT services.

Waiting List validation has been a key area of focus across acute and community to enable transparent understanding of performance and waiting times for our population. This work has enabled mitigation actions to take place to manage long waiting times where possible.

- Mental Health

For NHS Talking therapies (formally known as IAPT (Improving Access to Psychological Therapies)), the 6 and 18 weeks waiting time standards for people referred to the IAPT programme to start treatment has been sustainably achieved across Mid and South Essex throughout 2022/23.

However, the access rate for these services was below standard throughout 2022/23. A priority for MSE ICS is to increase the number of people accessing the programme through continued engagement and work with local PCNs to support referrals, as well as sharing across Alliances good practice to support recovery.

Dementia diagnosis rate remains below standard with the GP practice dementia register size ranging between 60% to 61% of the estimated size throughout 2022/23 for Mid and South Essex. Work has taken place supported by East of England Region to introduce with PCNs protocols to reduce over prescribing of diagnostic tests to support confirmation of dementia for diagnosis. The Mental Health team have worked and continue to work closely with the Alliances to support recovery of this standard.

The Early Intervention in Psychosis (EIP) standard of receiving a recommended package of care with 2 weeks of referral is being sustainably met across Mid and South Essex.

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

Financial Years	**2022/23 '000's'**
Mental Health Spend	£149,611
ICB Programme Allocation	£1,870,000
Mental Health Spend as a proportion of ICB Programme Allocation	8%

- Urgent and Emergency Care

2022/23 has seen a significant number of expectations of the System. Mid and South Essex have introduced, through partners, improvements to support recovery of ambulance handovers times and delays. These have included: Urgent Community Response Team, who with East of England Ambulance Trust (EEAST), have been able to pull patients from the ambulance queue to enable them to be assessed sooner.

This is to support EEAST recovery of their ambulance response times which has been below the NHS constitutional standards throughout 2022/23. The following table shows the 90th centile response times by category of call and respective standard.

EEAST: 90th centile response times by call category and respective standard

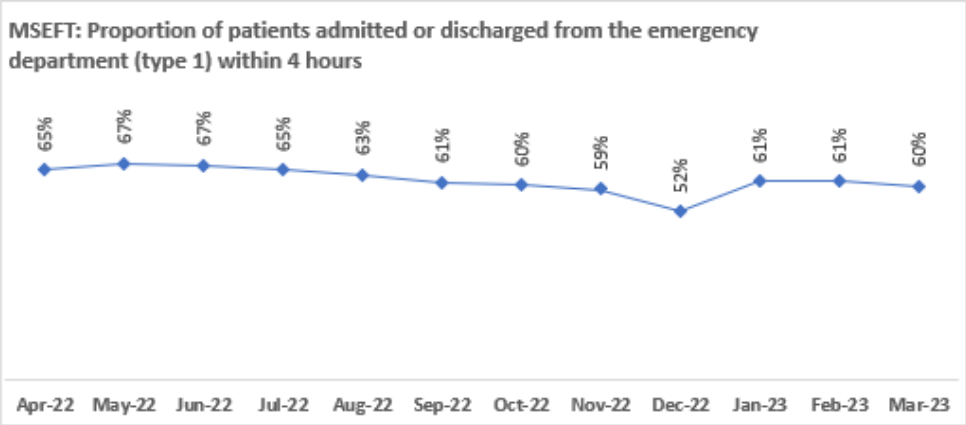
Category	Standard	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Category 1 (min:sec)	<= 15min	19:01	18:20	18:47	20:40	19:24	20:07	20:50	19:26	22:16	17:32	17:35	18:05
Category 2 (hour: min:sec)	<= 40min	2:20:31	1:47:01	2:02:30	2:54:53	2:17:46	2:47:37	3:13:50	2:18:54	5:16:40	1:46:15	1:36:55	1:58:22
Category 3 (hour: min:sec)	<= 02:00:00	7:52:55	6:24:24	6:57:53	10:08:24	6:57:20	9:10:49	10:21:32	7:42:50	13:29:50	4:28:28	5:13:24	6:20:12
Category 4 (hour: min:sec)	<= 03:00:00	9:01:16	10:49:16	10:32:35	12:45:17	11:54:22	13:10:06	14:15:17	12:54:11	18:32:35	6:22:10	8:28:42	11:23:37

Focussed work on flow to improve the emergency department standards have taken place. These continue as capacity and use of Same Day Emergency Care to support

ambulance offload has impacted on flow and acute performance in the emergency department.

> *"Patients appreciated being approached to complete the questionnaire especially those attending on their own who had been waiting a long time"*
>
> *Southend Hospital Urgent Treatment Centre patient engagement, autumn 2022*

Within MSEFT A&E (Type 1), the 4-hour performance has been below the 95% constitutional standard throughout 2022/23 as per the following graph.



NHS111 provides a valuable service that includes call answering and a clinical assessment service. NHS 111 performance has been challenged across the system and contributes to mitigation to support operational challenges.

Children and Young People (CYP) safeguarding

ICBs are responsible for several statutory duties set out in the Children Act 2004 and the Working Together to Safeguard Children [statutory guidance] 2018. Additionally, the Safeguarding children, young people, and adults at risk in the NHS - Safeguarding Accountability and Assurance framework (SAAF, 2022) sets out the safeguarding roles, duties, and responsibilities of ICSs.

> *"Make sure health professionals understand the whole picture when talking to a young person"*
>
> *MSE Young People's Panel member sharing their priority for CYP care*

<u>Mid and South Essex (MSE) ICB:</u>

- Complies with Section 10 and Section 11 of the Children Act 2004 and any subsequent statutory guidance relating to vulnerable groups.
- Participates in the Multiagency Safeguarding Arrangements (MASA)/Safeguarding Partnerships as one of the three Statutory Safeguarding Partners, alongside the Local Authority and Police. MSE ICB is a Partner of three local safeguarding children's partnerships: Essex Safeguarding Children Board (ESCB), Thurrock Local Safeguarding Children Partnership (TLSCP) and Southend Safeguarding Partnership (SSP). Below, there are the respective links for each of the Partnerships' latest published annual reports and MASA, demonstrating MSE ICB's delivery against safeguarding statutory duties.

Essex Safeguarding Children Board (ESCB)

- ESCB Annual Report 2020-21 (hyperlinks)
- ESCB Multi-Agency Safeguarding arrangements 2022-23 (hyperlinks)

Thurrock Local Safeguarding Children Partnership (TLSCP)

- TLSCP Annual Report 2021-22 (hyperlinks)
- TLSCP Multi-Agency Safeguarding Arrangements (hyperlinks)

Southend Safeguarding Partnership (SSP)

- SSP Annual Report 2021-22 (hyperlinks)
- SSP Safeguarding Partnership Arrangements (hyperlinks)

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

The MSE ICB safeguarding team work closely with other teams across the ICB to ensure that there are effective governance and quality assurance arrangements in place. The team also support GPs and Primary Care Networks for their roles in safeguarding adults at risk, child protection and meeting the needs of children in care.

MSE ICB has drafted its Safeguarding Assurance Framework (SAAF), which is out for consultation in readiness for the 2023/4 reporting year. It has brought together a Health Safeguarding strategic system group, which has co-produced a document set to provide health system safeguarding assurance to the local, regional, and national requests/requirements and priorities (SAAF - CP-IS; FGM; Prevent; Working Together; Modern Slavery and Human Trafficking; Domestic Abuse; Liberty Protection 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 with the Joint Forward Plan with ICPs.
- Listening to the voice of children and young people, especially children in care, care leavers and young carers.
- Producing an annual report on progress for the SAAF with Local Safeguarding Partnerships and Safeguarding Adults Boards.
- Making ready for being an LPS Responsible Body for NHS.
- Supporting workforce development strategies.

Some examples of MSE ICB Safeguarding Children work 2022-23

Implementation of national and local safeguarding reviews

Learning and emerging themes from reviews and incidents are shared across the system. Joint and collaborative working with partners, primary care and health system

Actions are implemented jointly with our health providers. The MSE ICB has facilitated workshops and forum to share the learning.

National reviews like Star, Arthur and Child Q recommendations have been cross referenced locally and reviewed to ensure local safeguarding arrangements are safe and effective.

Child Death reviews (CDR)

The team undertook work in relation to CDR as follows:

- Responding to child deaths from asthma.
- Sudden Unexpected Deaths in Infancy report and implementation.
- Child death annual review: child suicide (2023); early pregnancy and extreme prematurity; social media and unsafe content from the internet.

Female Genital Mutilation (FGM)

The MSE Safeguarding Team coordinated the development, approval, and publishing of two FGM pathways (one for all Health agencies and all Multiagency).

Non-Accidental Injuries (NAI) work

The ICB Safeguarding Team has worked closely with the Police and other partners to ensure babies, children and young people who are suspected of abuse and neglect are identified and timely referrals are put in place. To ensure there was a system awareness, the ICB Safeguarding team was heavily involved in planning and facilitating awareness conference across the Southend, Essex, and Thurrock (SET) partnership with over 400 participants on the call. Close ongoing work continues with police, acute and community health colleagues.

Looked After Children (LAC) and care leavers, SET LAC strategy, Unaccompanied minors (Separated Migrant Children).

The ICB has worked with Local Authorities/ Public Health Commissioners and the Initial Health Assessment (IHA) digital programme to ensure robust assessment processes are in place for our Children in Care. The ICB attends the Corporate Parenting meetings /workshops and have fully contributed to any improvement discussions. This is ongoing.

Contractual Safeguarding Policies

The ICB follows statutory safeguarding assurance processes through their contractual arrangements with all Providers. The ICB has commissioned for all policies to be reviewed and brought in line with current legislation and guidance. This ensured all policies with safeguarding sections had been reviewed and monitored.

Conclusion

Significant work continues between the MSE ICB Safeguarding team and partners across the system to constantly improve safeguarding, patient safety and governance. The team continues to be a well-used resource. Safeguarding assurance and

governance work has been strengthened through partnership working. In 2023/2024, the team will focus on its work programmes and local area lead portfolios, building on working relationships with the Alliances and key safeguarding objectives going forward.

Safeguarding Vulnerable Adults

Following the formation of the ICB in July 2022 the team established an all-age safeguarding resource. The team set themselves 4 very clear objectives and have gone on to deliver these objectives and made steps in developing an ICS wide safeguarding community:

1. Establish a revised safeguarding structure across the ICB that provides safeguarding expertise at a strategic, Place and provider level.
2. Establish an all-age approach to the team structure and the service this provides.
3. Develop a 2-year work programme that will deliver safeguarding assurance and governance to the ICB Board, the Essex Health Executive Forum, and the Safeguarding Statutory Boards across Essex.
4. Ensure that safeguarding principles are intrinsic in the quality approach of the nursing and quality directorate and wider ICB.

Working as part of the wider safeguarding system the team have participated in many learning exercises, addressed system delivery challenges and work proactively to address some of the inequalities and prevention work across the system.

Some examples include:

<u>Domestic Abuse (DA):</u>

- 3 local authorities are leading on implementation of the DA Act requirements, ICB participation in the delivery plans for all three areas.

- Development of DA Communication Strategy and successful delivery of perpetrator focused campaign #Reflect.

- Thematic review of domestic homicides identified key areas of learning for agencies including Think Family, co-existing mental health problems, drug/alcohol misuse, coercive control, and stalking.

<u>Mental Capacity Act (MCA)</u>

- MCA bespoke training sessions organised across the system health providers in preparation for Liberty Protection Safeguards. Lead role in place to work across 3 Essex ICBs. (April 2023: the Government decided to delay the implementation of the Liberty Protection Safeguards beyond the life of this Parliament).

- Emerging picture across Health economy of inconsistency in the application of MCA best interest assessments, to be a focus of work for 2023/24.

<u>Prevent</u>

- Home Office have led on the delivery of Channel Panel development across SET, ICB core membership of all three panels and Prevent Boards and are fully engaged with the work.

- MSE ICB developed a Memorandum of Understanding with Hertfordshire and West Essex ICB to share Channel Panel role across the Essex footprint, this will reduce duplication of effort and ensure engagement remains key to our ongoing working relationships.

Adult Safeguarding Enquires

- MSE ICB have supported Adult Social Care to with s42 enquiries regarding the safety and welfare of Continuing Health Care patients.

More work was undertaken at a strategic health level to support the above examples.

Environmental matters (Sustainability)

MSE ICB and the ICS are committed to delivering on the Greener NHS commitment of being net carbon zero by 2040 (scopes 1 and 2) and 2045 (for scope 3). Our approach to how this will be achieved is set out in our ICS Green Plan (hyperlinks) but can be summarised as saying we want to develop greener health and social care systems which strive to deliver high quality services and improve the health and wellbeing of the population.

There are 5 clear priorities that we are focusing on to achieve this: reduce carbon emissions, decrease pollution, improve health and wellbeing, increase financial efficiency, and enhance reputation.

Reduce Carbon Emissions

- Reducing gas, electricity, and water usage to cut carbon emissions.
- Ensuring 100% green electricity supply to all sites.
- Actively support and promote travel that does not use petrol/diesel-powered vehicles.
- All suppliers of goods and services to be aligned to net zero target, aligned with procurement frameworks.

Decrease Pollution

- Reduce waste to protect the environment.
- Eradicate single use plastics.
- Reduce causes of air pollution across the system and identify best practice.
- Procure products with an environmental lens, choosing low/no carbon options where possible.

Improve Health and Wellbeing

- Support on site health and wellbeing opportunities.
- Invest in green site enhancement and green spaces.
- Support and encourage active travel.
- Create an environment that promotes a highly motivated, engaged workforce.

Increase Financial Efficiency

- Reduce gas, electricity, and water consumption to save money.
- Reduce waste to cut costs.
- Review all Board/Committee templates to include a sustainability dimension.
- Ensure all future financial decisions have sustainability as a key driver in decision making.

Enhance Reputation

- Maintain our high reputation as individual organisations of an ICSs and other partners by sharing information and promoting action.
- Support and encourage green champions by creating a culture that enables compassion and inclusivity to thrive.
- Ensure our staff feel informed and empowered to consider sustainability as part of their decision making.
- Ensure we work in collaboration as a system and with other external partners.

MSE recognises the importance of viewing sustainability in the widest sense; with a focus on social, economic, and environmental; ensuring there's a joined-up approach with the Green Plan work and the need to reduce health inequalities. We have our governance structure in place, enabling us to deliver on our priorities, with representatives from across the whole ICS, allowing us to align the approach, maximising opportunities and reducing duplication. This is a long-term programme that is committed to achieving its objectives to support our people and protect our planet.

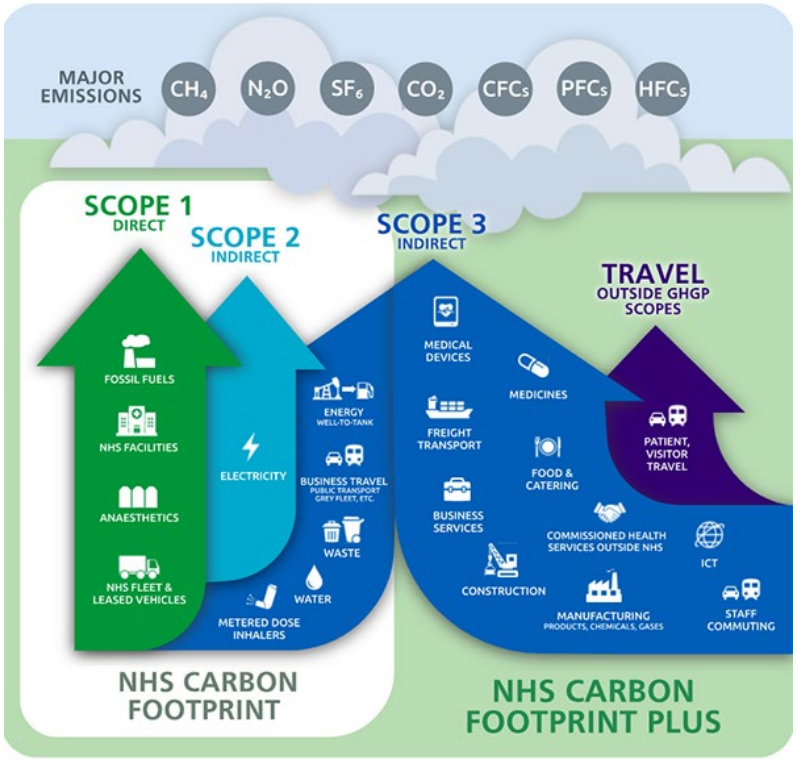


Figure 1: Greenhouse Gas Protocol (GHGP) scopes in the context of the NHS Plus *(Delivering A Net Zero National Health Service Report)*

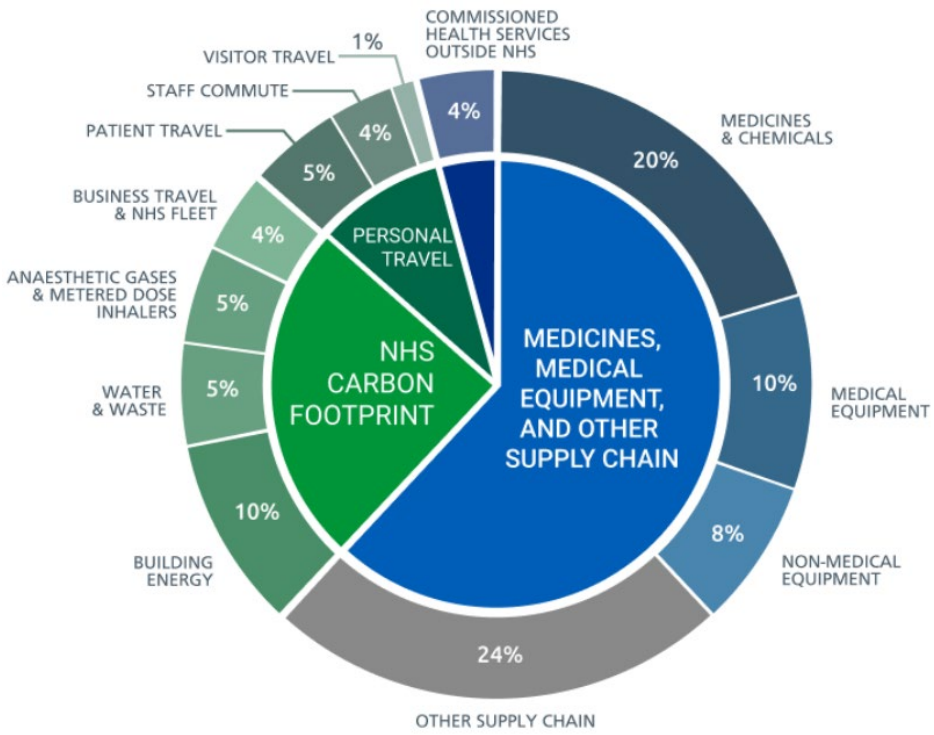


Figure 2: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus (Delivering A Net Zero National Health Service Report)

Improve Quality

In early 2022/23, the ICB published the 'ICB 2023/24 Quality Strategy and Implementation Plan' which has been extensively co-produced.

The strategy describes how the ICB aligns to national guidance, to enable the delivery of the quality agenda, and highlight's the ICB's priority areas:

- Ageing Well Integrated
- Planned, Emergency and Cancer Care
- Primary Care
- Mental Health
- Maternity and Neonatal
- Children's and Young People
- Learning Disabilities
- Safeguarding

Care Quality Commission (CQC)

The ratings of our providers are:

- Provide Community Interest Company – Outstanding.
- Essex Partnership University NHS Foundation Trust (EPUT) Community – Good.
- Mid and South Essex NHS Foundation Trust (MSEFT) – Requires Improvement.

- EPUT Mental Health Services – Good (ratings for Acute wards for adults of working age and psychiatric intensive care units currently suspended).
- North East London NHS Foundation Trust Community Services – Good.
- East of England Ambulance Service NHS Trust – Requires Improvement.

Maternity services

The most recent CQC inspection of all three mid and south Essex maternity services, resulted in the continued 'Requires Improvement' rating. The Maternity Improvement Programme provides oversight of the identified actions to address the CQC findings, as well as encompassing the recommendations of the Ockenden report and other national reports, such as the Kirkup investigation into East Kent, to help improve the quality of maternity services.

Focus continues on the Maternity Safety Support Programme actions and a Section 31 warning notice remains in place whilst sustainability of the actions is evidenced. The Mid and South Essex Local Maternity and Neonatal System (LMNS) are working collaboratively with the service to deliver the National Maternity Transformation programme workstreams, with a continued focus to address the key risks including challenges relating to workforce recruitment and retention.

Essex Partnership University NHS Foundation Trust (EPUT) Mental Health Services

The ICB Quality team and wider Essex partners continue to work closely with EPUT to ensure robust oversight of the quality and safety of care provided, particularly in response to recent significant quality concerns raised and the ongoing Essex Mental Health Independent Investigation.

System Quality

As the Mid and South Essex System Quality Group has developed, it has become a strategically significant forum that has strengthened the system quality surveillance, oversight and wider learning for all key providers and partners.

Quality Committee

The Quality Committee plays a vital role maintaining oversight and ensuring the delivery of the quality strategy. This is described in more detail within the governance statement section of the report.

Patient Experience

The ICB Quality team have continued to ensure the voice of the patient is heard for example through the programme of patient stories which capture authentic lived experiences which is shared with commissioners to influence the ICB's transformation agenda.

> *"Please take the impact [that] patients concerns have on… self-esteem seriously, even if their condition may not be life threatening. They do impact seriously on quality of life"*
>
> *Resident offering feedback during dermatology public engagement exercise*

This work sits alongside the wider ongoing engagement activity undertaken as part of our Integrated Care Partnership.

ICB Patient Safety agenda

A full time Patient Safety Specialist (PSS) was employed by the ICB in September 2022, in line with national requirements, who has a focus on the delivery of regional and national priorities. The ICS has a robust Patient Safety Specialist Network meeting in place with good engagement from acute and community partner organisations to support the implementation of the national Patient Safety Strategy. As part of this wide agenda the PSS has led on establishing the system Patient Safety Incident Response Framework (PSIRF) Implementation Group and developing the Patient Safety Partner roles.

Infection Prevention and Control

The Infection Prevention and Control team have continued oversight of living with Covid-19 across all parts of the system. Healthcare associated infections such as Meticillin resistant Staphylococcus aureus bacteraemia (MRSAB) and *Clostridioides* difficile infection (CDI) cases have seen an upturn for 2022/23 year, and IPC support continues to help manage this.

Special Educational Needs and Disability (SEND)

Mid and South Essex has strengthened the leadership and oversight of SEND to ensure the ICB meets its statutory obligations (Children and Families Act 2014) and continues to build on the collaboration with the three Local Authorities through the SEND Partnership Boards. Resources for the Clinical Designate Officer roles have been increased and a nominated Executive Lead for SEND has been identified with reporting through the ICB Quality Committee.

In January 2023, CQC and Ofsted introduced a new area SEND Inspection Framework 2 which will provide an independent, external evaluation of effectiveness of the local area partnership arrangements for children and young people with SEND. The ICB has been working with partners in parent carer forums, social care, and education in preparation and to continue in the delivery of the respective SEND Strategies. The ICB will be subject to three inspections aligned with Thurrock, Southend, and Essex Authority footprints.

Southend Ofsted and CQC conducted a Local Area SEND Inspection between 2nd – 10th March 2023 and await final publication of the report.

Thurrock Ofsted and CQC area SEND Inspection was conducted in 2019 resulting in a Written Statement of Action regarding three areas of significant concern. The revisit published report on the 1 February 2022 found that Thurrock had made sufficient progress in addressing all areas of concern and no further external monitoring was required.

Essex County Council Ofsted and CQC inspection was conducted in October 2019 which resulted in a Written Statement of Action identifying three areas of significant concern. A revisit took place in May 2022 and reported sufficient progress had been made in all areas with no ongoing external monitoring required. The Inspectorate noted

the improvement in partnership working with greater oversight and leadership, improvement in the accurate identification of needs and in the co-production of Educational, Health and Care Plans.

Significant challenges remain in ensuring services are responsive to the needs of children and partners, we continue to work together with our parent carer forums to improve services with priority for those requiring support from Speech and Language, Occupational therapy, and Physiotherapy along with the offer for children and young people with neurodiverse concerns.

Engaging people and communities

The Health Act 2022 reaffirmed the duty of healthcare planners to involve the public in developing NHS services. This duty is known as “working with people and communities”.

The ICB is co-designing (hyperlinks) a full Working with People and Communities Strategy with our residents, to be completed by 2024. Public involvement in NHS planning can help to deliver better services and reduce health inequalities, both ICB duties.

In the meantime, the stakeholder mapping we undertook as part of its creation has been held up as an example of good practice across the health and care system.

The most immediate need for public involvement after our establishment on 1 July 2022 was in addressing geographical variation in service provision across mid and south Essex. Analysis of the area’s former clinical commissioning groups (CCGs) showed that six NHS services were not delivered equitably.

To give mid and south Essex residents a say in fairer access to services and inform Board members’ thinking, NHS Mid and South Essex undertook a formal public consultation (hyperlinks) at pace to involve residents in the harmonisation process. This included tailoring our engagement with hard-to-reach groups and individuals who could be affected because of the harmonisation process as well as engaging more locally through our four Alliances.

We work collaboratively with our partners such as local authorities to engage with residents. We created a co-production panel for children and young people in our area where younger residents can share their feedback on service changes and proposals affecting them. Historically, engaging with young people has proven challenging, so this is a particularly pleasing outcome.

The new Integrated Care Strategy agreed by the Integrated Care Partnership (ICP), of which NHS Mid and South Essex is part, was informed by conversations with residents, community organisations, local authorities and health and care professionals and leaders. The ICP Chair and Vice Chairs, the three Healthwatch organisations and other ICP members at their first meeting in September 2022 all endorsed this approach.

Our Integrated Care Strategy commits us as partners to:

> *“a range of debates, talks, and workshops throughout the year, feeding into and from an annual symposium or conference. These will be open to all contributors, not just those organisations and individuals who attend the statutory Partnership meetings”*

We use various means to get the best from our engagement, for example through workshops, use of social media and targeting hard to reach groups, working with our local Healthwatch and other partners.

To achieve this, we will bring together Community Assembly, Independent and Private Providers' Network, and a Community Voices network to support and influence the work of our Partnership.

The development of co-production practice within the Mid and South Essex Integrated Care System has been sufficiently rapid that the ICB ran a "co-production workshop" for partner organisations and neighbouring systems in October 2022 to share best practice. More than 50 representatives of other local public and third sector organisations attended and feedback about the event from evaluation surveys was very positive.

While our full Working with People and Communities Strategy is developed, we continue to work with residents on specific programmes for people with long-term conditions.

Two stand-out examples are the "Blood Pressure @ Home (hyperlinks)" initiative, run as a pilot scheme in mid and south Essex before its national adoption, and supporting outreach to people who would benefit from targeted lung health checks (hyperlinks). We have established a visiting service that can get into the communities where they live and used knowledge gained from engagement to identify other target areas.

Reducing Health Inequality

Duty to reduce inequality

Health inequalities are the preventable, unfair, and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to act and access treatment when ill health occurs.

Central to the Integrated Care Strategy for Mid and South Essex is our desire to see residents united with health and social care services around the single 'Common Endeavour' of reducing inequalities together.

> *"We will… learn together through developing and delivering a plan to better understand and support the needs of… households experiencing poor health and care outcomes"*
>
> *Commitment from ICS partner made during Integrated Care Partnership Strategy design.*

The Common Endeavour will express our desire to work to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations, and agencies, focusing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them.

Statutory partners cannot achieve this alone. We must invite voluntary, community, faith and social enterprise organisations, residents, and others to join us in our Common Endeavour. Together we will work to significantly increase our focus on individual and community engagement, wider determinants, early intervention, and prevention, with a

transformed role for communities in relation to health and social care and with residents helping themselves and each other.

To achieve this will necessitate an alignment of our efforts, with the ICP acting as the fulcrum for engagement and community mobilisation, working alongside statutory and voluntary services and involving a ‘re-setting’ of our partnership with residents.

We will develop a simple, accessible, and inclusive campaign model, in which residents and services agree on a ‘shared social mission of purpose,’ through which we will harness the full potential of all contributors.

The ‘ask’ of us as residents is that we do everything we can to maintain our own health and wellbeing and that of our families, neighbours, and communities, keeping health and care services ‘in reserve’ for when we need them most.

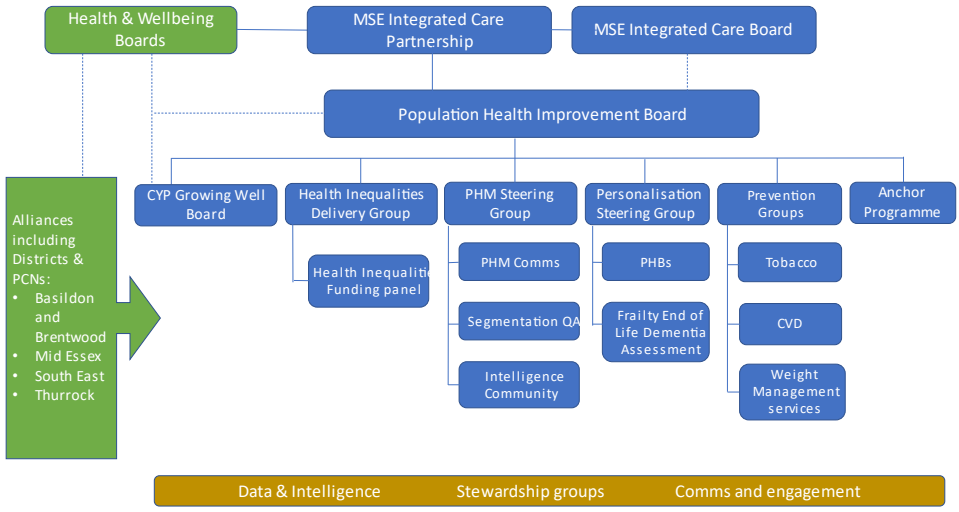
The corresponding ‘ask’ of the ICS will be: first, to support people to manage their own health by helping ‘upstream’ in a cost-effective manner before problems become serious, expensive, and irretrievable ‘downstream;’ and second, to integrate services around the individual once they need formal services.

We recognise this working together on this Common Endeavour will require commitment, courage, and most importantly, trust. Working together positively to build these will be a central theme for the ICB and our Partnership and is depicted in the diagram on page 9.

Population Health Improvement

We have therefore established a MSE ICS Population Health Improvement Board with representation from partners across the system to drive an integrated approach to inequalities improvement. This board brings together the programmes of work across the ICS on Health Inequalities, Population Health Management, Prevention, Personalised Care and the Anchor Programme, and the work of the Children and Young People’s Growing Well Board.

The Population Health Improvement Board will report up to both the MSE ICP to bring together the work around wider determinants of health and the ICB to drive improvements around specific healthcare priorities. The governance structure is outlined below:



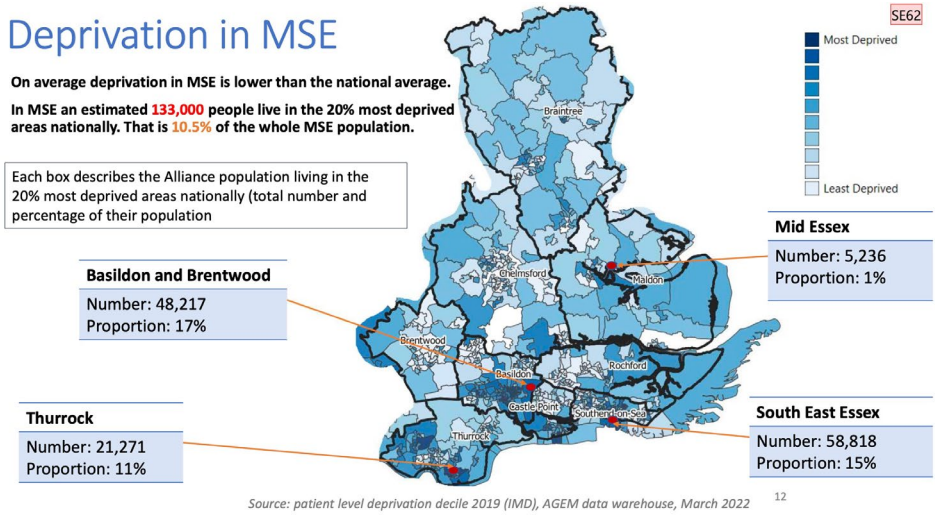
A Health Inequalities Delivery Group oversees the delivery of the programmes of work that support the reduction of health inequalities. It has cross organisational representation from NHS Providers, Local Authorities, Healthwatch, Public Health, Primary Care, and other NHS organisations.

To deliver our ambition the Population Health Improvement Board will ensure that the needs of our population and existing health inequalities are understood and areas for intervention prioritised with an emphasis on moving prevention work upstream.

CORE20PLUS5

As outlined in the Mid and South Essex Integrated Care Strategy, the ICB has adopted the NHS Core20plus5 frameworks for both Adults and Children and Young People to prioritise activities:

- The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD)



- Plus groups that experience poorer health outcomes. For MSE we have identified the following Plus groups; Black and Minority Ethnic groups, Carers, People with Learning Disabilities, people experiencing Homelessness, Gypsy, Roma, and Traveller communities.

- There are five clinical areas of focus for adults:

    - Maternity
    - People with Serious Mental Illness
    - Early Cancer diagnosis
    - Chronic Respiratory Disease
    - Hypertension case-finding and optimal management and lipid optimal management

- There are five clinical areas of focus for children & young people:

    - Asthma
    - Diabetes
    - Epilepsy
    - Oral health
    - Mental health

In addition, the MSE ICS has prioritised work related to reducing behavioural risk factors by supporting the adoption of healthy lifestyle choices such as healthy weight, physical activity, tobacco cessation and alcohol reduction.

In 2022/23 examples of work undertaken to support our most deprived communities and our Plus groups include:

- MSE Anchor programme has brought together MSEFT with South Essex Community Hub (SECH) and other partners to support people living in some of the most deprived areas of Southend to secure quality work at Southend Hospital or in another local health or care organisation. The centre aims to empower local people to realise their full potential by providing services such as digital support, in-person counselling and volunteering opportunities. Seven months into the project, we have seen almost 150 jobseekers, while 38 people have started a job in the NHS and 25 elsewhere. While this is good progress, the real impact is on our participants' life chances, where they are:
    - Changing their expectations.
    - Improving self-esteem and wellbeing.
    - Raising their children's aspirations.
    - Reducing poverty and inequality and being offered choice and hope.
- 'Core20plus Connectors programme' focusing on Chronic Obstructive Pulmonary Disease (COPD) and working within the six most deprived wards in Southend. The project involves collecting local knowledge, offering patients support, engaging with decision-makers and co-designing services.
- Improving Health and Digital Literacy for those in most deprived wards in Thurrock by working with library teams who already support volunteers to deliver digital skills training to residents.
- Utilising the 'Outreach bus' to visit the deprived areas within Canvey to increase hypertension case finding, cancer screening and vaccination uptake, health and wellbeing advice and onward referral thus increasing contact with appropriate services and alleviating loneliness and increasing wellbeing.
- 'Southend Integrated care for Homeless' brings together the NHS, Southend-on-Sea Borough Council, food banks, soup kitchens, hostels, outreach teams, hospital, mental health, and substance misuse providers to deliver an integrated health service to those experiencing homelessness.
- 'Understanding Inequality project,' run in partnership by Mid and South Essex NHS Foundation Trust and Healthwatch Essex involving people with learning disabilities to improve to access and experiences of hospital services.
- 'Improving access to health services for Thurrock's Gypsy, Roma, Traveller, and Showman communities' by establishing a monthly programme of visits to each of the key sites in order to a) introduce key services to the community, b) deliver some preventative health interventions, and c) facilitate subsequent registration with a GP practice.

Health Inequalities Funding

In 2022/23 the Mid and South Essex ICB received additional Health Inequalities funding of £3.4m to support innovative partnership solutions around the Core20plus5 priorities that were identified as meeting local needs by our four Alliances. We have started to mobilise over 70 projects that include:

- Microgrant scheme supporting small voluntary and community groups with grant amounts of £500 to £1500 to support grassroots responses to health inequalities.

- Improving access to health services for 'Plus' groups including Gypsy, Roma, Traveller and Showman communities and homeless communities in Thurrock and Southend.

- Increasing hypertension case finding through a variety of settings including primary care, community, leisure centres and retail parks and proving advice on how to maintain/obtain healthy blood pressure.

- Improving child oral health by expanding the Health Smiles programmes that supports young and primary school children to adopt teeth-friendly practices.

- Improving Health Literacy by building on the work of library teams to support health promotion and prevention around five clinical priority areas in the most 3 deprived wards in Thurrock.

- Supporting young people to become and stay physical and mentally healthy well in Basildon.

- Extending access to physical activities such as Essex Pedal Power and Street Tag to reach more (black, Asian, and minority ethnic) BAME communities in Basildon.

- Patient self-education programme for Mid Essex residents with poorly controlled respiratory disease that includes health promotion (e.g., smoking cessation, vaccination, obesity).

- The ICS has commissioned the University of Essex as an Evaluation partner to provide a framework and evaluation tools that enable us to assess the outcomes from the health inequalities funding investment and inform the future approach.

2022/23 Health inequalities planning priorities

We have undertaken action against the five national planning priorities for NHS organisations of areas for tackling health inequalities:

<u>Priority 1: Restore NHS services inclusively</u>

Analysis undertaken of waiting lists by ethnicity, sex and deprivation has enabled actions to be taken to improve equitable access to services by reducing barriers for example for working age women. The gap in waiting times between the most and second most deprived areas has halved in the last 12 months, but further improvements are still needed to eliminate the longer waiting times in more deprived areas.

An Equality Health Impact Assessment for elective recovery will be finalised by the end of 2022/23 that reviews data and evidence and sets out the mitigating actions required to

reduce disparities in access and outcomes.

Priority 2: Mitigate against digital exclusion

During 2022/23 partners within the Mid and South Essex system worked to agree a digital inclusion framework that sets out commitments to ensuring that our residents are digitally included and to ensure we do not worsen digital inequalities.

Maintaining access to face 2 face consultations remains a priority to ensure digital access does not disadvantage patients who wish to have non digital access to services.

Example of work to mitigate against digital exclusion include:

- Digital champions in pilot care home sites to support the roll out of Whazn telehealth solutions that supports measurement of vital signs so that deterioration or illness are identified earlier.
- User Centred Design Letters project - improving communications to support patients accessing outpatient appointments including F2F, Video and Telephone, these letters have been co-designed and include amendments to help address sensory impairments.
- Guidance on how to access digital options like video are included alongside contact numbers to call or email if technology issues occur.
- Introduction of innovations such as Cardmedic that allows clinicians to communicate clearly and confidently with patients whose first language is not English.
- Working with Public Health to install Wi-Fi in all sheltered housing in Thurrock and with the digital champions with libraries to improve Health Literacy and Digital Inclusion

Priority 3: Ensure datasets are complete and timely

We continue to strive to improve our recording of ethnicity and protected characteristics During 2022/23 we launched an awareness campaign under theme of “My Health Matters with residents of the need to maintain updated patient records.

Ethnicity recording is now more than 80% across primary care, community services and acute hospitals. In 2022/23 we saw a 10% improvement in the data completeness of recording of ethnicity in primary care following some targeted work to improve data collection.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

MSE ICP has adopted the Core20PLUS5 framework to accelerate its prevention programme work. Examples of the work undertaken in our most deprived communities and with our Plus groups is detailed above. Progress in the 5 clinical areas:

- ***Maternity***. Recruitment continues to support the continuity of carer programme with 47 WTE midwives appointed in Q3 2022/23 and 10 of 12 funded internationally recruited midwives will be in post by end of March 2023.

- ***SMI Health checks.*** There has been improvement from 54% to 60% of people with Severe Mental Illness within MSE having their annual health check. However, we want to improve the uptake of the health check and subsequent interventions further so during 2023/24 we will be working with the Institute of Healthcare Improvement as one of 7 ICS Core20Plus accelerator sites.

- ***Chronic Respiratory Disease***. We continue to utilise the roving van and bus to reach out into communities where uptake is lower to promote the uptake of Flu and Covid vaccinations along with other health promotion and prevention initiatives such as the integrated breathlessness pathway.

  "We don't want to be taking their breath away, more retaining what [breath] they've got"

  A patient representative evaluating targeted lung health check marketing materials.

- ***Early Cancer Diagnosis***. PCNs receive data by deprivation and includes protected groups including patients with LD, BAME patients, patients with SMI. Opportunities for improvement in uptake are identified, support provided and information on best practice shared including tailored communication packages. Thurrock Lung Health Checks pilot was completed in 2022/23 for all GP practices. This resulted in the detection of 22 Lung cancers of which 12 were stage one or two and nine other cancers were found.

- ***Hypertension***. MSE ICS was a national trailblazer pilot to BP@Home supporting residents improve their health outcomes through self-monitoring their blood pressure at home. Currently over 62,000 residents are participating in the program. The Integrated Breathlessness and Diagnostic service utilises the outreach van to undertake BP and ECG observations, referring to the relevant services and providing lifestyle advice and guidance / signposting.

<u>Priority 5: Strengthen leadership and accountability</u>

The MSE ICS has established clear leadership, governance, and accountability for health inequalities through the Population Health Improvement Board. This includes the designated Senior Responsible Officer (SRO) for Health Inequalities for Mid and South Essex ICB, supported by Clinical Leaders and the Associate Director Health Inequalities and Prevention.

Within Primary Care, the Tackling Neighbourhood Inequalities Directed Enhanced Service (DES) has called for a coordinated approach to tackling inequalities within Primary Care. All PCNs have nominated a health inequalities lead to act as a focal point and champion for this work. PCNs who are working with commissioners and Population Health Management (PHM) teams to design and deliver inequalities improvement intervention(s) for a selected population group experiencing inequality.

Work has commenced on a system performance framework to measure access, experience, and outcomes for ethnic minority communities and those in the bottom 20% of Indices of Multiple Deprivation (IMD) scores, this will be completed by end of Q2 2023/24.

Equality Delivery System

MSE ICB ensures equitable access using Equality and Health Inequalities Impact Assessments (HIIA) to assess impact and set out appropriate mitigations. In 2022/23 it has commissioned a digital tool to ensure high quality assessments are delivered consistently across the system supported by an organisation development approach that emphasises co-designing of services with residents with an effort to engage those from vulnerable groups.

Within MSE ICP, NHS Providers have agreed to work together to implement the EDS2 2022 on an ICS footprint for Domain 1 Commissioned or Provided services. The theme that we have selected for 2022/23 is Maternity and Antenatal Mental Health Services. Both services have been reviewed against the eleven outcomes, to measure successes and challenges with protected characteristic and vulnerable community groups using evidence and insight. MSEFT and EPUT have engaged with service users, patients, community, and faith groups and with other stakeholders who support or represent the views of patients, to gain feedback on current service provisions and how they can be improved to meet the needs of groups of patients. The outcome of the assessment alongside those in Domains 2 and 3 are published on the ICB website.

EDS Action plans have been developed for both services and will be 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). The Independent Chair, Chief Executive and/or one or more Alliance Director or Executive Director attends each Health and Wellbeing Board. Regular updates are provided on the work of the Integrated Care Board specifically and NHS providers more broadly. There are also regular presentations on specific strategic priorities and care areas, e.g., Primary Care development, Pharmacy, Optometry and Dentistry delegation, etc.

Senior representatives from each Upper Tier Local Authorities sit on the ICB Board and the ICB Director of Strategic Partnerships supports agenda setting for the Health and Wellbeing Boards, maintaining a close working relationship with the three Chairs. Due to the heavy programme of work for the ICB (with the Health and Wellbeing Boards being required to receive and comment on both the Integrated Care Strategy and the Joint Forward Plan) the Health and Wellbeing Boards have not been asked to specifically receive and comment on this Annual Report at this time. Also, two of the three Boards were not sitting during the time of drafting due to local elections and the ICB considers it essential to ensure parity for the three partner Upper Tier Local Authorities and does not consider it appropriate to engage inconsistently. The Annual Report will be brought to all three health and Wellbeing Boards at the earliest opportunity and the ICB is confident that there is regular engagement in the spirit of an integrated care system and the Health and Wellbeing Boards will be aware of and engaged in the work presented in this Annual Report.

The ICB participates fully in the work of the three Health and Wellbeing Boards and their work continues to underpin our priorities as an ICB. The ICB supports the development of Joint Strategic Needs Assessments and Local Health and Wellbeing

Strategies and meets with the three Chairs of the Health and Wellbeing Boards and the three Directors of Public Health regularly to share insights, data, and business intelligence.

The three Chairs of the Health and Wellbeing Boards sit as Vice Chairs of our Integrated care partnership, 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.

There is a requirement that, on completion, the ICS Integrated Care Strategy must be presented to the ICB, and the Health and Wellbeing Boards of our upper tier local authorities and the Strategy must be refreshed every time the upper tier local authorities publish a revised Joint Strategic Needs Assessment and/or a revised local Health and Wellbeing Strategy. In turn, the upper tier local authorities are required to consider the Integrated Care Strategy as they develop their own local plans.

Our Integrated Care Strategy has also been presented to the three Health and Wellbeing Boards, as described above. It should be noted the ICP will never seek to diminish or weaken the sovereignty of our partner organisations and agencies or our powerful local Alliances, nor will our Strategy replace or replicate their strategies and operational plans. It is simply intended to identify those shared priorities on which we will all work together and describe how we will do so.

In developing our Integrated Care Strategy, we reviewed the Joint Strategic Needs Assessments and Local Health and Wellbeing Strategies of our upper tier local authorities, and the strategic and operational strategies and plans of our city, district, and borough councils. In total, the strategies of 27 partner organisations and agencies were reviewed identifying several overarching themes, including:

***Persistent inequalities*:** Leading to lower quality of life and shorter life expectancy for many, particularly for residents in parts of Basildon, Thurrock, and Southend. Partners agree that eradicating these differences starts by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention and early intervention. This must also involve a real focus on babies, children, and young people, where many future health problems are seeded.

Growing and ageing population: Which brings a wide array of conditions including dementia, cardiovascular disease, cancer, diabetes, and COPD, as well as the wider challenges of frailty and increased social isolation. It is vital that solutions better meet the increasing volume and complexity of need in a sustainable way, including the provision of care closer to home. This could potentially adversely impact and increase pressure on Integrated Care System partners across health and care services if we do not act now.

Mental health conditions: Increasing in both adults and children and in some areas seeing suicide rates increasing at a worrying pace. Supporting people to feel comfortable talking about mental health, reducing stigma, and encouraging communities to work together are highlighted as key to improving mental health and wellbeing. Community partners have a particularly important role to play in the here and now, well before people present to mental health services for children and adults.

Financial review

Our full statutory financial accounts are included from page 79. This section provides a summary of our 2022/23 9-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 61. 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 108 for their full audit opinion).

ICB funding

The 5 CCGs in Mid and South Essex ceased to exist on 30 June 2022 and on 1 July 2022 they were replaced by the Mid & South Essex Integrated Care Board (ICB). The Mid and South Essex Health and Care Partnership became the Mid & South Essex Integrated Care System (ICS). Allocations for 2022/23 were given at a system level to CCGs in the first quarter and the ICB for the rest of 2022/23. The CCGs were required to break-even, and any allocation under / over was transferred to the ICB.

There was additional income received relating to Elective Recovery Fund (ERF). The ICB has a delegated Primary Care co-commissioning budget of £156.6m which included additional funding for Additional Roles Reimbursements for PCNs (ARRS).

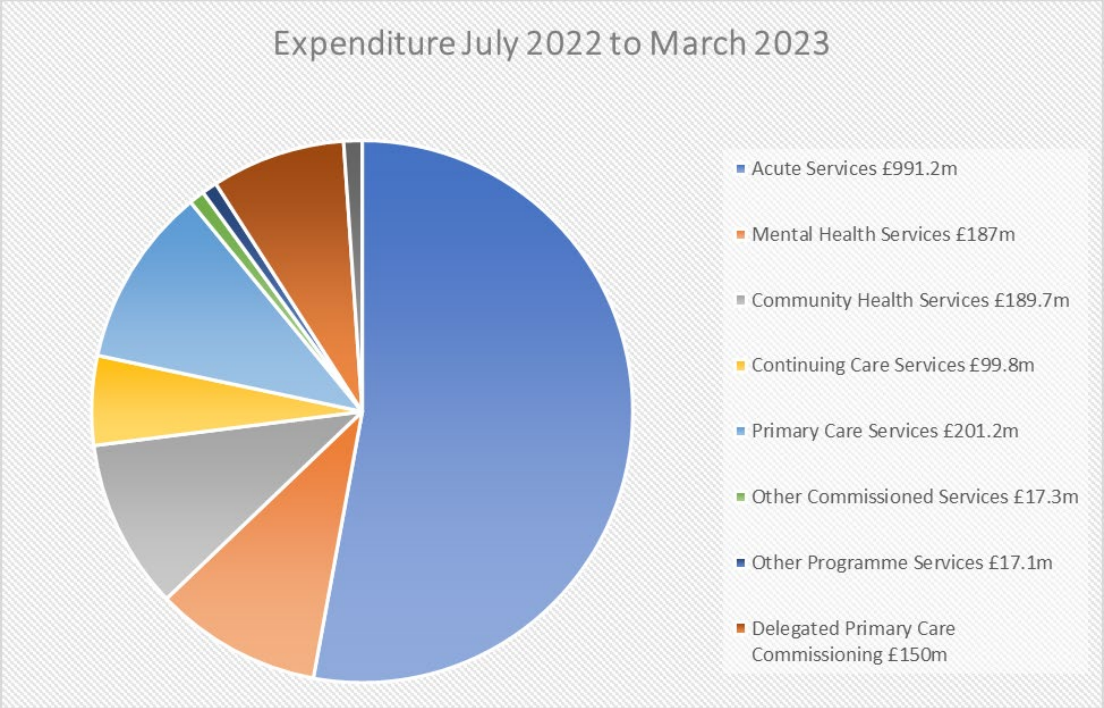
In the period 1 July 2022 to 31 March 2023 (9 months), the ICB in-year total healthcare funding was £1,870m and funding for running the ICB (called “running cost expenditure”) was £20.6m, resulting in total overall funding of £1,890.6m. ICB expenditure was £1,873.7m, resulting in £16.8m surplus for the financial year.

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 2022/23 the ICB has achieved the MHIS by increasing all Mental Health related expenditure by 5.6%.

How your money was spent

In 2022/23 we spent £1,853.17m on healthcare services and a further £20.58m on running costs, totalling £1,873.75m.

The following chart shows the major areas of expenditure for healthcare (including ICB running costs). (Core GP-led services (primary care) are commissioned by NHS England and are not accounted for in the ICB’s accounts).



Capital spending

The ICB did not receive an individual capital allocation for 2022/23, but accessed Primary Care Capital held by NHS England on behalf of the ICB towards primary care estates projects and GP IT.

Paying our suppliers and providers

National rules mean the ICB must aim to pay all valid invoices by the due date or within 30 days of receiving them, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. In 2022/23 the ICB either met or came very close to achieving 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

The national measures for payment performance do not include any delays in payment during the time that an invoice is on hold.

2023/24 financial plans and looking to the future

The 2023/24 Financial Plan was submitted on 4 May 2023 with £3m surplus which was further improved to £10m to assist with the system deficit. Allocations for 2023/24 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 Mid and South Essex. MSEFT and EPUT are part of our system control total, and our finances are reported separately and together to NHSE. As a system we expect to have a shortfall between our available funding and the spending we expect to incur during the year. We continue to work together and with our regulators to improve our financial position aiming and ensure the sustainability of our services.

ACCOUNTABILITY REPORT

Anthony McKeever
Chief Executive of Mid and South Essex Integrated Care Board

26 June 2023

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 July 2022 to 31 March 2023, 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 2023, the composition of the ICB Board was as follows:

- Professor Michael Thorne CBE, Chair
- Anthony McKeever, Chief Executive Officer
- Frances Bolger, Interim Executive Chief Nursing Officer
- Dr Ronan Fenton, System Medical Director
- Dr Ruth Jackson, Executive Chief People Officer
- Jennifer Kearton, Director of Resources (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
- Hannah Coffey, Mid and South Essex NHS Foundation Trust
- Peter Fairley, Essex County Council

- Mark Harvey, Southend City Council
- Les Billingham, Thurrock Council
- Dr Anna Davey, Primary Care Partner Member

Committee(s), including Audit Committee

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

Register of Interests

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

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

Personal data related incidents

There are processes in place for incident reporting and investigation of serious incidents. No serious incidents requiring investigation involving personal data were reported to the Information Commissioner in 2022/23.

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 2023 is published on the website at Modern Slavery Act Statement (hyperlinks).

Complaints to Parliamentary and Health Service Ombudsman

The ICB receives concerns, complaints and enquires from patients, carers, family members and Members of Parliament. Where the complaint relates directly to a provider the permission of the individual is sought to refer to the relevant provider.

From July 2022 to March 2023, there were 745 new complaints opened and 614 complaints closed. Themes and trends included difficulty accessing face to face GP appointments, GP registration issues, individual funding requests including ADHD, IVF and Continuous Glucose Monitoring (CGM), prescribing/GP medicines management including access to medication. Learning from complaints is shared with Providers, primary care alliances and internal stakeholders to inform pathways and services and improve patient experience. Complaints relating to primary care services are currently managed by NHS England.

In 2022-2023, four complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) and one to the Local Government and Social Care Ombudsman (LGSCO). These cases are still in the review and investigation stages.

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 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.

Anthony McKeever
Chief Executive of Mid and South Essex Integrated Care Board

26 June 2023

Governance Statement

Introduction and context

Mid and South Essex Integrated Care Board (the 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 July 2022 and 31 March 2023, 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 is to ensure that the group 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 (NHSE) ICB model constitution template, was approved by the Board at its inaugural meeting on 1 July 2022. The Constitution is supported by other documents setting out the ICB's governance arrangements, namely: Standing Orders; Scheme of Reservation and Delegation (SoRD); Standing Financial Instructions (SFIs); Governance Handbook, which includes a Functions and Decisions Map; and key policies.

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

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

The Board met in public on six occasions during 2022/23 at different venues across mid and south Essex (MSE). Each meeting was well attended and was therefore quorate. Members provided oversight and scrutiny of performance and the delivery of ICB objectives and made well informed decisions to support the development of the ICB and the Integrated Care Partnership Strategy.

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

The Board will undertake an annual review of its effectiveness in July 2023.

ICB Committees

To support the Board in carrying out its duties effectively, committees reporting to the Board are formally established to provide the Board with 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, information governance, cyber-security, emergency preparedness, resilience, and response (EPRR), business continuity management (BCM) and the ICB's responsibility to act effectively, efficiently, and economically.

As of 31 March 2023, the committee comprised of two members. The committee is chaired by George Wood, Non-Executive Member of the Board. An Associate Non-Executive Member will become the third member of the committee in 2023/24.

During 2022/23, the committee met on four occasions. In addition, virtual approval of the ICB's submission to NHSE regarding its EPRR arrangements was sought and given in September 2022.

Decisions were quorate in line with the committee's Terms of Reference (minimum of two members) on all occasions except for one meeting on 25 October 2022 when arrangements were made for the second Member to provide comments in advance of the meeting and to enable quoracy for decisions taken.

During 2022/23 the committee continued to focus upon ensuring the review of the systems, policies, procedures, and processes fundamental to the governance of the organisation. Minutes of ICB sub-committees were also received to provide the audit committee with oversight of established governance.

The committee has received assurance from internal audit of key systems and processes and, in addition to routine reporting, has 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 2022/23 on behalf of the Board.

The committee was involved with the development of the ICB's Board Assurance Framework (BAF) and maintains 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 2022/23 which identified 'reasonable' assurance.

The committee undertook a review of its effectiveness during 2022/23. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen the effectiveness of the committee has been developed.

Remuneration Committee

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

The committee also agrees 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 2023, the committee comprised of two members. The committee is chaired by Joe Fielder, Non-Executive Member of the Board.

During 2022/23 the committee met on six 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 the establishment of the ICB, implementation of the ICB staffing structure and approval of several new policies prior to their adoption by the Board.

The committee undertook a review of its effectiveness during 2022/23. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen the effectiveness of the committee has been developed.

Quality Committee

The Quality Committee provides assurance to the ICB 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 in the Quality Committee included arrangements for monitoring the quality of provider contracts; review of NHS Patient Safety Updates; review of the provider Quality Accounts 2021/22; serious incidents and never events; review of arrangements for the implementation of the Patient Safety Incident Response Framework; update on Special Educational Needs and Disabilities services; updates on Learning Disabilities Mortality Review (LeDeR) Programme; System Quality Strategy; Infection Prevention and Control Strategy; safeguarding escalations; approval of policies; all age continuing care; personal health budgets; review of patient safety and quality risks; quality and equality impact assessments; complaints and a review of any

virtual decisions taken since the last committee meeting. Deep-dive reviews into specific areas, including workforce, the prescribing and use of opiates, virtual wards, and maternity services 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.

The committee reviewed the equality and health inequalities impact assessments undertaken as part of the process to harmonise six commissioning policies.

As of 31 March 2023, the committee comprised of three members. The committee is chaired by Dr Neha Issar-Brown, 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 four occasions during 2022/23. Decisions were quorate in line with the committee's Terms of Reference (minimum of two members) on all occasions.

The committee undertook a review of its effectiveness during 2022/23. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. To further strengthen the effectiveness of the committee and how it interacts with system quality groups, the Quality Committee has been under review, aligning to the ICB quality guidance as set out by NHSE. This realignment focus's the quality agenda and provides strengthened assurances regarding the safety and quality of services directly commissioned by the ICB i.e., acute, community, learning disability and mental health services, as well as the quality of services within primary care and the care home sector.

Finance and Investment Committee

The Finance and Investment 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 approves any new finance policies prior to their adoption by the Board.

As of 31 March 2023, the committee comprised of eight 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 six occasions during 2022/23. Decisions were quorate in line with the committee's Terms of Reference (minimum of four members) on all occasions. Two additional virtual meetings were held in September 2022 and January 2023.

The committee undertook a review of its effectiveness during 2022/23. 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.

System Oversight and Assurance Committee

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

During 2022/23 the committee concentrated on addressing significant challenges relating to the recruitment and retention of staff across the MSE workforce; the quality and safety of services; performance, including clearing backlogs that arose during the COVID-19 pandemic relating to services including diagnostics, cancer, elective care; and improving system finances. In January 2023, the committee agreed that it would also focus on addressing data quality issues and primary care priorities across MSE.

As of 31 March 2023, the committee had nineteen members. The committee is co-chaired by Anthony McKeever, Chief Executive of the ICB, and Simon Wood, Regional Director for Strategy & Transformation, NHS England.

The committee met on nine occasions during 2022/23. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The committee undertook a review of its effectiveness during 2022/23. 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.

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 and associated improvement and transformation programmes.

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

As of 31 March 2023, the committee had ten members. The committee is chaired by Sanjiv Ahluwalia, Associated Non-Executive Member. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The committee met on seven occasions during 2022/23. Decisions were quorate in line with the committee's Terms of Reference (minimum of four members) on all occasions.

The committee undertook a review of its effectiveness during 2022/23. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference. An action plan to strengthen the effectiveness of the committee has been developed.

Clinical and Multi-Professional Congress

The Clinical and Multi-Professional Congress contributes to the overall delivery of the 'Triple Aim' of ICSs to deliver better health and wellbeing for everyone; better quality of health and care services; and sustainable use of health and care resources.

The work of the committee is driven by programmes of work within the ICB requiring expert clinical advice and assurance. The committee discharges its duties when reviewing, scrutinising, advising, and providing assurance on the programmes of work presented to it. During 2022/23 the work of the committee included harmonisation of six commissioning policies, individual funding requests and the Fracture Liaison Service.

> *"A very close friend… and her partner have been trying for over 10 years. It's heart-breaking to see them go through this and it would mean so, so much if they received NHS funding"*
>
> *Resident response to service harmonisation public consultation, autumn 2022.*

As of 31 March 2023, the congress had 13 members. The congress is chaired by Dr Ronan Fenton, ICB Medical Director. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The congress met on 6 occasions during 2022/23 and were quorate in line with the congress' Terms of Reference (minimum of eight members) on all occasions.

The committee undertook a review of its effectiveness during 2022/23. 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.

Better Care Fund (including Improved Better Care Fund) Governance

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

In line with the terms of the individual Section 75 Better Care Fund Agreements held individually with each of the upper tier local authorities, decision-making relating to the BCF is delegated to nominated representatives of the ICB and nominated representatives of each of the upper tier local authorities. Utilisation of the BCF funds was in line with national guidance and as detailed within the Section 75 Agreements. Reporting focused on expenditure on the approved services and performance against the nationally defined metrics. In 2022/23 the Better Care Fund also included additional funding made available nationally through the Adult Social Care Discharge Fund.

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 2022/23 will include an assessment which encompasses the relevant principles of the UK Corporate Governance Code.

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

Discharge of Statutory Functions

The ICB has reviewed the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. This review was supported by an assurance mapping exercise undertaken by the ICB's internal auditors during January 2023 which mapped the ICB's statutory duties against its committee structure, governance documents, policies, and procedures.

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

The ICB Board approved its Scheme of Reservation and Delegation at its inaugural meeting on 1 July 2022, which was updated in March 2023 to include preparations for receiving delegation from NHSE for the management of Pharmacy, Optometry and Dentistry in April 2023.

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 both clinical and non-clinical risks and the ICB's risk appetite statement, which assists managers to identify when risk levels are tolerable or where further action is required to reduce risk ratings to an acceptable level, was approved by the ICB board on 1 July 2022.

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

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

The ICB has identified its top strategic areas of risk which are monitored via the ICB's Board Assurance Framework (BAF). As of 31 March 2023, these risk areas were:

- Workforce
- Primary Care

- Capital
- Hospital Flow
- Diagnostics, Elective Care and Cancer Performance
- System Financial Performance
- Health Inequalities
- Mental Health Services Quality Assurance

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

Capacity to Handle Risk

During 2022/23 the ICB had the following arrangements in place:

- Clear ownership of risks, with responsible Directors and lead officers identified, with escalation arrangements in place to the Board.
- A Board Assurance Framework within which the latest updates from lead officers were recorded and reported to relevant committees and the Board.
- Recording and investigation processes for incidents, including identification of learning.
- Triangulation of learning from incidents, complaints, and claims (should they arise) as a standing item on the agenda of the Quality Committee.
- Monitoring of completion of Equality and Health Inequality Impact Assessments, Quality Impact Assessments and Privacy Impact Assessments.
- Regular review of anti-fraud, bribery, and security arrangements by the Audit Committee.
- Emergency Planning, Resilience and Response and Business Continuity Management Policies and Procedures.

The ICB's Raising Concerns Policy and arrangements, including the appointment of a Board level Freedom to Speak Up Guardian, 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 underlying or root causes of incidents, claims and complaints. The principal objective is to identify 'system failures,' rather than focusing on individual failures.

Stakeholders, including staff, patients and the public have been involved in the risk management process, for example by ensuring that relevant staff were identified to input into any risk assessments in their function or area of work; that ICB staff and contractors were made aware of agreed risk reporting procedures; that contracts clearly stated the responsibilities of contracted personnel with regard to risk identification, reduction, mitigation and reporting; that feedback on risk issues was encouraged via the ICB's complaints and enquiries services and through its public engagement and consultation mechanisms, e.g. patient stories at Quality Committee meetings, engagement with the public and other stakeholders on service harmonisation of six commissioning policies and the ICB's future plans for services.

"I believe that all patients should have the same choices since we have become one [system], but we will need to look at a patient as an individual"

Resident response to service harmonisation public consultation, autumn 2022.

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

The application of the risk management framework, including assessment of the level of risk via regular review of the risk register by risk leads, committees and the ICB Board, prevents 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' terms through promotion and training and the issuing of fraud alerts, with the help of 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 conflicts are managed appropriately.

Other sources of assurance

Internal Control Framework

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

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

The system of control in place is set out within the Board, Committee and Risk Management sections of this statement and has been reviewed by Internal Audit assessing the governance arrangements in place within the ICB. The outcome of the review is included within the Head of Internal Audit but concluded that the ICB has appropriate arrangements in place.

Annual audit of conflicts of interest management

The requirement for CCGs to report on their internal audit of conflicts of interest (via returns to NHS England) has fallen away with the formal establishment of ICSs in July 2022.

While the Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own Conflicts of Interest policy, which is included in the ICB's governance handbook, NHS England's engagement with local stakeholders suggests nationally commissioned basic training would be of value to avoid unnecessary duplication across systems. NHS England will provide updated national e-learning modules on managing conflicts of interest in the context of the new ICB arrangements and explore developing additional guidance on conflicts of interest in consultation with ICB Chairs.

The ICB annual internal audit of conflicts of interest 2022/23, which was undertaken as part of the wider audit of the ICB's risk management and governance arrangements, identified 'reasonable' assurance.

Data Quality

The oversight and management of data quality is embedded within the System Oversight and Assurance Committee and other relevant groups, e.g., Elective Care Board. As 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, which then enable the focus groups to be stood down.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure members of staff are aware of their information governance roles and responsibilities, and how to access information or assistance. We have nominated information asset owners who are completing the new records of processing activity system, which includes data flow mapping and information asset registers, to ensure compliance with the General Data Protection Regulations (GDPR). This was undertaken with support from the IG Team to ensure consistency of approach.

As of 31 March 2023, the ICB is on course to meet all mandatory assertions in relation to the requirements of the Data Security and Protection Toolkit 2022/23 (due for submission at the end of June).

Business Critical Models

The Integrated Care Board 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.

The ICB has a Business Continuity Plan, approved by the ICB Board supported by an overarching Essex-wide Business Continuity Policy, all of which have been approved by the ICBs' in the 'Essex' footprint (i.e., Mid and South Essex ICB, Suffolk and North East Essex ICB, and Hertfordshire and West Essex ICB). The documents are updated when a material change occurs, and a comprehensive annual review takes place each year. The ICB Directorates are undertaking the Business Impact Assessment work following the move to an ICB from July 2022 and the subsequent organisational structures being established.

A memorandum of understanding is in place across the ICBs covering the Essex footprint which sets out the intentions to provide mutual aid and assistance to each other during an incident which cannot be managed internally by the organisation/ICB. The ICBs continue to build on their joint working that was established in response to the Covid-19 pandemic.

Third party assurances

The ICB relies on several third-party providers which are listed below, together with information on how assurance is received from each provider, the effectiveness of these arrangements and whether any improvements are planned in the future.

The ICB relies on a third-party provider for payroll and pension services. This service is provided by Whittington Health NHS Trust which is based in North London. The ICB continues in a positive relationship with Whittington Health with regular virtual MS Teams meetings held between Whittington and ICB Human Resources Managers.

The ICB retains the services of a procurement expert company (Attain) to ensure probity during procurement processes. The Finance & Investment Committee receives procurement reports at each meeting and a register of procurement decisions, which is published on the ICB's public-facing website, is reviewed by the Audit Committee to ensure rigour is being applied.

The ICB holds a monthly contract review meeting with Arden and Greater East Midlands (AGEM) Central Support Unit (CSU) to monitor all aspects of the contract and review performance against service level agreements and key performance indicators. This includes extended services such as back-ups and business continuity planning. For GPIT and Primary Care Enabling Services exceptions or escalations are reported to the Primary Care Digital Board. The Audit Committee maintains oversight of cyber security and the associated Business Continuity planning and arrangements for maintaining corporate, operational, and clinical services in the event of a loss of either IT or data due to a cyber-attack. The ICB receives copies of all NHS Digital CareCert alerts and confirmation when AGEM has updated against them.

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 are being managed as follows:

- **Ambulance Services –** An Ambulance handover recovery plan is in place, overseen by the ICB Transformation and Improvement UEC Board. Twice daily system calls held with EEAST and MSEFT via the system control centre. The System Oversight and Assurance Committee (SOAC) receive the current performance and actions being undertaken to mitigate performance risks. Significant progress has been made to recover Ambulance performance by working closely with system partners and this will continue until performance matches our targets.

- **Performance against Cancer Constitutional Standards –** A Recovery Plan is in place with oversight via the MSE ICB Transformation and Improvement Cancer Board this reports performance and escalation to SOAC, formal sub-committee of the Board. The System attends the National Tier 1 meetings chaired by Regional Team overseeing performance improvements and 62-day recovery. These take place every two weeks. 62-day recovery is part of the MSEFT Undertakings and has a separate focussed SOAC meeting to ensure momentum and progress to recover 62 day and sustain recovery when achieved or as trajectory is on track to ensure no deterioration. Real progress has been made this year, which is expected to continue into 2023/24.

- **Elective Recovery -** A Recovery plan is in place with oversight via the MSE ICB Transformation and Improvement Elective Board which reports performance and escalation to SOAC. The System attends the National Tier 1 meetings chaired by the Regional Team overseeing performance improvements and 78 week wait recovery, held every two weeks. 52 week wait recovery is part of the MSEFT Undertakings which has a separate focussed SOAC meeting to ensure momentum and that sustainable recovery is achieved.

- **System Financial Performance -** The system has invoked the forecast outturn protocol process and consequently agreed a revised financial position with NHS England, noting that the ICB itself will maintain its break-even position. System financial performance will therefore be a focus of the work of the ICB and partner organisations during 2023/24, with robust governance around decision making to manage the financial position going forward.

- **Mental Health** – Following CQC inspection, Rapid Risk Review, and establishment of the Essex Mental Health Independent Inquiry, an EPUT recovery plan is in place with oversight via the MSE Partnership Board with reports and performance escalated to SOAC. There are also service improvement plans in place with EPUT, with trajectories for achievement/recovery updated via the relevant SOAC report.

- **Maternity –** The Section 31 Notice issued in respect of maternity and midwifery services at MSEFT by the Care Quality Commission (07/10/2020), includes specific improvement actions which are reflected in the Trust's Maternity Improvement Plan. Oversight of this is provided by the MSE Local Maternity and Neonatal System (LMNS) and the MSEFT Maternity Assurance Committee, as a sub-group to the Trust Board. The LMNS Senior Responsible Officer briefs the ICB's SOAC on Section 31 reporting. Maternity is part of the MSEFT Legal Undertakings which are monitored via a separate focussed SOAC meeting to ensure momentum and

progress. This meeting includes NHSE representation, the ICB Chief Nurse/SRO for the LMNS/Maternity and MSEFT representatives.

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

The ICB was formed on 1 July 2022 consisting of the 5-predecessor mid and south Essex Clinical Commissioning Groups (MSE CCGs). The allocation for the system for the year 2022-23 was allocated in part to the CCGs, reporting a breakeven position at the end of Q1 2022/23 with the resultant remaining allocation transferred to the ICB. The ICB is reporting a £16.9m surplus for the year, whereas the system is reporting a deficit of £46.3m.

The MSE CCGs' Finance and Performance Committees and the Boards each received regular financial reporting in Q1 and had the opportunity for detailed review of the financial position. The ICB Finance & Investment Committee and the Board then received regular financial reporting for the remainder of the financial year.

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

The ICB's 2022/23 running (management) costs were within nationally permitted expenditure limits.

The Internal Auditor has reviewed the ICB's financial systems and processes, including the arrangements for financial reporting and confirmed that the ICB has reasonable arrangements in place. The external auditor's comments on our arrangements for securing economy, efficiency, and effectiveness in use of resources in 2022/23 are included in their report immediately preceding the Annual Accounts (see page 108 onwards).

Delegation of functions

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

Counter fraud arrangements

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

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

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

At the end of the financial year, the ICB submits a self-assessment to the NHS Counter Fraud Authority against the Government Counter Fraud Functional Standards. The Director of Resources and Chair of the Audit Committee authorise the assessment prior to submission.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 July 2022 to 31 March 2023 for the ICB, the Head of Internal Audit issued a draft independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance, and internal control.

The Head of Internal Audit concluded that reasonable assurance could be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, puts the achievement of particular objectives at risk.

During the period, Internal Audit issued the following audit reports:

Assignment	**Assurance Opinion**
Financial Sustainability Implementation	Reasonable Assurance
Oversight of Quality of Mental Health provision	Reasonable Assurance
Implementation of Ockendon Review recommendations	Reasonable Assurance
Management of Conflicts of Interest and Gifts and Hospitality	Reasonable Assurance
Data Security and Protection Toolkit Process	Reasonable Assurance
Key Financial Systems	Reasonable Assurance
Patient, Carer and Resident Engagement	Requires Improvement
Payroll	Reasonable Assurance
EPRR and Business Continuity	Requires Improvement
Risk Management and Assurance Framework	Reasonable Assurance
Assurance Mapping	Assurance Report
Financial Governance/Sustainability National Audit	Assurance Report

Two audits, the 'Patient, Carer and Resident Engagement' audit and 'EPRR and Business Continuity' audit both received a 'Requires Improvement' assurance opinion with the key areas for improvement set out in the final reports.

Action plans have been established to address all recommendations made in the internal audit reports. Regular updates on progress are submitted to the Audit Committee.

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

My review of the effectiveness of the system of internal control is 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 is 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 and Governance Committee.
- Finance and Investment Committee.
- System Oversight and Assurance Committee.
- Primary Care Commissioning Committee.
- Clinical and Muti-professional Congress.
- Internal Audit.
- External Audit.

Conclusion

I concur with the Head of Internal Audit Opinion that during 2022/23 there has been a generally sound system of internal control, designed to meet the organisation's objectives, and that controls have been generally applied consistently.

Action plans to implement any outstanding recommendations from audits are in place and will continue to be monitored during the 2023/24 financial year.

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

Anthony McKeever
Chief Executive of Mid and South Essex Integrated Care Board

26 June 2023

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

For 2022/23 the membership of the remuneration committee was as follows:

- Joe Fielder
- Peter Fairley
- Neha Issar-Brown
- Ruth Jackson

This committee met on six occasions during 2022/23, during which the Committee Chair was present, and the meeting was quorate as set out within the governance statement above.

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

Pay Ratio Information

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in Mid and South Essex ICB in the financial period July 22 to March 23 was £265k - £270k and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay Ratio information table:

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

*No Performance Pay and Bonus Payments are paid by the CCG, therefore both Salary component and Total Remuneration are the same.

In 2022-23 (July 22 to March 23), 0 employees received remuneration in excess of the highest-paid director.

As at 31 March 2023, remuneration ranged from £6k to £266k based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers and very senior managers

Senior managers are subject to Agenda for Change terms and conditions, with the exception of 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 Director of Resources and Director of Human Resources) being considered in all decisions.

Senior managers' performance-related pay

The performance of all staff (including the Chief Executive Officer, directors, and senior managers) is monitored and assessed using a robust appraisal system. A formal appraisal review is undertaken at least annually.

Agenda for Change contracts do not contain provision for performance-related remuneration beyond the element introduced in 2018 for bands 8c, 8d and 9. Specifically, in the year after an employee has reached the top of any of those bands, subject to performance the employee will retain their basic salary, or their salary will be reduced by five per cent or 10 per cent. The employee will be able to restore their salary at the end of the following year by achieving agreed levels of performance.

Under the VSM pay framework, there is the potential for performance-related pay under the terms and conditions of the contract. No proportion of remuneration for any staff member has been subject to performance conditions at the ICB during 2022/23.

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 2022-23 (July 22 to March 23)

This Integrated Care Board Remuneration Report for 2022-23 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 Integrated Care Board specific Remuneration Report table of directors and senior managers.

ICB Pension Table:

This includes the Integrated Care Board specific Pension entitlements of directors and senior manager.

Mid and South Essex ICB Remuneration Report 2022-23 (July 22 to March 23)

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

Notes	Name	Title	2022/23 (July 22 to March 23)					Date served	
			Salary (bands of £5,000)	Expense Payments (taxable) (total to nearest £100)	Other Remun-eration (bands of £5,000)	All Pension Related Benefits (bands of £2,500)[1]	Total (bands of £5,000)	Commenced	Ceased
			£000	£	£000	£000	£000		
	Executive Directors								
	Anthony McKeever	Chief Executive Officer	150-155	0	0	45-47.5	195-200	01-Jul-22	
2	Jennifer Kearton	Director of Resources	65-70	0	0	50-52.5	115-120	10-Oct-22	
2,3	Dawn Scrafield	Interim Director of Resources	55-60	0	0	20-22.5	75-80	01-Jul-22	09-Oct-22
4	Frances Bolger	Interim Chief Nursing Officer	40-45	0	0	0	40-45	12-Sep-22	
4	Rachel Hearn	Chief Nursing Officer	10-15	0	0	7.5-10	20-25	01-Jul-22	24-Jul-22
5	Dr Ronan Fenton	System Medical Director	70-75	0	0	0	70-75	01-Jul-22	
	Dr Ruth Jackson	Executive Chief People Officer	100-105	0	0	0	100-105	01-Jul-22	
	Governing Body Members								
	Professor Michael Thorne CBE	Chair	45-50	0	0	0	45-50	01-Jul-22	
	Dr Neha Issar-Brown	Non-Executive Member	10-15	0	0	0	10-15	01-Jul-22	
	George Wood	Non-Executive Member	10-15	300	0	0	10-15	01-Jul-22	
	Joseph Fielder	Non-Executive Member	10-15	0	0	0	10-15	01-Jul-22	
6	**Partner members**								
7	Dr Anna Davey	Primary Care Services Partner Member	5-10	0	0	0	5-10	01-Jul-22	
	Paul Scott	Partner Member, Essex Partnership University NHS FT	0	0	0	0	0	01-Jul-22	
	Hannah Coffey	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Jul-22	
	Peter Fairley	Partner Member, Essex County Council	0	0	0	0	0	01-Jul-22	
8	Les Billingham	Partner Member, Thurrock Council	0	0	0	0	0	17-Nov-22	
8	Ian Wake	Partner Member, Thurrock Council	0	0	0	0	0	01-Jul-22	16-Nov-22
9	Mark Harvey	Partner Member, Southend City Council	0	0	0	0	0	13-Mar-23	
9	Benedict Leigh	Partner Member, Southend City Council	0	0	0	0	0	17-Aug-22	12-Mar-23
9	Tandra Forster	Partner Member, Southend City Council	0	0	0	0	0	01-Jul-22	16-Aug-22

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

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

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

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2023 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5,000) £000	Cash equivalent transfer value at 1st July 2022 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2023 £000	Employers contribution to stakeholder pension £000
Executive Directors									
Anthony McKeever	Chief Executive Officer	0	0	0	0	0	0	0	47
Jennifer Kearton	Director of Resources (CFO)	2.5-5	2.5-5	30-35	50-55	353	26	415	0
Rachel Hearn	Chief Nursing Officer	0-2.5	0	35-40	65-70	578	6	602	0
Dawn Scrafield	Interim Director of Resources	0-2.5	0-2.5	60-65	110-115	900	13	952	0

Note: Dawn Scrafield's costs were recharged from MSE NHSFT from 1 July 2022 to 9 October 2022. Both MSEICB and MSE NHSFT are including her full CETV figures, as these relate to the individual rather than the organisation and cannot be apportioned for different employments.

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

Cash Equivalent Transfer Values

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

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. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer.

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

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.

Compensation on early retirement for loss of office

For 2022/23 accounting period there were none.

Payments to past directors

For 2022/23 accounting period there were none.

Staff Report

MSE ICB was formed on 1 July 2022 and staff who were employed by the 5-predecessor mid and south Essex CCGs or who held system roles were transferred via the Cabinet Office Statement of Practice (COSoP) legislation to MSE ICB on 1 July 2022. In addition to this, there was a full consultation and organisational change process that ran simultaneously from 4 April 2022 date to 31 July 2022, which enabled staff to secure a role within the new ICB structure by 1 August 2022.

Number of senior managers

In 2022/23, the ICB had 99 senior managers.

Staff numbers and costs

EMPLOYED STAFF		
Employee category	Headcount	WTE
Permanent	458	424.71
Fixed-term	33	29.08
TOTAL	491	453.79
AGENCY & INTERIM		
TOTAL	82	38.84
GRAND TOTAL	**573**	**492.63**

Staff composition

Pay Band	2	3	4	5	6	7	8a	8b	8c	8d	9	VSM	Other	Grand Total
									Senior Managers					
Female	1	15	51	38	74	52	67	44	24	18	11	10	33	438
Male	5	3	8	5	12	13	15	12	14	7	9	6	26	135
Grand Total	6	18	59	43	86	65	82	56	38	25	20	16	59	573

Sickness absence data

Average FTE for 2022	Average Sick Days per FTE	FTE-Days recorded Sickness Absence	FTE-Days Available	Months
421	4.6	2,101	102,542	8

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

Mid and South Essex ICB participated in the NHS Staff Survey and the results have been presented across joint Directorates and teams. The ICBs chose Picker to run the survey and results were published nationally on 9 March 2023.

The ICB had a response rate of 64%. Key themes have been shared with the ICB Executive Team and they have been asked to work with their teams to write action plans in response to the staff survey results. In addition to this, the ICB has a Staff Engagement group that has been running since January 2022 and this group developed an action plan from the 2021/22 NHS Staff survey looking at key themes such as health and wellbeing and diversity and inclusion and will build on these themes and actions for the 2022/23 survey, supporting the development of the organisational planning in response to the survey and giving the opportunity to staff to shape this plan.

The ICB has an LGBTQ+ network, a women's network, and a peer support group for those with a long-term health condition. A BAME network is also in the process of being set up. A proposal for dedicated time for the network chairs as well as some budget for each network is also progressing through the governance of the ICB.

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

There are also opportunities for staff to meet at a more local level through Alliance briefings as well as team briefings and regular one-to-one meetings with their manager.

The ICB is also doing a dedicated piece of staff engagement around the organisational values, to ensure that staff are involved in the process of defining the values and shaping the behaviours that embody these values, so that this is clear and transparent across the organisation.

> *"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 Integrated Care Partnership Strategy design.*

Staff policies

Health and Wellbeing

The ICB is benefitting from a comprehensive staff health and wellbeing offer.

An Employee Assistance programme is available to all staff which provides a telephone support line and counselling, as well as a comprehensive occupational health provision.

The ICB also promote national, regional, and local (via Working Well) initiatives such as The NHS Digital Weight Management Programme, Stress Awareness Workshops, Mindfulness courses and many more.

In January 2023, the ICB also established a Wellbeing Champions Group to jointly input into the Wellbeing Strategy and regularly consider and raise wellbeing within local team meetings and the wider organisation. There is also a trained network of Mental Health First Aiders who act as a first point of contact for any employee experiencing emotional distress through to a mental health issue.

The ICB is committed to supporting disabled colleagues within the workplace through making reasonable adjustments as well as the use of regular risk assessments and supporting colleagues' mental health using stress risk assessments and other support tools. The ICB has also an established peer support group called "Positive Ways to Wellness" – open to employees with any long-term condition.

Equality, Diversity, and Inclusion

The ICB is committed to providing equal opportunities and to avoiding unlawful discrimination and the Recruitment and Selection Policy is designed to assist the ICB in putting this commitment into practice. The policy is compliant with the Equality Act 2010 and sets out specific actions undertaken by the ICB, in the context of employment and people management, in order to fulfil its Public Sector Equality Duty.

During 2023 all ICB staff will be offered further equality, diversity, and inclusion training. The offering will include unconscious bias training, awareness of protected characteristics, allyship (support for the rights of a minority group without being a member of it) and a complete review of policies, procedures, and practices to eliminate bias. This will be offered in line with the recommendations of the No More Tick boxes report and managers will also receive further training in how to use the De Bias toolkit for recruitment and selection.

The ICB also held an engagement event around the East of England Anti-Racism Strategy and has developed some actions in response to this strategy. These will be implemented and monitored through the Equality, Diversity and Inclusion Subgroup that is accountable to the Mid and South Essex People Board. The ICB is also committed to the delivery of the EDI framework through this subgroup.

The ICB has developed a WRES report and action plans that staff have had the opportunity to contribute to and will work on the WDES report and action plan in 2023. These will be regularly monitored to ensure progress against agreed objectives.

The ICB Executive Team will also participate in the MSE reciprocal mentoring for inclusion programme through the NHS Leadership academy, a commitment that has been made by the Executive teams from across the system.

Health and Safety

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

Risk assessment and inspections identify health and safety issues to enable appropriate action to be taken to reduce risks to staff and other users of ICB premises. Although ICB staff continue to work in a hybrid way, regular health and safety inspections, building system tests and maintenance continued throughout the year. Staff are also required to complete working from home risk assessments and have access to support in enabling them to have the correct DSE equipment.

Trade Union Facility Time Reporting Requirements

There was no Trade Union Facility Time in 2022/23.

Expenditure on consultancy

Administrative	£431k
Programme	£856k

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2023 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2023	8
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	0
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

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

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	27
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	25
No. subject to off-payroll legislation and determined as out of scope of IR35	2
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

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 July 2022 and 31 March 2023:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	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 financial year. This figure should include both on payroll and off-payroll engagements.	20

Losses and Special Payments

In the accounting period, the total number of NHS clinical commissioning group losses and special payments cases were 2.

Exit packages, including special (non-contractual) payments

In the accounting period, the total number of NHS clinical commissioning group exit packages were 13.

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

Table 1: Exit Packages

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

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

There were no Other Departures in the year.

Parliamentary Accountability and Audit Report

Mid and South Essex 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 76. An audit certificate and report is also included in this Annual Report.

ANNUAL ACCOUNTS

I confirm that the annual accounts adhere to the reporting framework.

Anthony McKeever
Chief Executive of Mid and South Essex Integrated Care Board

26 June 2023

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

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the period ended 31 Mar 23

	Note	1-Jul-22 to 31-Mar-23 £'000
Income from sale of goods and services	2	(10,386)
Total operating income		**(10,386)**
Staff costs	4	28,205
Purchase of goods and services	5	1,842,034
Depreciation	5	505
Provision expense	5	4,043
Other operating expenditure	5	9,336
Total operating expenditure		**1,884,123**
Net operating expenditure		**1,873,737**
Finance expense / gain on disposal	7, 8	13
Comprehensive expenditure for the period		**1,873,750**

The notes on pages 7 to 27 form part of this statement

Statement of Financial Position as at 31 Mar 23

	Note	31-Mar-23 £'000	1-Jul-22 opening balances post transfer £'000
Non-current assets:			
Right-of-use assets	10	2,815	3,357
Total non-current assets		**2,815**	**3,357**
Current assets:			
Trade and other receivables	11	9,644	9,015
Cash & Cash Equivalents		0	5,381
Total current assets		**9,644**	**14,397**
Total assets		**12,459**	**17,754**
Current liabilities			
Trade and other payables	13	(166,301)	(88,342)
Lease liabilities	10	(216)	(553)
Borrowings (book overdraft)	14	(2,808)	(2,587)
Provisions	15	(5,538)	(4,420)
Total current liabilities		**(174,863)**	**(95,904)**
Total assets less total current liabilities		**(162,404)**	**(78,150)**
Non-current liabilities			
Lease liabilities	10	(2,729)	(2,827)
Provisions	15	(13,967)	(11,294)
Total non-current liabilities		**(16,696)**	**(14,121)**
Assets less liabilities		**(179,100)**	**(92,271)**
Financed by taxpayers' equity			
General fund		(179,100)	(92,271)
Total taxpayers' equity		**(179,100)**	**(92,271)**

The notes on pages 7 to 27 form part of this statement

The financial statements on pages 3 to 6 were approved by the Audit Committee on 20 Jun 2023 and signed on its behalf by:

Chief Accountable Officer
Anthony McKeever

Statement of Changes In Taxpayers Equity for the Period Ended 31 Mar 23

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

The notes on pages 7 to 27 form part of this statement

Statement of Cash Flows for the Period Ended 31 Mar 23

	Note	1-Jul-22 to 31-Mar-23 £'000
Cash flows from operating activities		
Net operating expenditure for the financial period		(1,873,750)
Depreciation	5	505
Movement due to transfer by modified absorption		(76,532)
Other gains & losses		(6)
(Increase) in trade & other receivables	11	(9,644)
Increase in trade & other payables	13	166,301
Provisions utilised	15	(254)
Increase in provisions	15	4,043
Net cash (outflow) from operating activities		**(1,789,337)**
Cash flows from investing activities		
Interest on RoU leases		19
Net cash inflow from investing activities		**19**
Net cash (outflow) before financing		**(1,789,318)**
Cash flows from financing activities		
Grant in aid funding received		1,786,921
Repayment of lease liabilities		(411)
Net cash inflow from financing activities		**1,786,510**
Net (decrease) in cash & cash equivalents	12	**(2,808)**
Cash & cash equivalents at the beginning of the financial period		**-**
Cash & cash equivalents (including bank overdrafts) at the end of the financial period		**(2,808)**

The movement due to modified absorption includes cash and cash equivalents, receivables, payables, borrowings and PUPOC liability

The notes on pages 7 to 27 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 (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 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**.**
The Health and Social Care Bill was introduced into the House of Commons on 6 July 21. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 22.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When clinical commissioning groups ceased to exist on 1 July 22, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector.
Other transfers of assets and liabilities within the Department of Health and Social Care group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint Arrangements

The ICB has not been part of any pooled budget arrangements in 2022-23. The ICB has operated Better Care Funds during 2022-23 under a Section 75 agreements with Essex County Council, Southend City Council and Thurrock Council. The arrangements under which the Better Care Funds operated in 2022-23 do not constitute a pooled budgets as the risks of each scheme have remained with the respective commissioners. See Note 18 for further information.

1.5 Operating Segments

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

Notes to the financial statements

1.6 **Revenue**

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

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

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

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

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.70 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

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

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

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

Notes to the financial statements

1.8 **Other Expenses**
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

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

1.10 **Leases**
A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.10.1 **The ICB as Lessee**
A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

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

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The Right-of-Use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the Right-of-Use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, Right-of-Use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-Use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

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

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.

Notes to the financial statements

1.11 **Cash & Cash Equivalents**

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.12 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. 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:
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

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

1.14 **Non-Clinical Risk Pooling**

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

1.15 **Financial Assets**

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

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

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

1.15.1 **Financial Assets at Amortised cost**

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

1.15.2 **Financial assets at Fair Value Through Profit and Loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Notes to the financial statements

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

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

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

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

1.2 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical Accounting Judgements in Applying Accounting Policies**
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
The ICB has operated Better Care Funds with Essex County Council, Southend City Council and Thurrock Council during 2022-23, under section 75 agreements. These arrangement 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 18 for further information.

1.20.2 **Sources of Estimation Uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a 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 2022-23 that will be payable in 2023-24.

1.21 **Adoption of New Standards**
On 1 April 2022, the NHS adopted IFRS 16 'Leases'. The new Standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Notes to the financial statements

1.22 **New and Revised IFRS Standards in Issue but Not Yet Effective**

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

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. The Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

The ICB does not anticipate any significant impact from Standards that have not yet been adopted.

2 Operating Revenue

	1-Jul-22 to 31-Mar-23 Total
	£'000
Income from sale of goods and services (contracts)	
Education, training and research	**8,309**
Non-patient care services to other bodies	**915**
Other contract income	**1,162**
Total income from sale of goods and services	**10,386**
Total operating income	**10,386**

3 Disaggregation of Income - Income From Sale of Goods and Services (Contracts)

	Education, training and research	Non-patient care services to other bodies	Other contract income
	£'000	£'000	£'000
Source of revenue			
NHS	8,251	72	25
Non NHS	58	843	1,137
Total	**8,309**	**915**	**1,162**

	Education, training and research	Non-patient care services to other bodies	Other contract income
	£'000	£'000	£'000
Timing of revenue			
Point in time	-	-	-
Over time	8,309	916	1,162
Total	**8,309**	**916**	**1,162**

4 Employee Benefits and Staff Numbers

4.1.1 Employee Benefits

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

4.2 Average Number of People Employed - Whole Time Equivalent (WTE)

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

4.3 Exit Packages Agreed in the Financial Period

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

These tables report the number and value of exit packages agreed in the financial period. The expense associated with these departures may have been recognised in part or in full in a previous period or in a future period.

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change Section 16.

Exit costs are accounted for in accordance with relevant accounting standards.

4.4 Pension 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.

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:

4.4.1 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 Mar 23, is based on valuation data as 31 Mar 22, updated to 31 Mar 23 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full Actuarial (Funding) Valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5 Operating Expenses

	1-Jul-22 to 31-Mar-23 Total £'000
Purchase of goods and services	
Services from other NHS ICBs and NHS England	5,295
Services from NHS Foundation Trusts	1,046,688
Services from other NHS Trusts	96,974
Services from other WGA bodies	762
Purchase of healthcare from non-NHS bodies	352,257
Purchase of social care	87
Prescribing costs	158,178
General ophthalmic services	3
GPMS/APMS and PCTMS	148,446
Supplies and services – clinical	52
Supplies and services – general	19,736
Consultancy services	1,287
Establishment	3,725
Transport	323
Premises	4,662
Audit fees	263
Other non statutory audit expenditure	
· Other services	33
Other professional fees	2,294
Legal fees	360
Education, training and conferences	610
Total purchase of goods and services	**1,842,034**
Depreciation charges	
Depreciation	505
Total depreciation charges	**505**
Provision expense	
Provisions	4,043
Total provision expense	**4,043**
Other operating expenditure	
Chair and non-executive members	110
Grants to other bodies	9,112
Other expenditure	114
Total other operating expenditure	**9,336**
Total operating expenditure	**1,855,919**

6 Better Payment Practice Code

Measure of compliance	1-Jul-22 to 31-Mar-23 Number	1-Jul-22 to 31-Mar-23 £'000
Non-NHS payables		
Total Non-NHS trade invoices paid in the period	42,108	523,153
Total Non-NHS trade Invoices paid within target	40,563	495,465
Percentage of Non-NHS trade invoices paid within target	**96.33%**	**94.71%**
NHS payables		
Total NHS trade invoices paid in the period	983	1,165,895
Total NHS trade invoices paid within target	929	1,161,666
Percentage of NHS trade invoices paid within target	**94.51%**	**99.64%**

7 Other Gains and Losses

	1-Jul-22 to 31-Mar-23 £'000
(Gain) on disposal of Right-of-Use assets other than by sale	(6)
Total	**(6)**

8 Finance Costs

	1-Jul-22 to 31-Mar-23 £'000
Interest	
Interest on Right-of-Use lease liabilities	19
Total interest	**19**
Total finance costs	**19**

9 Net Gain/(Loss) on Transfer by Absorption

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

		01-Jul-22	
	Total	**NHS England parent entities**	**NHS England group entities (non parent)**
	£'000	**£'000**	**£'000**
Transfer of Right-of-Use assets	**3,357**	-	3,357
Transfer of cash and cash equivalents	**5,381**	-	5,381
Transfer of receivables	**9,015**	-	9,015
Transfer of payables	**(88,148)**	-	(88,148)
Transfer of provisions	**(15,696)**	-	(15,696)
Transfer of Right-of-Use liabilities	**(3,380)**	-	(3,380)
Transfer of borrowings	**(2,588)**	-	(2,588)
Transfer of PUPOC provision	**(19)**	(19)	-
Transfer of PUPOC liability	**(193)**	(193)	-
Net loss on transfers by absorption	**(92,271)**	**(212)**	**(92,059)**

Transfer of Provisions and Right-of-use assets and liablities are exluded from the statement of cash flows movement due to transfer by modified absorption

10 Leases

10.1 Right-of-Use Assets

1-Jul-22 to 31-Mar-23	Buildings excluding dwellings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 1-Jul-22	-	-	-
Transfer from other public sector body	3,499	**3,499**	3,141
Additions	76	**76**	0
Derecognition for early terminations	(123)	**(123)**	0
Cost/valuation at 31-Mar-23	**3,452**	**3,452**	**3,141**
Depreciation 01-Jul-22	-	-	-
Transfer from other public sector body	142	**142**	123
Charged during the period	505	**505**	439
Derecognition for early terminations	(10)	**(10)**	0
Depreciation at 31-Mar-23	**637**	**637**	**562**
Net book value at 31-Mar-23	**2,815**	**2,815**	**2,579**
Net book value by counterparty			
Leased from other group bodies - NHS Property Services			2,579
Net book value at 31-Mar-23			**2,579**

10.2 Lease Liabilities

	1-Jul-22 to 31-Mar-23 £'000
Lease liabilities at 01-Jul-22	-
Transfer from other public sector body	(3,380)
Derecognition for early terminations	119
Reclassifications	(76)
Repayment of lease liabilities (including interest)	(19)
Lease remeasurement	411
Other - accrued invoices	-
Lease liabilities at 31-Mar-23	**(2,945)**

10 Leases continued

10.3 Lease Liabilities - Maturity Analysis of Undiscounted Future Lease Payments

	1-Jul-22 to 31-Mar-23 £'000	Of which: leased from DHSC group bodies £000
Within one year	(468)	(382)
Between one and five years	(1,675)	(1,522)
After five years	(899)	(899)
Balance at 31-Mar-23	**(3,042)**	**(2,803)**
Balance by counterparty		
Leased from other group bodies		(2,803)
Balance as at 31-Mar-23		**(2,803)**
Effect of discounting	97	
Included in:		
Current lease liabilities	(216)	
Non-current lease liabilities	(2,729)	
Total	**(2,945)**	

10.4 Amounts Recognised in Statement of Comprehensive Net Expenditure

	1-Jul-22 to 31-Mar-23 £'000
Depreciation expense on Right-of-Use assets	505
Interest expense on lease liabilities	19
Expense relating to short-term leases	5

10.5 Amounts Recognised in Statement of Cash Flows

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

10.6 Narrative

Phoenix Court, Basildon

The leasing activities falling under IFRS 16 relate to the administration premises at Phoenix Court, Basildon and associated car
There are also the below charges relating to this lease, which are excluded from the calculation of the liability and asset.
- Rent Management Fees
- Rates
- Service Charge
- Facilities Management

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

Thurrock Borough Council Civic Offices

The leasing activities falling under IFRS 16 relate to the administration premises at the Thurrock Borough Council Civic Offices for the ICB.
There are also the below charges relating to this lease, which are excluded from the calculation of the liability and asset.
- Service Charge
- Landlord's costs
- Utilities

The ICB holds the lease directly with Thurrock Borough Council.

Fair Havens Hospice

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

The lease for Fair Havens includes access to office space and associated working facilities. common areas, access routes, toilet facilities and car parking. The ICB holds the lease directly with Fair Havens Hospice.

Southend Civic Centre

The leasing activities falling under IFRS 16 related to the administration premises at Southend Civic Centre.

The lease for Southend Civic Centre included access to common areas, access routes and car parking. The ICB held the lease directly with Southend City Council.

The lease was derecognised for early termination, following agreement with the council to end the lease early.

St.Edmund's Community Hall

The leasing activities falling under IFRS 16 related to car parking facilities at St.Edmund's Community Hall.
Ther ICB receives an annual charging schedule from NHS Property Services in relation to the costs.

Wren House

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

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

11 Trade and Other Receivables

	31-Mar-23	1-Jul-22 opening balances post transfer
	£'000	£'000
NHS receivables: revenue	5,712	1,410
NHS accrued income	122	30
Non-NHS and other WGA receivables: revenue	1,174	2,550
Non-NHS and other WGA prepayments	2,255	480
Non-NHS and other WGA accrued income	47	3,415
VAT	333	1,130
Other receivables and accruals	1	-
Total trade & other receivables	**9,644**	**9,015**

11.1 Receivables Past Their Due Date but Not Impaired

	31-Mar-23	31-Mar-23
	DHSC group bodies	**Non DHSC group bodies**
	£'000	**£'000**
By up to three months	(12)	31
By three to six months	-	2
By more than six months	63	10
Total	**51**	**43**

12 Cash and Cash Equivalents

	1-Jul-22 to 31-Mar-23 £'000
Balance at 01-Jul-22	-
Transfer from other public bodies under absorption	2,793
Net change in period	(5,601)
Balance at 31-Mar-23	**(2,808)**
Made up of:	
Cash with the Government Banking Service	(2,808)
Total bank overdrafts	**(2,808)**

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

13 Trade and Other Payables

	31-Mar-23 £'000	1-Jul-22 opening balances post transfer £'000
NHS payables: revenue	5,161	1,364
NHS accruals	13,853	7,020
Non-NHS and other WGA payables: revenue	52,282	14,498
Non-NHS and other WGA accruals	81,955	61,423
Non-NHS and Other WGA deferred income	271	83
Social Security costs	374	382
Tax	353	311
Payments received on account	12	-
Other payables and accruals	12,040	3,263
Total trade & other payables	**166,301**	**88,342**

Other payables include £1,720k outstanding pension contributions at 31 Mar 23

14 Borrowings

	31-Mar-23 £'000	1-Jul-22 opening balances post transfer £'000
Bank overdrafts:		
· Government Banking Service (book overdraft)	2,808	2,588
Total borrowings	**2,808**	**2,588**

14.1 Repayment of principal falling due

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

15 Provisions

	Current 31-Mar-23 £'000	Non-current 31-Mar-23 £'000
Restructuring	4,084	-
Legal claims	2	-
Continuing health care	1,057	13,021
Other	395	946
Total	**5,538**	**13,967**
Total current and non-current		**19,505**

	Restructuring £'000	Legal claims £'000	Continuing health care £'000	Other £'000	Total £'000
Balance at 1-Jul-22	**-**	**-**	**-**	**-**	**-**
Transfer from other public sector body under absorption	2,886	4	12,227	599	**15,716**
Arising during the period	2,482	-	2,034	1,058	**5,574**
Utilised during the period	(15)	(2)	(183)	(54)	**(254)**
Reversed unused	(1,269)	-	-	(262)	**(1,531)**
Balance at 31-Mar-23	**4,084**	**2**	**14,078**	**1,341**	**19,505**
Expected timing of cash flows:					
Within one year	4,084	2	1,057	395	**5,538**
Between one and five years	-	-	13,021	946	**13,967**
After five years	-	-	-	-	**-**
Balance at 31-Mar-23	**4,084**	**2**	**14,078**	**1,341**	**19,505**

Restructuring provisions

A restructuring provision has been made as the ICB have a requirement to reduce costs by 20%. Engagement on the restructure began during March 23. With the information available the ICB has estimated potential one-off costs which could come to bear, throughout 2023-24 as a result of decisions made during 2022-23. These costs are associated with displacement of staff, retraining or redeployment on the basis of the new organisational form.

Legal claims provision

A provision has been made for legal proceedings against an individual for the non-payment of debt.

Continuing health care provisions

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

An additional provision is included to cover the cost of reimbursing residents for CHC amenity top ups back to 2012 as per the national CHC guidance. The provision was calculated based on a year's packages extrapolated back to 2012 and reduce to during Q1 2022-23 following furthur investigation.

Other provisions

A provision has been created for dilapidation of rented buildings, estimated at 7.5% per year of occupation and for returning Brentwood Community Health to its original condition following the end of temporary arrangement to use the space for clinical purposes during covid.

A provision has been created following the Manchester ruling to cover the impact on providers that will require additional funding following this ruling. The Manchester ruling has found that healthcare assistants (HCAs) in hospitals across Manchester have been performing clinical duties that are above their pay grade.

16 Financial Instruments

16.1 Financial Risk Management

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

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

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

16.1.1 Currency Risk

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

16.1.2 Interest Rate Risk

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

16.1.3 Credit Risk

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

16.1.4 Liquidity Risk

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

16.1.5 Financial Instruments

As the cash requirements of NHS England 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 England's expected purchase and usage requirements and NHS England 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-23 £'000	Total 31-Mar-23 £'000
Trade and other receivables with NHSE bodies	5,810	**5,810**
Trade and other receivables with other DHSC group bodies	295	**295**
Trade and other receivables with external bodies	951	**951**
Cash and cash equivalents	0	**0**
Total at 31-Mar-23	**7,056**	**7,056**

16.3 Financial Liabilities

	Financial liabilities measured at amortised cost 31-Mar-23 £'000	Total 31-Mar-23 £'000
Loans with external bodies	2,808	**2,808**
Trade and other payables with NHSE bodies	2,906	**2,906**
Trade and other payables with other DHSC group bodies	18,862	**18,862**
Trade and other payables with external bodies	146,468	**146,468**
Total at 31-Mar-23	**171,044**	**171,044**

17 Operating Segments

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

18 Joint Arrangements - Interests in Joint Operations

Better Care Funds

Essex County Council

The ICB has operated a Better Care Fund of £48,547k from 1 Jul 22 to 31 Mar 23), 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 £12.842k during 2022-23 (1 Jul 22 to 31 Mar 23), together with Thurrock

The lead commissioner for the Better Care Fund (BCF) in 2022-23 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 £11,071k during 2022-23 (1 Jul 22 to 31 Mar 23), together with Southend City Council under a section 75 agreement. This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. This conclusion has been reached as both parties have retained the financial risks associated with each of the schemes as existed before the fund was set up. The arrangements for each scheme within the Better Care Fund have been reviewed to determine the appropriate accounting treatment by the ICB and Southend City Council. Control of the commissioning arrangements has been key to determining the nature of each scheme within the fund.

Transforming Care Partnership

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

19 Related Party Transactions

Details of related party transactions with individuals are as follows:

Part one - Transactions with board members and those with significant influence over the CCG

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 2022-23

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	Hannah Coffey, Partner Member, Mid and South Essex NHS FT Ronan Fenton, Partner Member, Essex County Council Dawn Scrafield, Interim Director of Resources	799,337	-	12,063	0
Essex Partnership University NHS FT	Paul Scott, Partner Member, Essex Partnership University NHS FT	159,919	-	3,310	9
Essex County Council	Peter Fairley, Partner Member, Essex County Council	55,582	706	4,809	211
North East London Foundation Trust	Joseph Fielder, Non-Executive Member	31,370	-	44	-
Barking, Havering & Redbridge University Hosptals NHS Trust	George Wood, Non-Executive Member	24,003	-	-	-
Thurrock Council	Les Billingham, Partner Member, Thurrock Council Ian Wake, Partner Member, Thurrock Council	15,805	108	467	28
Southend City Council	Tandra Forster, Partner Member, Southend City Council Mark Harvey, Partner Member, Southend City Council Benedict Leigh , Partner Member, Southend City Council	8,064	-	1,359	-
Springfield Hospital/Ramsay Healthcare	Peter Fairley, Partner Member, Essex County Council	18,532	-	1,771	-
UCL Partners Limited - Board Member	Anthony McKeever, Chief Executive Officer	6,353	-	-	-
Princess Alexandra Hospital	George Wood, Non-Executive Member	1,541	-	-	-
Colne Valley Primary Care Network	Anna Davey, Primary Care Services Partner Member	608	-	-	-
Essex Cares	Peter Fairley, Partner Member, Essex County Council	224	-	15	-
Suffolk & North East Essex ICB	Frances Bolger, Interim Chief Nursing Officer	77	97	926	195
NHS England and Improvement	Joseph Fielder, Non-Executive Member Rachel Hearn, Chief Nursing Officer	56	-	114	5,532
Barnet Enfield & Haringey Mental Health Trust	Dawn Scrafield, Interim Director of Resources	11	-	-	-
HFMA	Dawn Scrafield, Interim Director of Resources	5	-	2	-
Faculty of Medical Leadership & Management	Anthony McKeever, Chief Executive Officer	3	-	3	-

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

Coggeshall Surgery	Anna Davey, Primary Care Services Partner Member	1,510	-	-	-

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

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

Barking, Havering and Redbridge 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
Hertfordshire Partnership University NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
North East London NHS Foundation Trust
NHS Business Services Authority
NHS England
NHS Property Services

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

Part Five - Department of Health and Social Care

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group. We have reviewed the list of individuals and entities and the ICB does not have any material disclosable transaction with any of the entities.

Part Five - Department of Health and Social Care

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group. We have reviewed the list of individuals and entities and the ICB does not have any material disclosable transaction with any of the entities.

20 Events After the End of the Reporting Period

There are no events after the end of the reporting period which will have a material effect on the financial statements of the ICB.

21 Special Payments

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

22 Financial Performance Targets

ICBs have a number of financial duties under the NHS Act 2006 (as amended).

The ICBs performance against those duties was as follows:

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

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Mid & South Essex Integrated Care Board ("the ICB") for the nine month period ended 31 March 2023 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 state of the ICB's affairs as at 31 March 2023 and of its income and expenditure for the nine month period 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 26 April 2023 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; 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 also identified a fraud risk relating to the liabilities and related expenses for purchases not being completely identified and recorded in response to the requirement for the ICB to meet their revenue resource limit creating an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred and the opportunity to manipulate the period-end balance sheet expenditure items such as accruals in order to achieve this.

We also 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 Revenue and Expenditure.
- Evaluating the business purpose of significant unusual transactions.
- Inspected a sample of invoices or expenditure, in the two months after period end, to determine whether expenditure has been recognised in the correct accounting period

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 regulated 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 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 these 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 period is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 47 the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the

preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

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.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 47, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body

incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Mid & South Essex Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Mid & South Essex ICB for the nine-month period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Emma Larcombe
for and on behalf of KPMG LLP
Chartered Accountants
Dragonfly House
2 Gilders Way
Norwich
NR3 1UB

29 June 2023