Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Mid and South Essex Integrated Care Board

Annual Report:

April 2025 – March 2026

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Chair’s Foreword

Writing this foreword to the Annual Report for 2025–2026 feels, in several respects, like marking the close of a chapter. This is the final report of NHS Mid and South Essex, as a standalone Integrated Care Board, before the transition into the planned Essex-wide ICB from April 2026. Moments of institutional change invite reflection not only on what has been achieved, but on what remains unfinished.

Over the past year, the contribution of the ICB is best understood through the practical changes it has supported across the system, particularly in relation to the three shifts now shaping NHS policy.

In moving from analogue to digital, continued progress on the Shared Care Record and wider digital infrastructure has improved the availability and consistency of information across organisational boundaries. Alongside this, the development of system-wide analytics through platforms such as Athena has begun to provide a more coherent basis for clinical and operational decision-making. These are not, perhaps, developments that are immediately visible to patients, but they are foundational to a more integrated and effective service.

In shifting care from hospital to community settings, there have been a number of more tangible developments. The Unplanned Care Coordination Hub has supported more appropriate triage and reduced avoidable hospital attendance. The continued expansion of Integrated Neighbourhood Teams, with a particular focus on frailty and end-of-life care, has begun to demonstrate measurable improvements in outcomes, including reductions in admissions and re-admissions. Work to develop community-based diagnostic provision, including eye care pathways, reflects a similar intention: to provide timely care closer to home and reduce reliance on acute settings.

In strengthening primary and preventative care, the high uptake of Additional Roles Reimbursement Scheme (ARRS) roles has broadened the skill mix within general practice, supporting improved access and more proactive management of patients. This sits alongside wider work on population health and inequalities, including improvements in data quality and targeted prevention programmes across the system.

It would, however, be misleading to suggest that such progress resolves the challenges we face. Demand continues to outpace capacity in several parts of the system, workforce pressures remain evident and performance in areas such as cancer and elective care requires sustained attention. The requirement to significantly reduce ICB running costs reinforces the need for clarity about the organisation’s role as a strategic commissioner and for disciplined prioritisation in how resources are used.

Looking ahead, a particular and immediate challenge will be the creation of a single Essex ICB from three existing organisations. This is not simply a matter of structural alignment. It involves bringing together different organisational cultures, ways of working and professional identities, while maintaining delivery and supporting staff through a period of uncertainty. Doing so effectively will be as important as any formal governance change.

As Chair, I remain struck by the professionalism and steady commitment of colleagues across the system. The progress described here has been achieved incrementally, often under pressure, and should not be underestimated.

The year ahead will demand continued realism, careful judgement and a willingness to make difficult choices. Yet the foundations established through Mid and South Essex, particularly the strength of partnership working, provide a sound basis for what comes next.

My thanks go to staff, partners and our communities who continue to contribute to this work.

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

18 June 2026

PERFORMANCE REPORT

Introduction with Tom Abell

This has been a significant year for NHS Mid and South Essex: a year of pressure, progress and change, and my first full year as Chief Executive.

It has been a year that has tested our system. Demand has remained high, workforce pressures have continued, and services are still living with the effects of disruption from recent years. Across urgent and emergency care, elective care and community services, the pressure has been constant. At the same time, we have been asked to improve performance, transform care and live within tight financial constraints. That is a demanding combination, and it has required difficult choices.

What has stood out to me most over the past year is the determination of people across our system. In every part of Mid and South Essex, colleagues in the NHS, local government and the voluntary sector have kept going, kept working together and kept their focus on the people we serve. That commitment has made a real difference, and I am grateful for it.

We should be honest: there is still too much variation in people's experience of care, and too many residents still face delays, frustration or difficulty accessing the support they need. But we should also be clear that progress has been made.

Over the past year, we have strengthened the coordination of urgent care, continued to build integrated neighbourhood teams and made better use of data and insight to support earlier, more joined-up action. We have taken further steps to improve access to primary care, widen digital inclusion and support more care closer to home. We have also continued to strengthen our focus on population health, so that we are better able to identify need early, target support and tackle inequalities in a more systematic way.

These changes matter because they are about making care work better for local people. In the end, the public will judge us not by how well we describe our plans, but by whether services are easier to access, whether care feels more joined up, and whether outcomes improve. That is the test that matters.

Alongside this, financial discipline has remained essential. Delivering a breakeven position while supporting recovery across the system has required strong grip, partnership and clear prioritisation. Looking ahead, the requirement to reduce ICB running costs significantly will bring further challenge. We will need to meet that challenge in a way that strengthens our role as a strategic commissioner, keeps our focus on improving outcomes and protects the core capabilities we need to lead well on behalf of our population.

The transition to an Essex-wide ICB marks the beginning of a new chapter. It will bring uncertainty, as change always does, but it also creates an opportunity to build a stronger, clearer and more consistent approach across a larger population. If we get this right, we can combine stronger strategic commissioning with strong local partnerships and a continued focus on the needs of our communities.

I want to thank all those who have contributed to the progress set out in this report. Nothing in this year has been easy, and none of it has been achieved by accident. It

reflects the professionalism, resilience and shared purpose of people across our system.

As we move forward, our priorities are straightforward: improving access, improving outcomes, reducing inequalities, strengthening integration and securing long-term financial sustainability. NHS Mid and South Essex has helped lay important foundations for that next phase, and those foundations will continue to shape the future of health and care across Essex.

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

18 June 2026

Performance Overview

What we do

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

Following several years of locally led development, recommendations from NHS England (NHSE) and the passage of the Health and Care Act (2022), forty-two ICSs were established across England on a statutory basis on 1 July 2022. This will change from 1 April 2026 where ICSs have been re-organised to 36, to be further refined in April 2027. On 1 April 2026, the Essex Integrated Care Board will be created whereby the mid and south Essex, north east Essex and west Essex areas will come together as NHS Essex. The ICS is made up of two main Boards/committees:

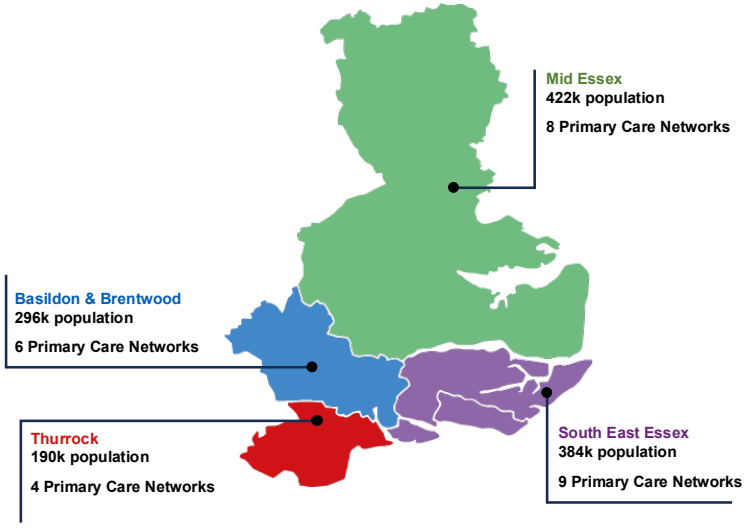
Integrated Care Board (ICB*):* A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the ICS area.

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

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

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

What is the Mid and South Essex Integrated Care Partnership?



Neighbourhoods*:* The areas covered by our 27 Primary Care Networks (PCNs), and 24 local integrated neighbourhood teams (INTs).

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

System: The whole of MSE.

Our partnership includes:

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

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

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

Three main community and mental health service providers: Essex Partnership University NHS Foundation Trust (EPUT) delivers community and mental health services; North East London NHS Foundation Trust (NELFT) delivers community and the Child and Adolescents Mental Health Service (CAMHS); Provide Community Interest Company (CIC) delivers community services. These three providers work together in the delivery of community services (physical health) as the *Mid and South Essex Community Collaborative.*

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

Primary care: 27 Primary Care Networks (PCNs) covering 144 GP Practices. 196 Community Pharmacies (as of March 2025). 107 Mandatory Service Providers of Optometric Services. 117 Primary Dental Providers and 15 Orthodontic Providers.

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

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

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

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

Commitment from ICS partners made during the ICP strategy design process

Our Vision and Journey

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

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

The ICB published its first Joint Forward Plan (JFP) for 2023-2029 in June 2023, refreshed in April 2024 and again in April 2025. The JFP outlined a set of shared ambitions for the system, drawing on priorities from within the NHS as well as our local government partners as set out in joint local health and wellbeing strategies. The JFP provides a five-year framework for how we want to deliver and improve services for people living in MSE, which will be reviewed each year in line with NHSE guidance. The full JFP is published on the ICB website, alongside the updated 2024-2029 version. Joint Forward Plan - Mid and South Essex Integrated Care System (ics.nhs.uk) [hyperlinks]. The April 2025 refreshed plan (Section 2) provides the detailed assessment of the extent to which the ICB has exercised its functions in accordance with the plan and highlights the work that has been delivered as a result, which is also reflected throughout this annual report.

Within the 2023-29 JFP (April 2025 refresh), the ICB, including its partner NHS organisations, committed to a set of strategic ambitions that have guided the system's work. These ambitions are:

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

Throughout 2025/26 the ICB and its partners have continued its efforts to recover the system in terms of quality, performance and financial sustainability as outlined within both the JFP and the Medium-Term Plan. The ICB has also worked with partners to produce its first Population Health Improvement Plan, in preparation for the establishment of Essex ICB, which will describe our future strategic ambitions and delivery priorities, building on previous Joint Forward Plans and Medium-Term Plan strategic objectives. Further guidance on the NHS England Medium-Term Planning framework 2026/29 can be found here: NHS England » Medium term planning.

MSE ICS developed a Joint Capital Resource Plan, formally published as a standalone plan in 2024/25 and subsequently updated through the ICB Finance Plan submitted to the ICB Board in May 2025. This set out the system's planned capital expenditure for the year ahead, including associated risks and mitigations.

Following resubmission to NHS England on 30 April 2025, the ICB and its system partners agreed an opening capital plan of £164.4m. This comprised £67.6m of operational capital across the three partner organisations and £96.8m of externally financed schemes, including national programme funding for critical infrastructure, estates safety, and constitutional standards.

Delivery against the plan was overseen through the Mid and South Essex System Investment Group and the ICB Finance and Performance Committee. During the year, the plan evolved in response to the non-progression of some externally financed schemes, receipt of additional national allocations, and the reprioritisation of operational capital.

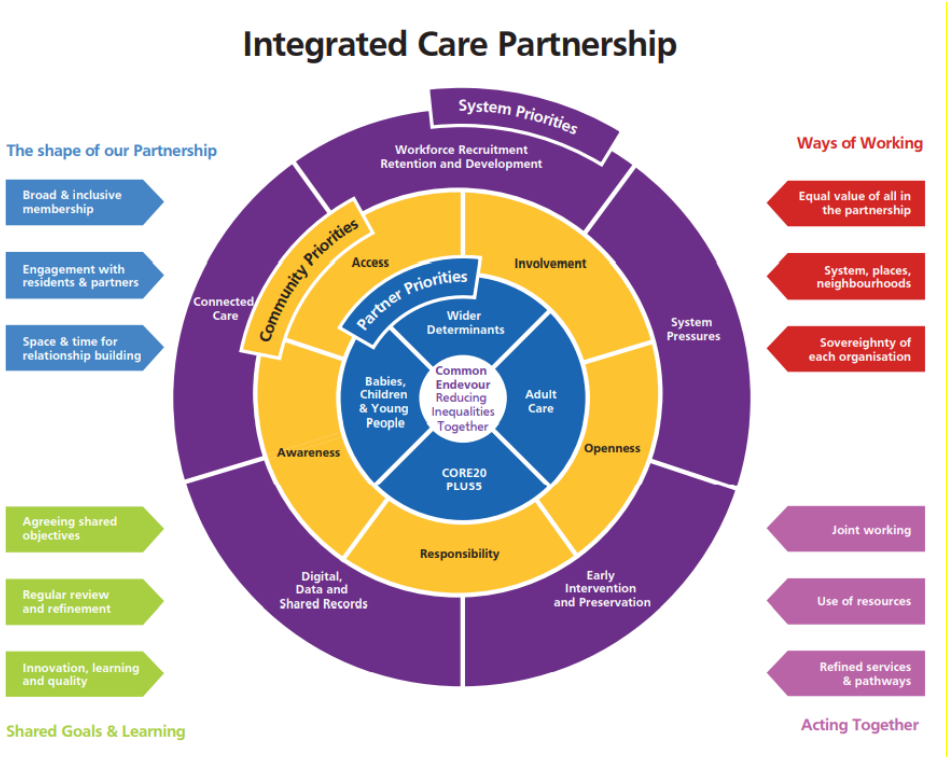
Final capital expenditure across the system totalled £166.4m. This included the following substantial items:

- £51.8m on provider 'business as usual' requirements, compared with a planned £50.4m, funded through a combination of operational capital and externally financed schemes
- £21.0m on the Electronic Patient Record programme, against a plan of £18.8m

- £20.9m on critical infrastructure, estates enhancements, and the Estates Safety Fund, against a plan of £18.6m
- £21.8m on constitutional standards, compared with an opening plan of £38.8m
- £14.0m on sustainability investments, against an opening plan of £4.8m.

Our Common Endeavour

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



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

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

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

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

CORPORATE OBJECTIVES

Considering our strategic ambitions and the strategies and planning documents referred to above, the ICB set corporate objectives for 2025/26 as:

- Through strict budget management and good decision making, the ICB plans and purchases sustainable services for its population and manages any associated risks of doing so within the financial position agreed with NHS England.

- Being assured that the healthcare services we strategically commission for our diverse populations are safe and effective, using robust data and insight, and by holding ourselves and partners accountable.

- Achieve the objectives of year one of the ICB Medium Term (5 year) Plan to improve access to services and patient outcomes, by effectively working with partners as defined by the constitutional standards and operational planning guidance.

- To strengthen our role as a strategic commissioner and system leader by using data and clinical insight to make decisions that improve patient outcomes, reduce health inequalities, and deliver joined-up care through meaningful collaboration with partners and communities.

- Through compassionate and inclusive leadership, consistent engagement and following principles of good governance, deliver the organisational changes required, whilst ensuring staff are supported through the change process and maintaining business as usual services.

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

Performance Analysis

Introduction

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

During 2025/26, system performance was delivered within a challenging operating context characterised by sustained demand, workforce pressures and financial constraints. In addition, the transition to a new Essex-wide ICB and the requirement to significantly reduce running costs created organisational pressure which, while not directly impacting frontline service delivery, had the potential to affect the pace and consistency of system improvement.

These transition-related risks influenced the environment in which commissioning, oversight and transformation activity were undertaken. In particular, they required careful prioritisation of resources, management of organisational change and continued focus on maintaining delivery alongside structural transition.

As a result, while progress has been made across a number of areas, performance in key pathways—including urgent and emergency care, elective recovery and cancer—remained under pressure and requires sustained system-wide action.

During 2025/26 the ICB, with partners, focused on recovery of performance. The section below outlines the 2025/26 achievement and delivery for MSE and incorporates case studies to demonstrate how the ICB has worked to improve performance and patient care.

Constitutional Standards

Urgent and Emergency Care (UEC)

Unscheduled Care Coordination Hub Activity Overview

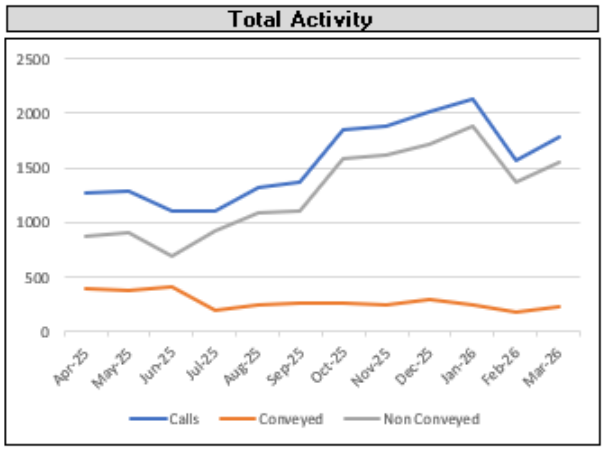
Throughout the reporting year, the Unscheduled Care Coordination Hub (UCCH) has demonstrated sustained and significant growth in monthly call volume, reflecting the continued development of the service and the expansion of its multidisciplinary workforce and skill set. As the team has strengthened, the Hub has been able to support an increasing number of patients, ensuring that individuals are directed to the most appropriate urgent care pathway for their needs rather than defaulting to the Emergency Department.

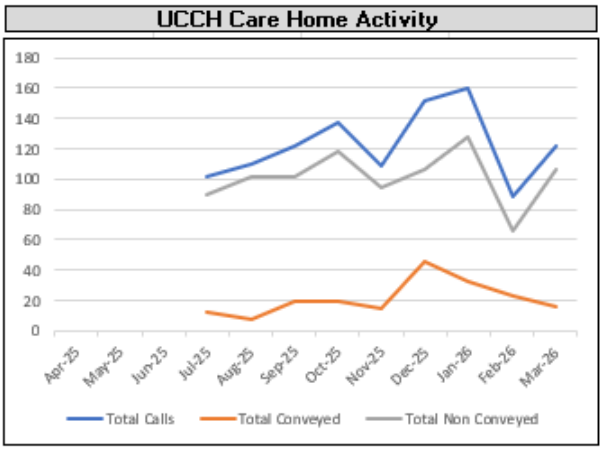
This enhanced clinical assessment and coordination capability has made a measurable impact on system flow. The UCCH's average conveyance rate for the year stands at 18%, marking a positive reduction compared with the previous year of 40%. This improvement evidences the Hub's effectiveness in safely reducing avoidable conveyances, preserving emergency department capacity for those with the greatest

clinical need, and ensuring patients access the right care in the right place at the right time.

In the second half of the year, the service has also placed an increased focus on supporting care homes, providing targeted clinical advice and rapid coordination of alternative pathways. This has strengthened relationships with care home teams, reduced unnecessary emergency conveyances, and enhanced the ability to manage residents safely within their familiar environment.

Overall, the UCCH continues to evolve into a critical component of the urgent and emergency care system, delivering high-quality clinical decision-making, improving patient experience, and contributing to system resilience across the region.





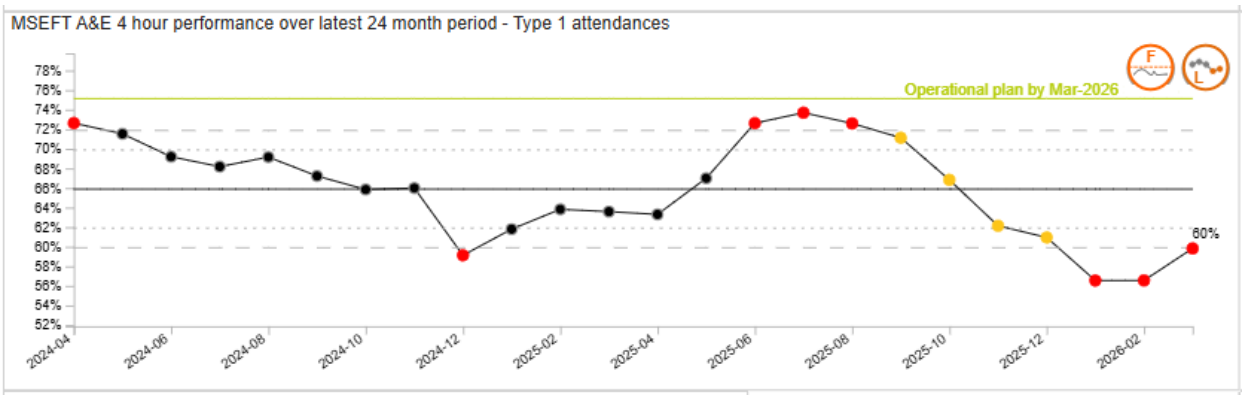
Integrated Care Transfer Hub: During November 2024 MSE ICS established a system-wide discharge cell with tactical / strategic overview of commissioned beds (acute, intermediate, stroke rehab, hospice, mental health and virtual wards). Since inception the Discharge Cell has seen a 30% reduction in hospital discharge delays. During December 2025 the hub has been expanded to include a Mental Health Flow Co-Ordinator to support mental health patients to receive care within the most appropriate setting.

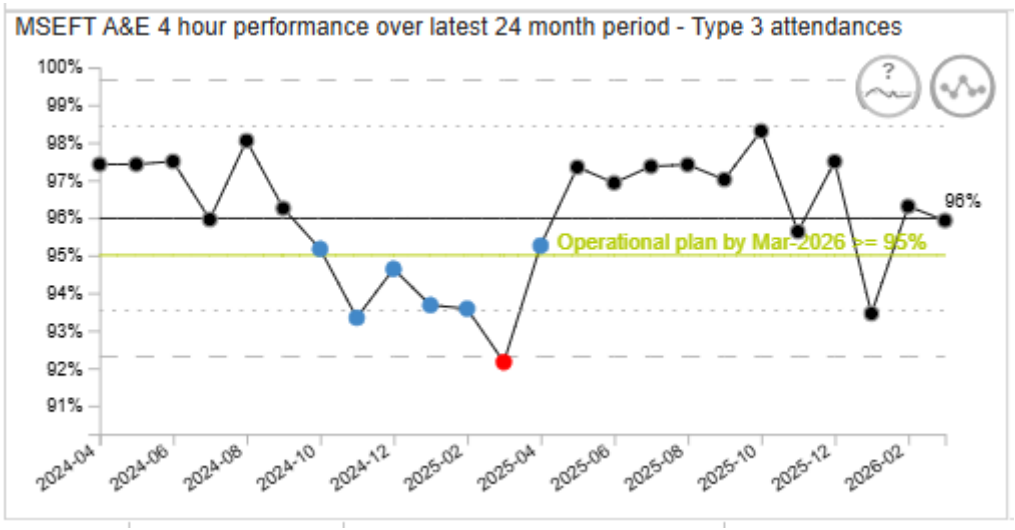
<u>UEC performance – ambulance handovers / 4 & 12 hour access targets</u>

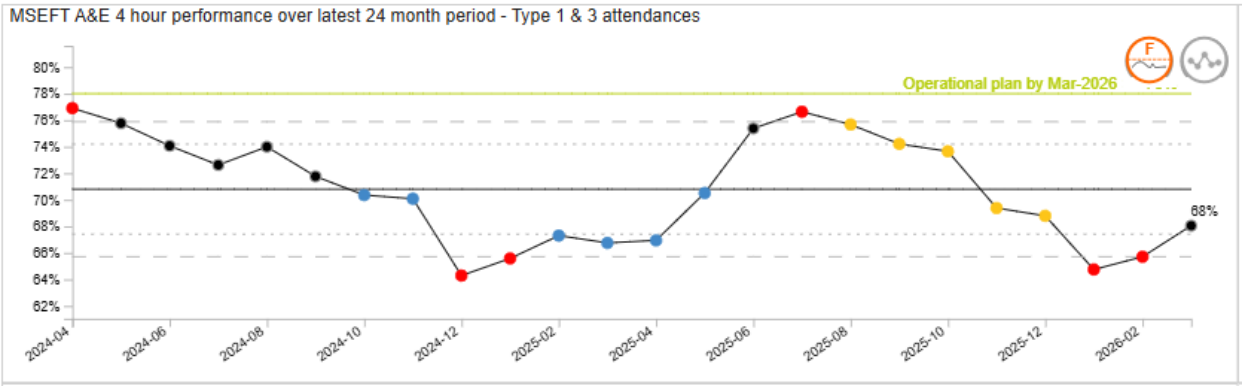
A&E four-hour performance over the last 24 months reflects the sustained operational pressures experienced across urgent and emergency care services. Performance for Type 1 attendances declined through 2024, reaching a lower point during winter 2024/25. A period of improvement followed in early 2025, supported by targeted recovery actions, with performance peaking during summer 2025 broadly in line with the operational plan trajectory. However, performance deteriorated again from late summer onward, concluding the period below plan, underscoring the impact of seasonal demand and ongoing patient flow constraints.

Four-hour performance for Type 3 attendances has remained comparatively stronger across the reporting period. Following a reduction in performance during mid-2024, sustained improvement was achieved, with performance exceeding the operational plan trajectory for much of 2025/26. This reflects the positive impact of focused interventions and the effective utilisation of alternative care pathways.

When Type 1 and Type 3 attendances are considered collectively, performance declined during 2024 before improving steadily through early and mid-2025, followed by a subsequent deterioration during the latter part of the year, particularly over the winter period. While the improvements achieved indicate that recovery is attainable, the pattern observed over time highlights the need for sustained, system-wide action to strengthen patient flow, support timely discharge, and enhance resilience.

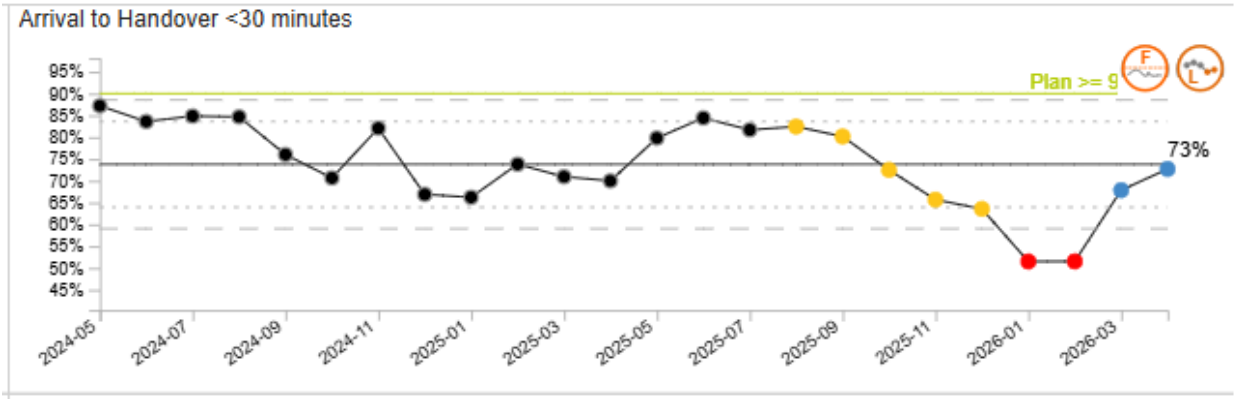


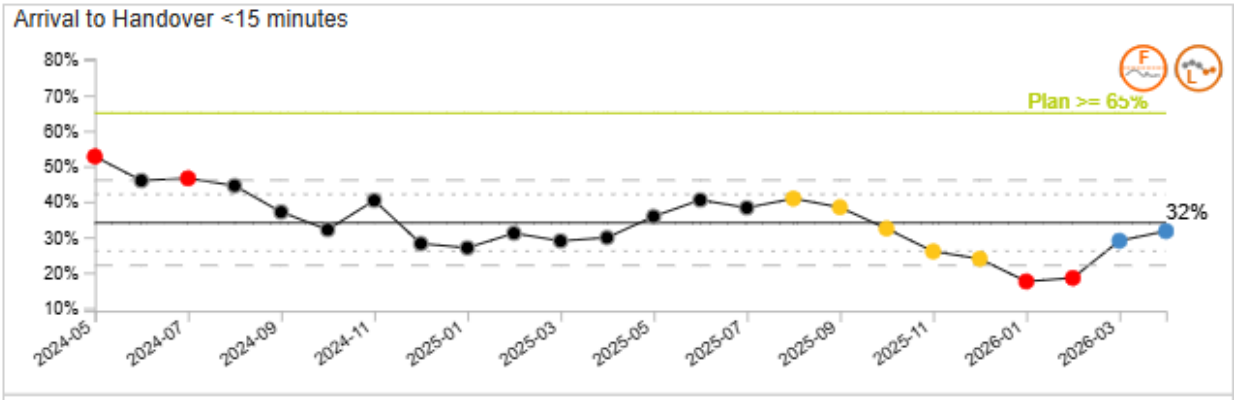




Ambulance arrival-to-handover performance within 30 minutes has shown a deteriorating trend, reflecting pressure across urgent and emergency care pathways. Performance improved during mid-2025, with delivery closer to the ≥85% plan threshold. However, from late summer 2025, performance declined significantly, falling below plan and reaching 52% at the end of the period. This sustained reduction highlights the impact of constrained flow through the emergency department and patient flow pressures affecting the timely handover of patients from ambulance services.

Arrival-to-handover performance within 15 minutes has remained materially below the ≥60% plan threshold throughout the period shown. Performance stabilised at relatively low levels during mid-2025 before deteriorating further from late summer onwards, reaching 18% at the end of the period. Continued under-delivery against this standard indicates ongoing challenges in achieving rapid handover and reflects the cumulative effect of emergency department crowding and patient flow constraints.



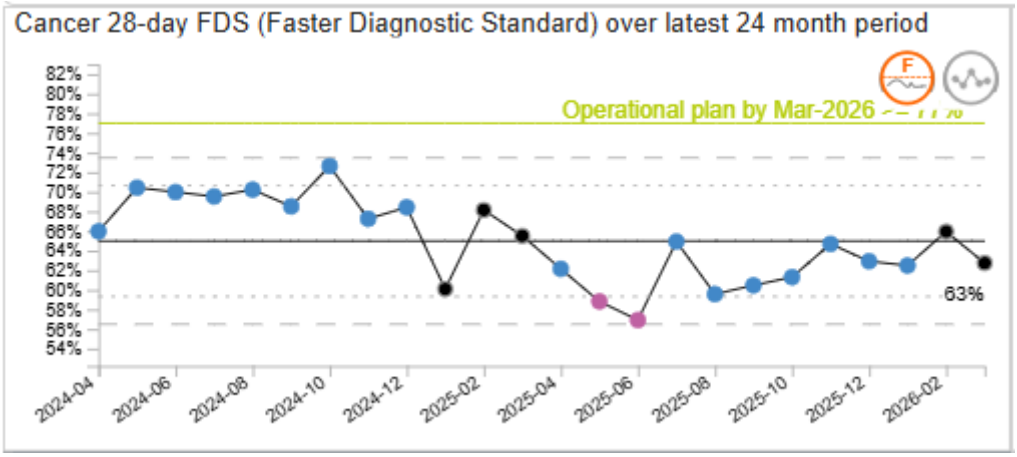


Cancer Care

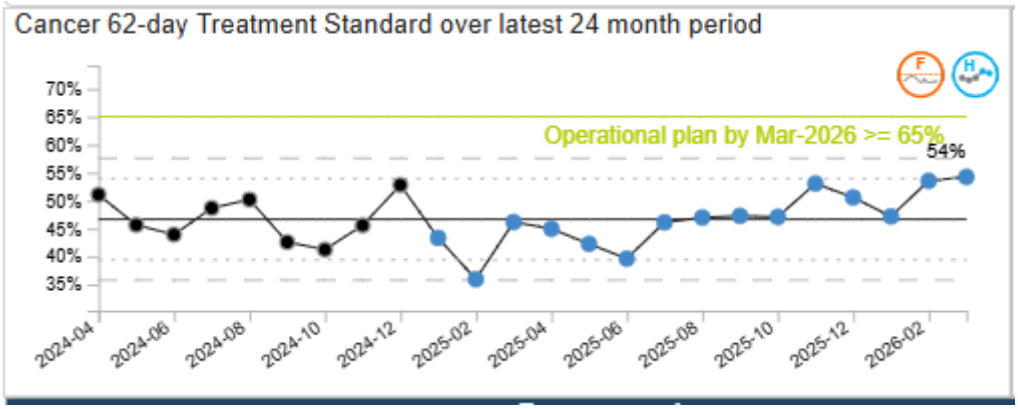
Performance against the cancer Faster Diagnostic Standard (28-day) has remained below the operational plan target, with delivery showing variation over the period. Following relatively stable performance during earlier months, a decline was evident through late 2024 and early 2025, reaching a lower level in mid-2025.

More recent months have seen partial recovery, with performance stabilising at approximately 62% at the end of the period, although this remains below the trajectory set for March 2026. Performance against the cancer 62-day treatment standard has similarly remained below the operational plan threshold of 65%, with delivery fluctuating between the low-40% and mid-50% range. While improvement is evident from June 2025, sustained recovery remains challenging, reflecting ongoing pressures across diagnostic and treatment pathways and the need for continued focus on pathway productivity, capacity and coordination.

28-day faster diagnostic standard



62-day cancer treatment standard



Case study: Improving access to cancer services – radiotherapy machine

Improving Access: Cancer Services

During spring 2025 a radiotherapy machine that is helping to transform cancer treatments saw its first patient.

Leslie Cast, 79, from St Lawrence, Maldon, was the very first person to receive his radiotherapy on the £3.5million machine, known as a LINAC.

The LINAC, which joins three other machines in use at Southend Hospital, works by using beams of high-energy X-rays or electrons. It gives focussed radiation treatments to target and destroy cancer cells in nearly all types of cancer, anywhere in the body.

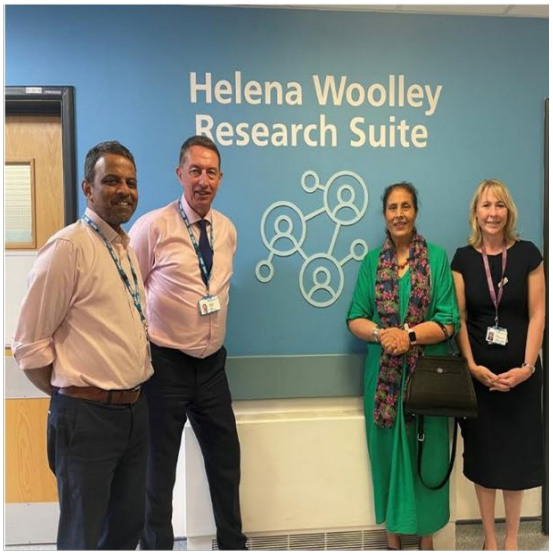
Speaking about being the very first person to experience the new state-of-the-art equipment, Leslie said: "It feels great to be the first patient. The treatment itself was really comfortable. The staff made sure everything was set up just right for me, and I didn't feel any discomfort at all. They were also very knowledgeable and supportive". Its sophisticated tracking and imaging technology is used to guide radiotherapy, meaning that radiation is delivered to the exact location of the tumour, minimising damage to surrounding healthy tissue.
The £5.3million purpose-built extension to the radiotherapy department, which the new LINAC is housed in, is a major leap forward in cancer treatment at Mid and South Essex NHS Foundation Trust, where Southend is the Essex Cancer Centre.

Case study: Improving access to cancer services – cancer research suite

Improving Access: Cancer Services – dedicated cancer research suite

In May 2025, Southend Hospital unveiled its first-ever dedicated inpatient cancer research suite, thanks to a remarkable £430,000 legacy gift from Helena Woolley of Thundersley, Benfleet. The Helena Woolley Research Suite will allow patients to take part in cutting-edge drug and treatment trials without travelling to London or Cambridge.

Dr Krishnaswamy Madhavan, Consultant Clinical Oncologist, said: "This exciting new research suite will open access to trials previously unavailable at the Trust and significantly expand local research capacity. Helena's legacy isn't just this suite but the lives she will help prolong or save."

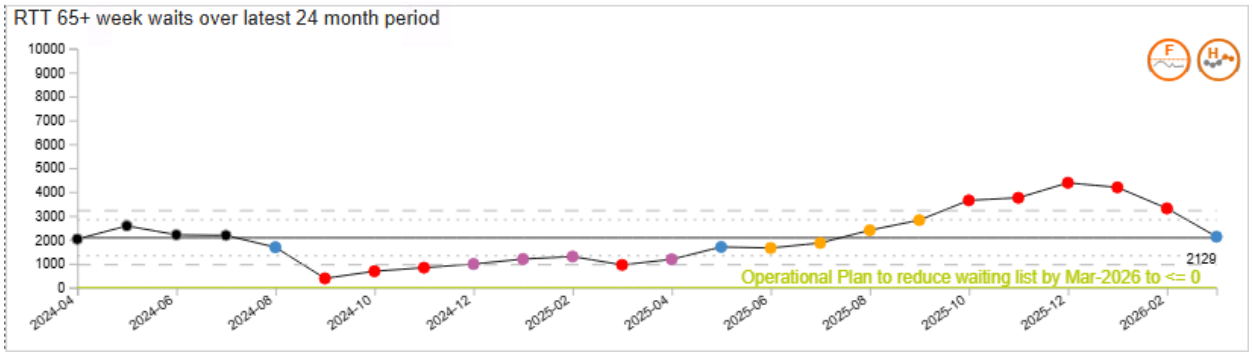


Elective Care Referral to Treatment (RTT)

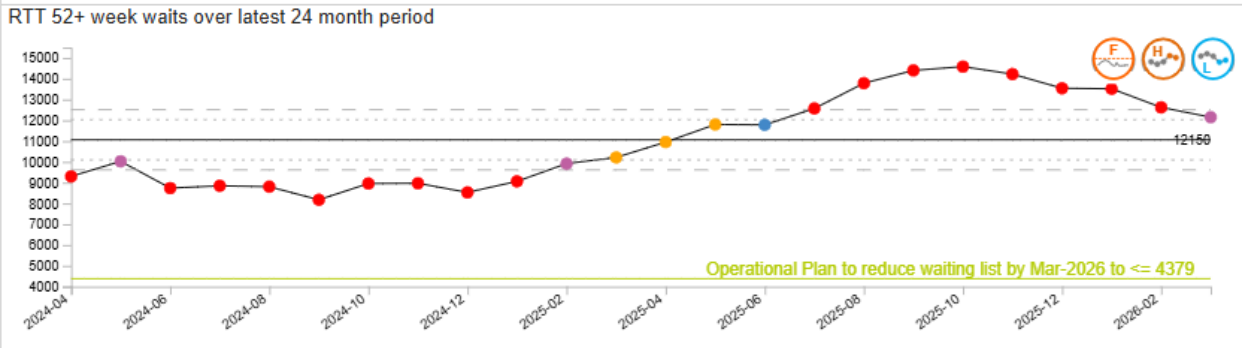
Elective care performance against the Referral to Treatment (RTT) long-wait standards continues to reflect sustained pressure across elective pathways. The number of patients waiting more than 65 weeks remains above the national expectation of zero, with the long-wait position deteriorating towards the end of the period shown.

The number of patients waiting over 52 weeks has also remained materially above the Elective Recovery Programme trajectory through 2025/26. In line with the Elective Recovery Programme, the Integrated Care Board committed to commissioning circa 7,000 additional clock stops above the contracted value in 2025/26, to increase elective capacity and support reduction of long waits. These trends underline the ongoing challenge of delivering sustained improvement against national recovery expectations, while balancing available capacity, productivity and patient flow across elective services.

65+ week waiting standard



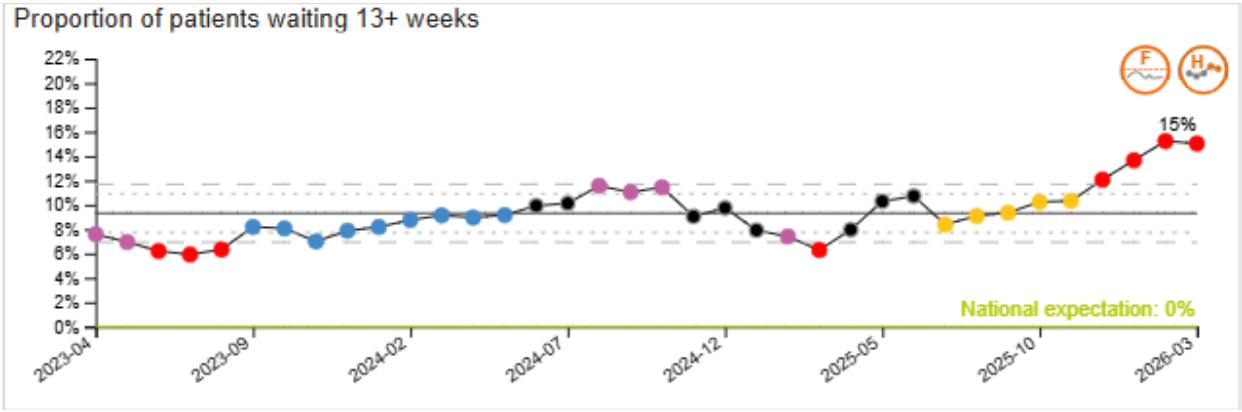
52+ week waiting standard

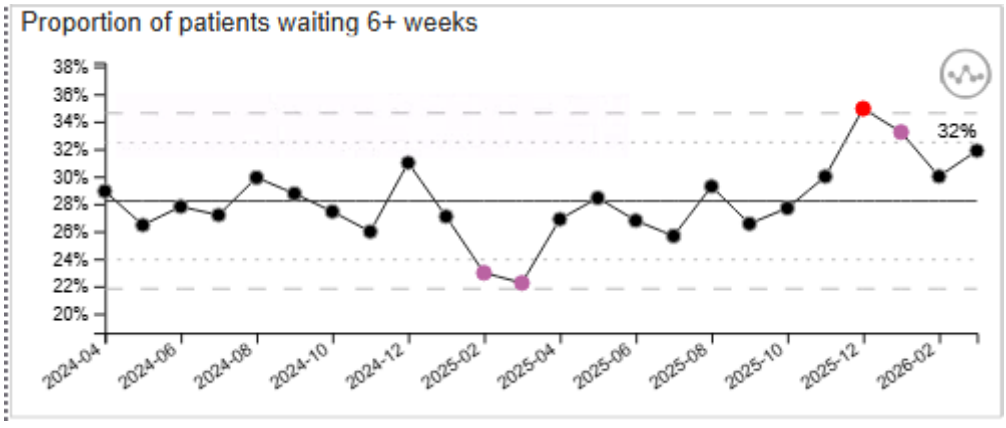


Diagnostics

The proportion of patients waiting longer than 13 weeks has remained above the national expectation of 0% throughout the period, with performance showing fluctuation over time. Following gradual increases during 2024, improvement was evident during early 2025 before performance deteriorated again in the latter months, with a rising proportion of patients breaching 13 weeks at the end of the period.

The proportion of patients waiting over 6 weeks has remained consistently elevated, generally fluctuating in the low-to-mid-20% range, with only limited periods of improvement below this level. Together, these trends reflect sustained pressure on elective pathways and the ongoing challenge of recovering backlog positions while balancing available capacity, throughput, and demand.





Case study: Improving access to community diagnostics

Improving Access: Community Diagnostics

Thurrock's brand-new Community Diagnostic Centre (CDC) officially opened in 2025, marking a major step forward in delivering faster, more accessible healthcare for local residents.

The centre began seeing patients in September with services including MRI and CT scans, ultrasounds, x-rays, blood tests and echocardiograms. Respiratory, anticoagulation and audiology services will be added in the coming months.

Once fully operational, the CDC will provide more than 75,000 diagnostic appointments each year, all in a central, easy-to-access location at the Thurrock Community Hospital site in Grays, Thurrock.

Three further CDCs are under construction in mid and south Essex, with centres due to open in Southend (early 2026), Braintree (Summer 2026) and Pitsea (Summer 2027).

Mental Health

Dementia Services

The national ambition for 2025/26 was for 67% of people estimate to be living with dementia to have a formal diagnosis and be included on a dementia register. During the year, the ICB maintained strong performance against this target. As at December 2025, 68.1% of people aged over 65 with an estimated diagnosis of dementia were recorded on the Dementia Register, remaining broadly consistent with performance in the previous year (68% in February 2025).

In addition, progress was made in increasing the identification and diagnosis of people under the age of 65 with early-onset dementia. This ensured that appropriate support was available earlier for a wider group of people living with dementia. Neighbourhood teams supported continued growth in the Dementia Register, helping to ensure that more people received timely, coordinated care and support closer to home.

Out of Area Placements

Due to limited local inpatient capacity, some people with serious mental illness continued to require admission to inpatient beds outside of the local area, where this was not planned, it was considered an inappropriate placement. The national ambition is to eliminate inappropriate out of area placements by March 2027. For 2025/26, the planning submission target was set at 23 patients, with monthly figures fluctuating between 23 and 42.

Across the year, an average of 27 people were placed in out of area acute mental health beds at any given time, while between one and six people (an average of three) were placed in Psychiatric Intensive Care Unit (PICU) beds for those with complex needs. Significant work was undertaken with providers and partners to reduce lengths of stay and prevent inappropriate admissions wherever possible. This supported

improved patient experience and increased the number of people receiving care closer to home.

Serious Mental Illness – Physical Health Checks

People living with serious mental illness (SMI) are at increased risk of poorer physical health outcomes. Nationally, a target of 60% has been set for the completion of a full annual physical health check for people on the SMI Register. These checks cover a number of health areas and must be fully completed to count towards performance, using nationally standardised GP Extraction Service (GPES) data.

At Quarter 2 of 2025/26 (data current to September 2025 and published in February 2026), the ICB achieved 59% uptake against the GPES measure, just below the national minimum standard. However, local reporting through SystmOne showed stronger performance at 64.3%, exceeding the national threshold. This represented a marked improvement from the equivalent position in 2024/25, when performance stood at 57%.

An action plan was implemented and overseen by the Physical Health Improvement Group, focusing on consistent delivery of physical health checks across all providers and General Practice. A new Standard Operating Procedure and step-by-step guidance were rolled out to support staff, alongside patient-friendly materials co-designed with people with lived experience. Further improvements included better access to follow-up support, direct referrals into integrated wellbeing services, increased outreach activity such as home visits, and full enrolment of all local practices into the national GPES data system (which should improve reporting figures).

Talking Therapies

** Please note this report uses National Data from NHS Digital and NHS England

	Early Intervention In Psychosis (EIP)		Dementia	NHS Talking Therapies, for anxiety and depression						
	Jan-26		Feb-26	Jan-26						
	People experiencing first episode treated within two weeks (60%)	Total Completed EIP Pathways	Estimated Diagnosis Rate (66.7%)	M186-Percentage_Improvement (68%)	M195-Percentage_ReliableRecovery (50%)	Recovery Rate (50%)	6 Week Waiting Time (75%)	18 Week Waiting Time (95%)	% First To Second Treatment Over 90 days (<10%)	M076 - Count Finished Course of Treatment
NHS BASILDON AND BRENTWOOD		0	60.50%	71%	58%	60.00%	100.00%	100.00%	2.22%	160
NHS CASTLE POINT AND ROCHFORD		5	71.40%	79%	53%	53.00%	98.00%	99.00%	78.57%	95
NHS MID ESSEX	93.0%	15	64.80%	70%	50%	52.00%	98.00%	100.00%	59.09%	240
NHS SOUTHEND		5	82.50%	83%	50%	53.00%	99.00%	99.00%	78.38%	130
NHS THURROCK		5	63.60%	74%	56%	59.00%	99.00%	100.00%	0.00%	190
MID AND SOUTH ESSEX ICB	93.0%	30	67.70%	75%	53%	55.40%	98.80%	99.60%	43.65%	815
ENGLAND	-	-	66.10%	68%	47%	50.00%	89.00%	98.00%	24.50%	50951

The above data set shows that Talking Therapies services continued to perform strongly against national access standards. Throughout the year, the six-week and 19-week referral to treatment waiting time standards for people access Improving Access to Psychological Therapies (IAPT) programme were sustainably met across mid and south Essex. As of January 2026, 99.6% of people were seen within 18 weeks (against a 95% standard), and 98.8% were seen within six weeks (against a 75% standard).

Work continued with providers to reduce the proportion of people waiting longer than 90 days between their first and second treatment appointment. Whilst national ambition is to reduce this to 10% or below, performance remained challenging, with 43.7% of people waiting over 90 days as of January 2026. There was significant variation across the system (as shown in the table above), and this remained a key focus for improvement.

Outcomes for services users however, remained positive. During the year, 53% of people accessing Talking Therapies achieved 'reliable recovery', exceeding the national target of 50%. This demonstrated the continued effectiveness of services in supporting people's mental health and wellbeing. The case study below gives an example of how we have worked with Providers and the community to support patients in their journey.

Case study: Recovery and Wellbeing

Mobilising Communities: Recovery Café at Brockfield House

In December 2025, Peer workers at Essex Partnership University NHS Foundation Trust (EPUT) are proud to have launched a new Recovery Café to support patients at a mental health unit in Wickford.

The Recovery Café at Brockfield House is a weekly, patient-led space designed to offer warmth, connection and peer-to-peer support for patients throughout their mental health and addiction treatment journeys.

The idea was created by the Trust's peer workers, an expanding team of people who use their personal experiences of mental health challenges to support patients and ensure their voice remains at the heart of care.

Every Friday, patients are invited to drop in for refreshments and conversation in a relaxed, stigma-free space focused on wellbeing. They are welcome to stay for the full session or simply pop in for a chat and a cuppa – whatever feels right on the day.

Mental Health Expenditure

All ICBs were required to plan to achieve the Mental Health Investment Standard (MHIS) in 2025/26 and were required to spend greater than or equal to the 2025/26 target spend number provided by NHS England, see Note 25 (page 27 of the accounts section) Mental Health Expenditure in the statutory accounts.

For 2025/26 target spend was £255,714k and the actual spend was £256,054k.

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

Financial Years	2025/26	2024/25
Minimum expenditure in mental health services to meet the MHIS as notified by NHS England (£000's)	£255,714	£229,720
Eligible mental health expenditure (£000's)	£256,054	£229,737
Mental health expenditure above minimum investment (£000's)	340	17

Financial Years	2025/26	2024/25
Mental health expenditure as proportion of total expenditure	7.6%	7.3%

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

Following delegation from NHS England, the ICB is responsible for commissioning general medical services, community pharmacy, optometry and dental services for the population of mid and south Essex. This section outlines the ICB's key priorities and achievements in the delivery and development of primary care services during 2025/26.

Improving access to Primary Care services

Improving access to primary medical care was a key priority during 2025/26. While primary care providers led the transformation of local services, this work was supported by the ICB's Connected Pathways programme.

With ICB support, all general practices across mid and south Essex implemented online consultation tools to support patient access. From October 2025, these tools were available between 8am to 6:30pm, Monday to Friday. Patients were able to submit requests online, which were triaged by practice teams to ensure they received the most appropriate care.

Use of the NHS App continued to exceed national targets following local promotional campaigns. By the end of the year, 62% of our population aged 13 and over were registered to use the NHS App. This enabled patients to manage appointments, access their health records and test results, and order repeat prescriptions. Usage continued to increase month on month, with nearly 120,000 prescriptions ordered via the app each month across mid and south Essex.

The ICB also worked with partners to improve patient navigation to voluntary and community-based services using *Frontline*, a navigation tool commissioned by the ICB. This supported both patients and professionals to identify local community solutions, with over 5,000 people per month signposted to appropriate support.

Primary care activity continued to rise. In the 12 months to December 2025, there were 7.1 million consultations delivered in primary care, compared to 6.9 million in the previous year. Of these, 43% of patients were managed on the same day as contact, and around 75% of consultations were delivered face to face.

During the year, primary care also led several service developments, including the introduction of an enhanced service to improve the identification and management of chronic kidney disease. Through earlier detection and preventative care, this initiative aimed to reduce disease progression. Over 90% of practices (130 in total) signed up to deliver this service.

Pharmacy

During 2025/26, the ICB focused on maximising the benefits of national community pharmacy initiatives, particularly the expansion of *Pharmacy First*. This resulted in an increase in patients accessing community pharmacies directly for common conditions, as well as more patients being appropriately redirected to pharmacy services following triage in general practice.

Case study: Improving Access: Pharmacy First

Improving Access: Pharmacy First

Over 125,000 Pharmacy First consultations provide fast access to care in mid Essex since it launched in 2024.

194 pharmacies across mid and south Essex have offered expert advice to help manage a range of illnesses, meaning thousands of local people have benefitted from fast access to treatment without needing to see a GP.

Building on this success, Pharmacy First has also been introduced in Mid and South Essex hospitals, allowing patients to be referred directly from hospital to community pharmacists for timely advice and treatment, helping to avoid unnecessary waits in Emergency Departments.

As part of the national Community Pharmacist Independent Prescribing Pathfinder Programme, four pharmacies in Mid and South Essex showed how pharmacist prescribers can safely manage suitable conditions within community pharmacy. The pathfinder showed how independent prescribing can provide timely treatment and reduce the need for GP appointments when issues can be resolved in pharmacy. Learning from this work contributes to the national evaluation and supports future planning for wider adoption.

The ICB continued to support the Community Pharmacy Independent Prescribing Pathfinder pilot across four sites. This enabled pharmacists to prescribe where appropriate, reducing the need for patients to return to their GP and improving the efficiency of care.

To strengthen collaboration between community pharmacy and other services, the ICB continued to commission Community Pharmacy Integration Leads. These roles supported closer working between general practice and pharmacy, improving patient experience and service utilisation.

A Primary Care Commissioning and Transformation Group was established during the year, reporting to the Primary Care Commissioning Committee. The group focused on identifying further opportunities to improve care pathways through greater use of community pharmacy services.

Optometry

Through the Primary Care Commissioning Committee and the Ophthalmology Transformation Board, the ICB worked closely with the Local Optometry Committee to improve the use of optometry services across mid and south Essex. Particular emphasis was placed on promoting Minor Eye Care Service pathways as an alternative to general practice, supported by the Connected Pathways programme.

Dental Services

During 2025/26, the ICB refined existing dental schemes and commissioned new services to improve access to oral health care. National guidance was implemented to support increased access to urgent dental care as part of the national initiative to deliver 700,000 additional urgent appointments. As a result, 64 dental practices across mid and south Essex offered urgent care appointments.

Case study: Improving Dental Access

Improving Access:
New NHS dental practice - Thurrock

In December 2025 a new NHS dental practice was opened in south Essex, bringing a significant boost to dental care access across Thurrock.

Grays Dental Care, delivered by Dentistry for You in partnership with NHS Mid and South Essex Integrated Care Board, features five modern surgeries and two new dentists.
The site is expected to deliver 5,000 NHS dental units in its first year, increasing to 10,000 annually.
Located on Milton Road, the practice aims to tackle long-standing shortages in local NHS dentistry.

The launch was marked by an event attended by the MP for Thurrock, Jen Craft, and senior NHS leaders.

Three key dental pilots continued to deliver improved outcomes. The Access Pilot provided 49,000 appointments during the year, with pathway refinements enabling direct booking from the emergency departments at Broomfield, Southend and Basildon and Thurrock hospitals.

The care home dental service was incorporated into core commissioning arrangements following demonstrated improvements in residents' oral health. Activity increased by nearly 5% compared to 2024/25, and the initiative received both local and national recognition.

Case study: Improving Dental Access in care homes

104-year old Ivy celebrated 105th birthday with a smile, thanks to dental initiative.

Improving Access:
Dental care in care homes

Care home residents are not always able to communicate dental pain or discomfort and may be unable to travel to dental practices. For this reason, delivering dental care directly within care homes is essential.

Historically, care homes were required to arrange dental care themselves or refer residents to Community Dental Services CIC, a referral-only service for people unable to access general dental practice. High demand on this service created challenges for residents in accessing timely care.

To address this, the ICB developed a care home dental initiative to ensure all care home beds across Mid and South Essex were covered by a dedicated dental practice. Commissioned dental teams now visit care homes to provide regular oral health assessments and deliver treatment where required.

By September 2025, every care home in Mid and South Essex had access to a dedicated dental provider. To date, more than 7,500 courses of dental treatment have been delivered following these assessments, significantly improving access to oral healthcare for care home residents.

The Children and Young People pilot expanded to 320 schools across mid and south Essex. The service aimed to improve oral health outcomes while increasing access to high street dentistry for children without regular dental care.

Overall, contractual delivery across commissioned dental providers improved during the year, supporting better access to services. Several smaller, targeted pilots were also delivered to address specific local needs.

Mid and South Essex Primary Care Training Hub

The Primary Care Training Hub continued to support recruitment, retention and workforce development across general practice and primary care networks.

The Hub delivered a wide range of programmes for GPs, nurses, allied clinical roles and nonclinical staff. During 2025/26, the final year of the GP and Practice Nurse Fellowship Programme was completed, with 38 GPs and 30 nurses undertaking blended roles that supported workforce sustainability, particularly in hard to recruit areas.

Peer support networks continued to expand, including the *First 5* group for early career GPs, which grew to 100 members, and the *Wise Five* group, which had 60 active members.

The Training Hub also administered the Educator and Training Programme locally, supporting engagement in GP training. By the end of the year, there were 88 approved Learning Organisations across mid and south Essex, including three at Primary Care Network level.

In addition, the Hub delivered a range of initiatives including Return to Practice programmes, continuing professional development, advanced practice schemes, non-clinical training, and implementation of the Oliver McGowan mandatory training programme.

Place based alliances

Alliances operate as place-based delivery structures within the Integrated Care System (ICS), providing a framework for local health and care partners to plan, commission and deliver services collaboratively in response to the needs of their communities. Through partnership working, pooled resources and strong relationships with local communities, Alliance teams focused on reducing health inequalities, accelerating the development of Integrated Neighbourhood Teams, and laying strong foundations for Neighbourhood Health in line with the NHS 10Year Plan.

Positioned at the heart of the ICS, Alliances played a central role in improving population health, reducing inequalities and embedding prevention at scale. By working closely with system partners, the voluntary and community sector, and local residents, Alliances enabled tailored, data driven and neighbourhood focused approaches to service transformation. This ensured that national priorities were delivered through locally led, sustainable solutions that reflected the needs of local populations.

Integrated Neighbourhood Teams

During 2025/26, Alliances continued to lead and support the delivery of Integrated Neighbourhood Teams (INTs), with a particular focus on improving outcomes for residents through at scale delivery of frailty and end of life (EoL) care. This work aimed to support people with complex needs to receive coordinated, proactive care closer to home.

All 24 INTs across mid and south Essex had either a full or partial focus on frailty and EoL care embedded within their operating models. Teams continued to implement the agreed frailty and EoL framework, supported by Alliance teams to ensure consistent application and shared learning across places.

Digital tools to support population identification were strengthened during the year. The INT Cohort Finder and Case Finder tools were made available through the Athena platform, enabling teams to identify residents who would benefit most from an INT approach. Training was delivered to support effective use of these tools, with 20 of the 27 Primary Care Networks (PCNs) now signed up to access Athena.

Peer learning remained an important enabler of progress. Ongoing collaboration between PCN Clinical Directors supported the sharing of learning between areas with more established INT models and those at earlier stages of development. The primary care team also worked closely with PCN leads to support workforce planning and integration with wider community services.

Alliance teams continued to provide support to all 24 INTs, building on existing good practice while maintaining a consistent focus on frailty and EoL care across mid and south Essex. A system-wide support tool was developed and shared with INT leadership teams to aid implementation, alongside continued engagement with partners across health, care and the voluntary sector.

Early signs of impact were reflected across several key performance indicators, which showed an improving trajectory compared to the previous year. These included:

- a reduction in the proportion of emergency admissions related to falls
- fewer people being readmitted to hospital within 30 days of discharge
- a reduction in non-elective admissions from care homes
- lower levels of unplanned admissions for ambulatory care sensitive conditions

Taken together, these trends provide growing confidence that the frailty and EoL framework, when implemented at scale through INTs, can contribute to improved outcomes and experience for residents.

Alliance delivery is embedded across the full breadth of the ICB’s work, rather than operating as a standalone programme. The place-based activity described in this section underpins and contributes directly to systemwide priorities, including quality improvement, prevention and tackling health inequalities. As such, the impact of Alliance led delivery is reflected throughout this annual report, particularly within the

sections on quality and health inequalities, which showcase how locally led, neighbourhood-based approaches are improving outcomes for populations across mid and south Essex.

Digital, data, technology, and business intelligence

Business Intelligence tools:

Since early 2023, mid and south Essex has implemented a system-wide data and analytics platform, *Athena*, to replace fragmented and inconsistent access to data across the system. Athena supports population health management, operational performance, service planning and clinical insight, providing a single, shared data foundation for partners across the system.

The platform has been developed to:

- improve population health outcomes
- reduce health inequalities
- support strategic planning and operational decision making
- enable clinicians, analysts and leaders to work from a consistent and trusted data source
- replace multiple legacy business intelligence tools with a unified and cost-effective model

Athena has strengthened the ICB's analytical capability and supported more data driven decision making. This has underpinned effective planning, performance management and the development of service transformation programmes aimed at improving outcomes for the population of mid and south Essex.

In 2025, an Integrated Neighbourhood Team (INT) Case Finder tool was introduced within Athena. This application identifies specific groups of people within neighbourhoods who would benefit from proactive, multidisciplinary support. The tool supports:

- identification of residents at rising or high risk, enabling earlier intervention
- prioritisation of INT caseloads based on need, risk and inequalities
- anticipatory care by highlighting individuals at risk of deterioration without proactive support
- reduction in avoidable accident and emergency attendances and hospital admissions across Basildon, Southend and mid Essex
- creation of actionable cohorts, including frailty, long term conditions, mental health and high intensity service users

The Case Finder tool is used alongside a Rapid Evaluation capability within Athena, which supports the assessment of the financial impact of interventions, including avoided activity and potential cost savings.

The tool is now being used across Primary Care Networks in mid and south Essex to support the identification and management of people living with frailty. This has

strengthened care planning and coordination, helping to reduce unplanned attendances and hospital admissions and supporting improved outcomes for patients.

System-Wide Digital Projects

We have continued our journey to deliver the strategic ambitions for digital, with further progress across our three strategic programmes of work to support innovative solutions to improving patient care both in and out of hospital:

- Patients Know Best
- Shared Care Record
- Unified Electronic Patient Record

The Patient Portal Programme expanded the **Patients Know Best (PKB)** service to improve digital access to information and communication for patients. Mid and South Essex Foundation Trust enabled PKB across Fracture Liaison Services and Learning Disability and Autism services, with further pathway work progressed for maternity and surgery. This improved patients' ability to access information digitally and communicate with clinical teams. Work progressed to implement pathology results, subject to final system updates. Essex Partnership University NHS Foundation Trust successfully piloted digital questionnaires for Patient Reported Outcome Measures, significantly increasing response rates, while rolling out appointment sharing, digital appointment letters and automated questionnaires integrated with clinical systems, reducing administrative burden and saving staff time.

The **Shared Care Record** was embedded system-wide, enabling professionals across acute, primary care, mental health, community services, social care, hospices and out-of-hours services to access shared patient records, with over 23,500 user accounts created. Sustained and growing adoption was demonstrated through more than 13,500 active users, over 1.6 million patient summaries viewed, 2.5 million documents accessed and between 4,000 and 5,200 weekly active users.

Core health and care datasets were integrated at scale, including GP records (97% of practices live), acute, mental health, community, adult and children's social care, hospice and NHS 111/out-of-hours data, with progress made towards regional and national record sharing. The programme delivered measurable productivity benefits across the system, identifying approximately £4.7m per annum in efficiencies through reduced avoidable admissions, fewer missed appointments and significant time savings for clinical and care staff. Phase 1 delivery has been completed and Phase 2 outcomes advanced, including the implementation of single sign-on, access to advanced mental health documents, enablement of children's social care data coming on board for the local authorities (Thurrock and Southend respectively), onboarding of hospices, piloting with care homes and progress towards integrated care planning to support Discharge to Assess.

The **Unified Electronic Patient Record** (Nova) programme has made strong progress in 2025/26, establishing a clinically led approach to deliver a single record across acute, community and mental health services. Extensive planning, design and localisation activity was completed, enabling clinical and operational subject matter experts to

shape workflows and system configuration. Programme workforce capability was developed and engagement strengthened across partner organisations through design sessions, digital summits and clinical showcases.

Delivery advanced through current and future state reviews, system design and build activity, with 87% of acute functionality build and design completed, enabling progression towards testing. Significant progress was also made on the build of community and mental health functionality. The programme laid strong foundations for a first-of-type implementation across community and mental health services, supporting improved visibility, safer care and consistent digital transformation across the mid and south Essex health and care system.

Improve quality

The ICB has a statutory responsibility to continuously improve the quality of healthcare services for the population it serves. This includes supporting people to stay well, identifying health needs earlier, and ensuring that care is safe, effective and delivers a positive experience for patients, families and carers.

The Nursing and Quality Directorate leads this work, working in close partnership with healthcare providers, system partners and local communities. Through robust oversight, shared learning and assurance processes, the Directorate supports continuous improvement in care quality and patient experience across the system.

During 2025/26, the ICB strengthened its approach to quality monitoring and improvement. The MSE System Quality Group and Quality Committee played a central role in this work, ensuring that patient and resident feedback informed decision making and that learning was shared consistently across partners.

To improve transparency and accountability, clear and accessible quality dashboards were developed. These provided timely insight into service performance, supported the early identification of emerging risks, and enabled prompt action where improvement was required.

Where serious concerns about quality or safety were identified, Rapid Quality Reviews were undertaken. These focused reviews enabled swift assessment of risks and the agreement of clear actions to improve patient safety, care standards and experience.

The ICB remains committed to working in partnership with patients, families and healthcare teams to ensure care across mid and south Essex is safe, effective and compassionate.

The following sections highlight some of the work undertaken during the year to deliver our statutory responsibilities.

All Age Continuing Care

The All Age Continuing Care (AACC) team has maintained a strong focus on the timely delivery of assessments, alongside the commissioning and review of personalised

healthcare packages for NHS Continuing Healthcare (CHC), Funded Nursing Care (FNC), and Children and Young People's Continuing Care (CYPCC).

A key development has been the establishment of a dedicated Discharge to Assess Multidisciplinary Team (D2A MDT), jointly managed with Mid and South Essex Foundation Trust. The D2A MDT supports individuals with recovery, reablement, and rehabilitation before determining their longer-term care needs following hospital discharge. This model was implemented following a successful pilot during 2024/25, which demonstrated improved patient outcomes and experience, alongside reductions in delayed discharges and overall length of stay.

In addition, the ICB commissioned Xyla Services to provide targeted support for backlog recovery, specifically addressing retrospective reviews of Previously Unassessed Periods of Care (PuPOC) and NHS Continuing Healthcare appeals.

Looking ahead, key priorities include improving outcomes through the delivery of personalised and coordinated care, reducing unwarranted variation in commissioning and service delivery, advancing digital development, and strengthening partnership working across the system.

Hospice Rapid Access Service

The Hospice Rapid Access Service (HRAS) continued to play a vital role across mid and south Essex, providing timely assessment and coordinated onward care for adults experiencing rapid deterioration due to a primary health need. Operating ahead of the Continuing Healthcare Fast Track pathway, the service supported people to access personalised care aligned to their assessed needs.

In October 2025, the ICB Quality Team undertook Quality Assurance Visits across the three hospices in mid and south Essex: Farleigh Hospice, St Luke's Hospice and Havens Hospices, which included review of the HRAS. Ongoing contract monitoring meetings, attended by the Quality Team, provided continued oversight and ensured that any emerging quality or safety concerns were promptly identified and addressed.

The Quality Team also supported the award of a new contract for the HRAS in September 2025, reviewing the Quality Impact Assessments submitted by St Luke's Hospice, Havens Hospices (Fair Havens) and Farleigh Hospice.

Annual Quality Accounts submitted by all three hospices highlighted the positive impact of the service in improving access to timely, coordinated end of life care for the local population.

Special Educational Needs and Disabilities (SEND)

During 2025/26, Mid and South Essex ICB worked closely with local authority partners to deliver the three Local Area Partnership Special Educational Needs and Disabilities (SEND) strategies through a number of priority workstreams. Targeted training for local authority SEND operational teams, health professionals and multiagency partners

improved staff confidence, strengthened the quality of health advice, and enhanced preparedness for SEND inspections. Monthly health drop-in sessions and improved health representation at panels supported more effective case discussion and better coordinated support for children and young people with SEND.

The development and expansion of SEND data dashboards significantly improved strategic oversight across the Local Area Partnerships and proved instrumental during the Essex and Thurrock SEND inspections. Progress was also made in embedding quality assurance processes across providers, leading to greater consistency in practice and clearer identification of workforce development and training needs.

Stronger system relationships further supported improvement. The SEND Health Champions Forum and enhanced collaboration between Designated Clinical Officers across Essex improved system cohesion, supported consistent practice and strengthened inspection readiness. Increased engagement with Special Educational Needs Co-ordinator forums and schools improved understanding of frontline challenges and informed future planning.

Collectively, these actions strengthened multi-agency integration, increased system confidence, and established firm foundations for continued improvement in SEND outcomes for children and young people.

Patient Safety

During 2025/26, patient safety governance across the mid and south Essex system continued to strengthen and mature, providing increased assurance. Collaborative working between organisations improved how patient safety incidents were reviewed, learned from and used to drive improvements in care.

System-wide learning was shared through established forums, including the System Learning Forum, Learning from Deaths Forum and the Patient Safety Collaborative. These forums enabled partners to jointly understand incidents, identify common themes and agree actions to reduce harm and improve outcomes for patients and families.

The ICB reviewed the effectiveness of the implementation of the Patient Safety Incident Response Framework (PSIRF) across key providers, including MSEFT, EPUT, Provide CIC and NELFT. These annual reviews strengthened shared accountability for patient safety, identified areas of good practice and highlighted where further focus was required to embed learning and improvement consistently across the system.

Looking ahead, plans were put in place to develop a maturity assessment tool aligned to national PSIRF standards. This will support providers to understand their progress in embedding patient safety principles and identify opportunities for further improvement, with continued ICB oversight and support in line with national NHS guidance.

Infection Prevention and Control

During 2025/26, the Infection Prevention and Control (IPC) team continued to provide supportive oversight and assurance across primary care premises, undertaking environmental and governance audits to assess compliance with the Health and Social

Care Act 2008: Code of Practice on the Prevention and Control of Infections. The team also worked closely with acute and community provider IPC teams, carrying out site visits to strengthen assurance arrangements and support measures to reduce infection transmission and healthcare associated infections (HCAIs).

While year-end HCAI data was not complete at the time of reporting, emerging trends indicated that *Clostridioides difficile* infection (CDI) cases across the system were unlikely to exceed 2024/25 levels. Year to date data for *meticillin resistant Staphylococcus aureus* (MRSA) bacteraemia also suggested a reduction compared to the previous year.

Strong collaborative relationships were maintained with local and regional partners, supporting effective management of HCAIs, outbreak response and pandemic preparedness. The IPC team also contributed to estates IPC assurance for new builds and refurbishments, as well as quality input into service tendering and contract renewal processes.

Mandatory IPC training continued to be made available to primary care colleagues, with increased promotion of online learning to support compliance. Targeted IPC lead training was also delivered to strengthen understanding of roles and responsibilities and support consistent application of IPC standards across primary care settings.

Quality Oversight and Assurance

Throughout 2025/26, the Quality Team worked closely with providers to support preparedness for Care Quality Commission (CQC) inspections and to provide ongoing system level assurance. The current CQC ratings for main providers are set out below.

Provider	**Rating**
Mid and South Essex NHS Foundation Trust (MSEFT)	Inadequate (Well-led)
Essex Partnership University NHS Foundation Trust (EPUT) Mental Health Services	Requires Improvement
Essex Partnership University NHS Foundation Trust (EPUT) Learning Disability Services	Requires Improvement
Essex Partnership University NHS Foundation Trust (EPUT) Community Services	Good
East of England Ambulance Service NHS Trust	Requires Improvement
Provide Community Interest Company	Outstanding

Provider	Rating
North East London NHS Foundation Trust Community Services	Good (Well-led)

Mid and South Essex NHS Foundation Trust (MSEFT)

The Quality Team maintained a structured programme of Quality Assurance Visits (QAVs) across clinical areas within MSEFT. During 2025/26, 37 QAVs were undertaken, providing insight into areas of good practice and identifying opportunities for improvement. Findings and recommendations were shared with the Trust, with targeted action plans developed and progress monitored through Quality, Contract and Performance Meetings (QCPMs).

Where concerns met the thresholds set out in the National Quality Board Framework, they were escalated through the *Emerging Concerns Protocol* to ensure a timely and coordinated system response. The team also remained responsive to intelligence from external sources, including the CQC, Healthwatch and specialised commissioning. This included targeted quality visits to review specific issues, such as discharge lounge safety and its impact on patient flow and experience.

Throughout the year, the Quality Team continued to support MSEFT in responding to reported incidents, ensuring that risks to patient safety were identified, assessed and managed in line with established governance and patient safety processes.

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

The Mental Health Quality Team provided system level oversight and assurance of mental health services delivered by EPUT across the ICB footprint. This included a structured programme of planned QAVs across inpatient and community services, supporting assurance on quality, safety and responsiveness to population need. These visits enabled constructive engagement with providers and supported timely follow up where improvement actions were required.

A continued focus was placed on triangulating intelligence from multiple sources to inform robust assurance and risk management. This included collaboration with neighbouring ICBs, alongside analysis of incident reporting, patient experience feedback, safeguarding intelligence, regulatory information and performance data. This approach strengthened the ICB's ability to identify emerging risks, recognise effective practice and target quality improvement activity appropriately.

Through this work, progress was made in supporting improvements in the quality and safety of mental health services. The Mental Health Quality Team will continue to work in partnership with providers to support the consistent delivery of high quality, safe and person-centred care.

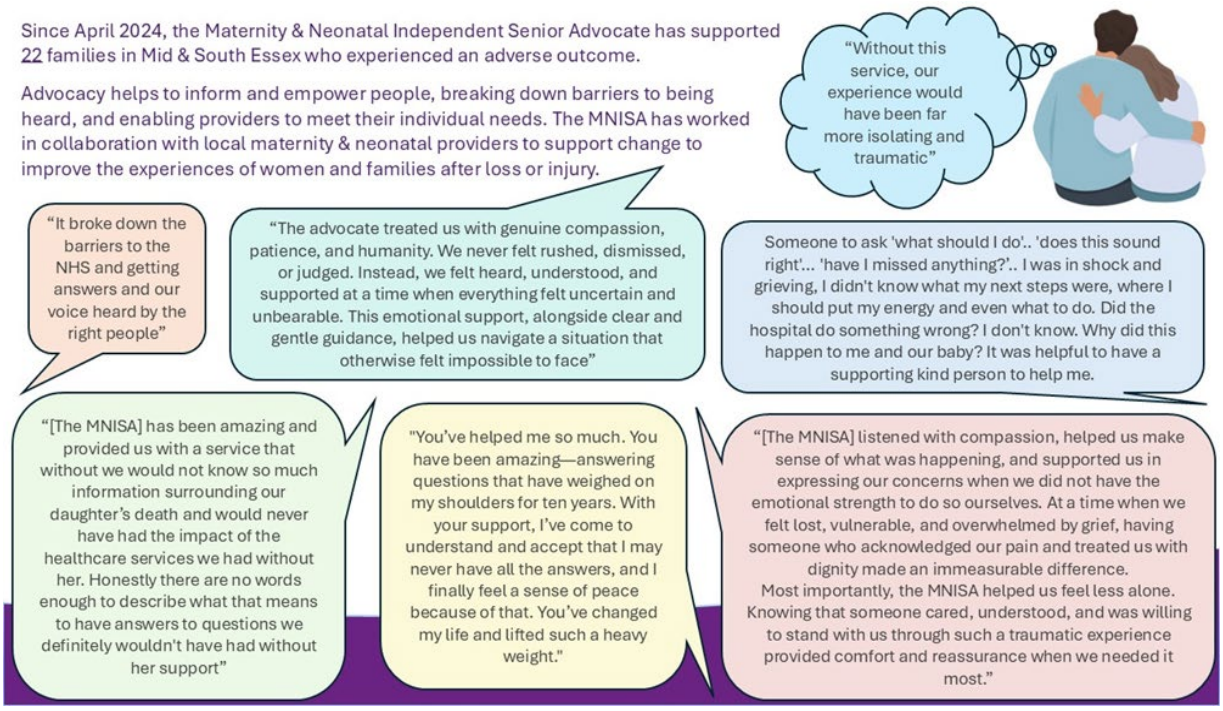
Local Maternity and Neonatal System

During 2025/26, the Local Maternity and Neonatal System (LMNS) continued to work closely with local providers and system partners to improve experience and outcomes for people using maternity and neonatal services. This work focused on ensuring care was safer, more personalised and more equitable.

A key mechanism for improvement was the Maternity and Neonatal Voices Partnership (MNVP), which represents the views and experiences of service users and supports their direct involvement in service development. Targeted engagement activity during the year, including work with the Jewish Orthodox community, identified the need for improved cultural awareness within services and informed local training and improvement actions.

Since April 2024, the ICB has participated in a pilot providing a Maternity and Neonatal Independent Senior Advocate (MNISA) service. The service supported 22 families across mid and south Essex who experienced adverse outcomes, including stillbirth, neonatal death and neonatal brain injury. Feedback from families highlighted the value of independent advocacy in navigating services, accessing information and support, and contributing to learning and improvement. A case study is included below.

Case study: Maternity and Neonatal support for families



Community Collaborative

The Community Collaborative brings together three provider organisations: Provide Community Interest Company, Essex Partnership University NHS Foundation Trust and North East London NHS Foundation Trust, to deliver community services for residents across mid and south Essex.

During the year, the Quality Team maintained a programme of planned Quality QAVs across community settings delivered by all three providers, including inpatient and community nursing services. Findings and recommendations from these visits were monitored through the QCPMs, providing ongoing assurance and oversight.

Any concerns relating to community service provision were managed in line with the *Emerging Concerns Protocol*, with feedback shared promptly with providers as required. An example of this collaborative approach was the review of the community wound management specification, where risks relating to access and potential impact on patient experience were identified. Joint escalation with commissioning teams and providers enabled the issue to be reviewed and addressed, with progress and outcomes reported through the Community Collaborative and QCPMs.

Learning Disability and Autism (LDA)

During 2025/26, the Learning Disability and Autism (LDA) Quality Team continued to work collaboratively with system partners across Essex to provide assurance on the quality, safety and effectiveness of commissioned services. While commissioning responsibility for LDA services remains delegated to Essex County Council, the ICB's role continued to evolve in response to system priorities and emerging assurance requirements.

As part of this, a formal review of the Section 75 delegation arrangements was initiated in partnership with Essex County Council, Hertfordshire and West Essex ICB, and Suffolk and North East Essex ICB. This work focused on ensuring that governance, accountability and quality oversight arrangements remained robust, transparent and fit for purpose.

The ICB further strengthened oversight through the establishment of the Learning Disability and Autism Assurance Delivery Group. This system-wide forum provided structured oversight of quality, safety and performance, supported shared learning, and enabled the timely identification and escalation of risks and concerns.

Regular quality assurance visits to inpatient services continued throughout the year, providing direct oversight of care delivery. This was complemented by the establishment of a dedicated Care and Treatment Review group, supporting consistent, high-quality reviews and promoting person centred, least restrictive care for people with a learning disability and autistic people across the system.

Primary Care Quality

The Primary Care Quality Team provided quality assurance oversight for 143 general practice providers and 117 dental contracts during the year. Hertfordshire and West Essex Integrated Care Board continued to be responsible for pharmacy and optometry services. Working collaboratively with providers, the team supported the delivery of safe, effective care and positive patient experiences across primary care.

A programme of annual, face to face QAVs was delivered to all general practice providers. Where concerns were identified; either through these visits or via wider intelligence sources such as the CQC, Healthwatch or system feedback; targeted

support and action planning were implemented. This included increased monitoring and additional visits where required to support improvement and ensure issues were addressed in a timely way.

During the year, one general practice provider achieved an *Outstanding* rating under the CQC's new assessment framework, representing a significant achievement and reflecting continued improvement across the system.

Progress was also made in embedding the Primary Care Patient Safety Strategy. Increased awareness and use of the Learn from Patient Safety Events platform supported improved incident reporting, learning and continuous improvement across primary care services.

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

Mid and South Essex ICB holds statutory safeguarding responsibilities under the Children Acts 1989 and 2004 and the Care Act 2014, alongside relevant statutory guidance. This includes compliance with *Working Together to Safeguard Children* (2023) and the NHS England *Safeguarding Accountability and Assurance Framework* (SAAF), which sets out the roles and responsibilities of NHS organisations, including ICBs.

Governance and Accountability

The ICB's safeguarding governance framework provides clear accountability, leadership and assurance in line with statutory and national requirements. Overall accountability sits with the ICB Board and Chief Executive, with delegated responsibility for safeguarding assurance held by the Executive Chief Nurse. Strategic and operational leadership is supported by senior nursing leadership and delivered through a dedicated all age Safeguarding Team, which provides clinical expertise and maintains statutory safeguarding functions.

Throughout 2025/26, the ICB worked closely with Safeguarding Partnerships and Community Safety Partnerships across Southend, Essex and Thurrock (SET), strengthening multi-agency collaboration to safeguard children, adults at risk and families.

Safeguarding Assurance and Compliance

SET Safeguarding Partnerships undertake biennial audits to assess agency compliance with statutory safeguarding duties. Due to organisational changes, the ICB will next be required to complete these audits in 2026/27. The most recent safeguarding compliance audit (2024/25) demonstrated full compliance with all standards, providing assurance that strong leadership and governance arrangements were in place.

Links to the most recent published annual reports and Multi Agency Safeguarding Arrangements (MASA) for each partnership are included below, evidencing the ICB's delivery of its statutory safeguarding responsibilities.

Southend	Essex	Thurrock
Southend Safeguarding Adults Board Annual Report and Safeguarding Arrangements	Essex Safeguarding Adults Board Annual Report and Strategy	Thurrock Safeguarding Adults Board Annual Report
Southend Safeguarding Children Partnership Annual Report and Safeguarding Arrangements	Essex Safeguarding Children Board Annual Report and Safeguarding Arrangements	Thurrock Safeguarding Children Partnership Annual Report and Safeguarding Arrangements

Professional Leadership and System Support

The ICB employs designated clinical safeguarding experts who provide strategic system and place-based leadership. Operating through an all-age safeguarding model, the team is overseen by a Deputy Director of Nursing for Safeguarding and works across the ICB to ensure effective governance, quality assurance and professional support.

This includes supporting General Practice, Primary Care Networks and community dentistry in meeting their safeguarding responsibilities for children, adults at risk and children in care. An established Safeguarding Assurance Framework underpins this work, providing oversight and consistency across NHS services.

Learning from Safeguarding Reviews

Significant capacity was dedicated to learning from serious safeguarding incidents during the year. A structured approach to reviews supported system-wide learning and improvement. At year end, the Safeguarding Team was supporting 50 safeguarding reviews, including:

- 7 Child Safeguarding Practice Reviews
- 18 Safeguarding Adult Reviews
- 20 Domestic Abuse Related Death Reviews

Key learning themes included neglect and self-neglect; neurodiversity, mental ill health and suicide; domestic abuse and coercive control; and the impact of substance misuse on individuals and families. Learning from these reviews informed system improvement activity and workforce development.

Safeguarding in General Practice

The General Practice Safeguarding Audit and Assurance Programme continued, with a refreshed two-year cycle launched in summer 2025. The revised programme strengthened assurance by promoting good practice, clarifying expectations and improving evidence requirements.

By January 2026, 129 of 144 GP practices (90%) had submitted assurance returns. Of the standards assessed:

- approximately 75% were rated as *Established Practice*
- around 19% were *Actively Improving*

- approximately 6% were identified as *Priority for Development*

Targeted support was provided to practices requiring additional input, and engagement continues with those yet to submit returns. Bi-monthly GP safeguarding forums remained well attended, supporting shared learning and professional development.

The Safeguarding Team also contributed to the Time to Learn Programme, delivering all age safeguarding sessions across the four Alliances. Over 700 participants attended, with consistently positive feedback used to inform ongoing improvement.

Safeguarding in Dentistry

In partnership with the Early Years Oral Health Team, two safeguarding pathways were developed and received positive regional and national feedback:

- a *Safeguarding Pathway for Dental Teams* [hyperlinks], supporting identification, response and escalation of safeguarding concerns
- *Children's Oral Health: Recognising and Responding to Signs of Neglect* [hyperlinks], supporting early identification and intervention linked to oral health

Initial Health Assessments for Looked After Children

Delivery of statutory Initial Health Assessments (IHAs) within the 20-day legal timeframe has remained challenging. In response, a Task and Finish Group developed a nurse led hybrid model, supported by paediatric oversight, to improve access, flexibility and workforce resilience.

The business case was approved by the ICB in January 2025, securing investment in additional consultant, nursing and administrative capacity. While implementation was delayed, mobilisation work continued during 2025/26 through the Community Collaborative.

The model is expected to improve compliance with statutory timescales, enhance the experience of children and young people, and enable earlier identification of health needs.

The Safeguarding Team played a key role in shaping this model, ensuring statutory health duties were embedded within a wider safeguarding framework and supporting improved outcomes for looked after children and care leavers.

Designing Pathways for Children

Progress was made in developing pathway-based approaches to support children with long term conditions and children who are looked after. This included work on asthma and diabetes pathways to ensure unmet health needs were identified early and access to support improved.

In partnership with the East of England Academic Health Science Network, a pilot was launched to support improved asthma diagnosis in primary care. Fifteen practices received Fractional Exhaled Nitric Oxide (FeNO) machines (a simple breath test machine to identify airway inflammation to help diagnose and manage asthma),

alongside development of a toolkit to support implementation of updated national guidelines.

Following updated national guidance, MSEFT Audiology Services were commissioned to deliver hearing checks in residential special schools across mid and south Essex, improving access for children and young people with SEND who may otherwise face barriers to assessment.

Case study: Shaping Asthma Care for Children

Co-production of services: Children Help Shape Future of Asthma Care

Children have been helping to shape the future of asthma services across south east Essex while having fun at the MegaCentre in Rayleigh.

Young patients under the care of the children's community asthma service run by Essex Partnership University NHS Foundation Trust (EPUT) were invited to share their experiences as part of a unique co-production event designed to put patient voice at the centre of care.

The fun and informal setting encouraged children to share their feedback on the care they receive while enjoying themselves with soft play and laser tag.

Parents and carers also had the chance to speak directly with clinical staff, ask questions and contribute their views on how the service helps children manage their asthma conditions.
The event is just one example of EPUT's commitment to co-production, ensuring the lived experiences of patients, their families and carers shape future delivery of the Trust's services.

Reducing health inequalities

NHS Mid and South Essex is committed to reducing health inequalities and supporting equality and inclusion. It recognises and has implemented all legislation relevant to its role and functions including the Equality Act 2010, the Equality Delivery System (EDS), and the Equality and Health Inequalities Impact Assessments (EHIIAs).

Public Sector Equality Duty

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

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

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

Equality Delivery System (EDS) 2022

Within the system, the ICB and NHS providers have been working together to implement the EDS 2022 on an ICS footprint. The EDS is an improvement tool that supports health organisations to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. For Domain 1: Commissioned or provided services, the services selected for review in 2025/26 were:

- Children's Asthma Service
- Community Mental Health
- Ophthalmology.

All services were reviewed against the eleven outcomes, to measure successes and challenges with protected characteristic groups and vulnerable community groups using evidence and insight. MSEFT, EPUT and the Community Collaborative engaged with service users, patients, community, and faith groups and with other stakeholders who support or represent the views of patients, to gain feedback on current service provisions and how they can be improved to meet the needs of groups of patients. The outcome of the assessment alongside those in Domains 2 and 3 are published on the ICB website. Equality Delivery System - Mid and South Essex Integrated Care System [hyperlinks]

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

Integrating health inequalities within decision making

NHS Mid and South Essex is committed to ensuring that the needs of our population and existing health inequalities are understood, and areas of interventions prioritised with an emphasis on moving towards prevention of ill health. It does this by considering the Joint Strategic Needs Assessments undertaken by the three local authorities and by adopting a Population Health Management (PHM) approach.

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

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

We recognise that good quality, robust data enables the NHS and wider system partners to understand more about the populations we serve. During 2025/26 the ICB utilised its population segmentation tool, that integrates data sets across the health and care system, to establish where health inequalities exist and develop interventions to support the needs of the population. A health inequalities dashboard has been developed to monitor progress in reducing health inequalities.

The ICB Health Inequalities Information Statement for 2025/26, published alongside this annual report, provides key outputs from the PHM team, insight to where health inequalities exist, and an overview of actions being taken at a system and alliance level to address these gaps. The metrics within this statement align with the national five strategic health inequality priorities alongside the clinical areas of the Core20PLUS5 approach.

The ICB has adopted the NHS Core20PLUS5 frameworks for both adults and children and young people to prioritise activities both across the system and through the local work delivered by alliance partnerships. Below are some examples of achievements from the health inequalities work:

- The Smoke Free Pregnancy Pathway has driven smoking at time of delivery to 4%, down from 9% in 2023, with the greatest reductions in the most deprived areas. This sustained improvement exceeds the national target of 6% and is helping to narrow long standing inequalities in maternal outcomes.
- Targeted system-wide action has driven a significant improvement in hypertension management, with performance rising from 67% to 71% in a year and the ICB moving from 41st to 13th nationally. Improvements have been seen across all deprivation groups, supported by community outreach that identified 484 residents with uncontrolled blood pressure, many from seldom-heard communities.
- Lipid optimisation has increased to 47%, keeping mid and south Essex on track for the national 50% ambition and contributing to reductions in avoidable cardiovascular events. Uptake has improved in the most deprived communities and among global majority ethnic groups, helping narrow inequalities in CVD risk management.
- Early years oral health programmes have narrowed the deprivation gap, supported by Thurrock's initiative which distributed 11,000+ toothbrush packs, implemented supervised brushing in 17 settings, and contributed to improving dental attendance for over 2,300 children. This targeted approach underpinned a 23% reduction in enamel decay among five-year-olds, particularly benefiting the most deprived communities.

Case study: Health Inequalities: Early Years Oral Health

Health Inequalities: Child Oral Health

Our supervised toothbrushing programme continues to improve children's oral health in mid and south Essex. We commissioned this initiative in Thurrock with support from local authorities and it is being rolled out across 24 early years and primary school settings. Thanks to this initiative over 1,000 children are now brushing their teeth in these settings, which are predominately located in the Index of Multiple Deprivation 1 and 2 decile areas (first and second most deprived areas).

During 2025/26 the Brush Bus has been out supporting our local community by:
Supporting parents: Offering valuable resources and advice to parents, helping them continue good oral health practices at home.
Preventing future issues: Contributing to the long-term oral health of our children, reducing the likelihood of dental problems as they grow."

Find out about toothbrushing basics, healthy eating and more at our Oral Health webpages.

- Audley Mills Surgery in Rayleigh is the first GP practice in mid and south Essex to be accredited as Learning Disability Friendly, recognising its strong commitment to accessible, high-quality care for people with learning disabilities.
- Basildon Early Response Team (BERT) brings together health, social care and voluntary sector partners to deliver proactive, personalised care in the community. This integrated approach has not only reduced hospital admissions but also supported tackling health inequalities by ensuring coordinated support for people with complex needs particularly for those less likely to access traditional GP services.
- Basildon Hospital has introduced a new exchange-transfusion service that improves equitable access to specialist sickle cell care, addressing a long-standing health inequality affecting predominantly Black African and Caribbean communities.
- Across mid and south Essex, suicide prevention training was provided to address increased risk of suicide in LGBTQ+ groups.

Case study: Health Inequalities: Suicide Prevention

Health Inequalities: Pride Month
Free suicide prevention training for Essex

Pride Month is a time to celebrate diversity and equality. Throughout 2025/26 NHS Mid and South Essex offered free suicide prevention training to address LGBTQ+ mental health inequalities affecting our communities.

Why LGBTQ+ mental health support matters
LGBTQ+ people are more than twice as likely to experience mental health conditions like depression and anxiety. Around half have experienced suicidal thoughts, with young people and trans individuals at particularly high risk.

These disparities stem from homophobia, transphobia, family rejection, and barriers to accessing inclusive healthcare. Understanding these challenges is the first step in providing effective support.

Suicide is preventable. Talking saves lives. The Let's Talk About Suicide training is a free, 20-minute online suicide prevention training Essex course that gives you practical skills to support someone in crisis.

Complete the Let's Talk About Suicide training at letstalkaboutsuicide.co.uk

This NHS mental health support takes just 20 minutes and could help you save a life. The training is available 24/7 and can be completed on any device.

For additional mental health resources, visit our NHS mental health services page or explore local community support groups.

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

- **Priority 1: Restore NHS services inclusively.** Implementation of the ICB's Primary Care Access Recovery Programme in 2025/26 has demonstrated improved access, measured via the GP survey. MSEFT completed an annual impact report and evaluation of access on the waiting list and patient experience that was presented to their public Board in June 2025.
- **Priority 2: Mitigate against digital exclusion.** The ICB continues to work with local partners to deliver the MSE Digital Inclusion Framework, with social prescribers supporting residents to use health apps and access free digital support such as data vouchers and SIM cards. In 2025, the ICB also donated nearly 200 retired NHS digital devices to local school children through the Digital Essex project, to widen access to online learning and supporting digital confidence from an early age.
- **Priority 3: Ensure datasets are complete and timely.** The ICB continues to strengthen the quality and consistency of ethnicity recording across all care settings, with data completeness routinely monitored and remaining high at over 91% of records containing a stated ethnicity. This strong baseline will support future improvement, as ethnicity data completeness will be incorporated into provider contract monitoring, ensuring continued focus on reducing inequalities across diverse communities.
- **Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes.** The ICB continues to accelerate work through adoption of Core20PLUS5 frameworks, and highlights of delivery are included across this report with detailed progress reported bi-annually to the MSE ICB Board.
- **Priority 5: Strengthen leadership and accountability.** Clear leadership roles established with senior responsible officer, system and alliance clinical leadership for health inequalities, and PCN health inequalities leads. Population Health Improvement Board and supporting governance structures are embedded across ICB.

Health and Wellbeing Strategy

The ICP and ICB strategies for mid and south Essex take account of the priorities identified in each of the three Health and Wellbeing Boards for Essex, Southend and Thurrock. The themes from the three HWB strategies align strongly with the ICB's priorities, which include:

1. **Population based themes:**
    a. **Improving health and reducing health inequalities**: supported by an increased focus on prevention and early identification and shifting the delivery of more care closer to people's homes.
    b. **Addressing the needs of the whole person:** recognising and supporting people in addressing the factors or 'wider determinants' of health, beyond healthcare services, that impact on individual health outcomes. This includes factors such as physical activity, healthy weight, smoking, housing, education and the environment.

c. **Focusing on children and young people:** recognising the importance of supporting babies, children, young people and families through the early years of development as foundational to lifetime health outcomes.
d. **Supporting people to age well:** supporting the increasing number of aging residents to live healthy lives for longer, having care plans in place for those who need them, particularly those who are frail or are living with frailty, and improving access to services that help them stay well at home.

2. **Care delivery-based themes:**
    a. **Integrated care, close to home:** aiming for more integrated, person-centred care that is focused on meeting the needs of the individual as close to home as possible, maximising digital innovation and supporting people to stay well and out of hospital wherever possible.
    b. **Place-based, local delivery:** recognising the importance of places and neighbourhoods to support delivery of care that meets the needs of local communities and is provided locally in their communities.

3. **Governance and partnership working:** working in partnership to deliver on the shared ambitions to improve health and reduce health inequalities.

Through active participation in each of the three HWB, the ICB is ensuring that its work continues to align with these strategies and there is mutually reinforcing action across partners to support improve outcomes and reduce health inequalities across Essex. Ongoing updates to the HWBs have ensured that each Board has been engaged in the work reported throughout this annual report. Additionally, each Local Authority represented on the ICB Board has received the annual report for review and provided positive feedback on the collaborative work we have undertaken.

Engaging people and communities

Engagement and involvement

Over the past year, Mid and South Essex Integrated Care Board (ICB) has continued to strengthen and broaden its approach to engagement, ensuring that people and communities remain central to our planning, commissioning and decision-making. Through the continued development of the Research Engagement Network (REN), expanded use of digital platforms, and deeper partnership working across our system, we have built more inclusive, responsive and impactful ways of working with our communities.

Strengthening research with our underserved communities

The Research Engagement Network (REN), established in January 2024, was created to encourage participation in health and care research with our underserved communities.

September 2025 funding round:

This year we encouraged organisations from our underserved communities to bid for funding that matched the NHSE Research criteria, as well as increasing the number of people signing up to research opportunities.

- 22 organisations submitted bids for the £70,000 funding pot
- 15 applications were successful
- All successful bids met NHS England research criteria by demonstrating how they would increase participation in research studies

Working closely with REN community champions, we have expanded engagement within underserved communities and strengthened alignment with our health inequalities programmes. This has included supporting improved uptake of blood pressure monitoring and vaccination initiatives and embedding research awareness within wider prevention activity.

Delivering innovative and inclusive engagement

We have continued to increase the reach and impact of the MSE Virtual Views engagement platform, which supports wide-ranging engagement across key procurement, commissioning and service transformation programmes.

During 2025/26:

- 25,792 people were reached
- 5,801 meaningful contributions were received

Through this method, more than 1,440 people shared their views on our vaccination services. We targeted outreach through REN community champions to ensure responses reflected the diversity of the mid and south Essex population.

Regular surveys and engagement activity continued to support service planning and new commissioning plans across a range of areas, including:

- Patient travel (with Mid and South Essex NHS Foundation Trust)
- Diagnostic test experiences
- “Your Heart, Your Health” cholesterol survey
- Community health events
- Endoscopy services
- A range of mental health services

Across all survey work, we proactively engage underserved communities, primarily through the REN network, to ensure more inclusive, representative data for commissioners.

This year also saw the number of GP Surgeries engage with the ICB to set up Virtual Patient Participation Groups (VPPGs) to reach out to their patient population. This has enabled practices and the ICB to share insight and avoid duplication. For example, Colne Valley PCN received 435 replies on a breast screening survey. This important feedback has help the ICB create and deliver a range of materials to encourage take up of breast screening. This included a video, Easy Read documents and breast screening information in other languages. Staff and community members supported the ICB in translation the information. Macmillan Cancer Support funding also enabled us to offer community grants to specific groups to share the information and support take up.

To provide stability and security for local engagement, we have agreed a further three-year contract to continue operating and developing the Virtual Views engagement platform to support the planned Essex ICB.

This year, the BCYP Team piloted the *15 Steps* approach at Broomfield Hospital to engage children, young people and their families in sharing feedback on local services.

Staff were very welcoming, and the visit generated rich insight into the experiences of children, young people and their families within an acute setting. As part of this early implementation phase, the team will also carry out visits in a community-based service and in primary care.

Community events and capacity building

Our programme of face-to-face engagement has continued to grow in both reach and impact.

Mega Research Events – Rayleigh (August and October 2025)
Two highly successful, family-friendly events were attended by over 220 people from underserved communities. To encourage participation, transport, children's activities and refreshments were provided.

Building on the original August event delivered in partnership with National Institute for Health Research (NIHR), the October event was expanded to include additional research partners and Community Pharmacy. There was strong demand for on-site vaccinations, cholesterol checks, and blood pressure testing with queues throughout the day.

All the partner agencies who attended on the day, including Essex County Council, MSEFT, Community Pharmacy, Social Spark, Healthwatch, were very pleased with the connections they made with the large number of community groups who attended. Many of the participants signed up to studies and got involved in engagement opportunities.

REN Learning Event – Basildon (January 2026)
Our second annual learning event, hosted by Signpost Basildon, brought together community champions and system partners to showcase the impact of local research and engagement initiatives. Thirty participants attended, with nine groups presenting their work and sharing learning across the network.

Community Champion Development
In summer 2025, we trained a new cohort of community champions and continued to strengthen partnerships across the academic and voluntary sectors. This includes collaboration with Anglia Ruskin University to connect REN champions with the new Primary Care Research Centre, and partnership with University of Essex to support engagement in mental health research.

Digital Inclusion

During the year, we supported three REN groups to secure funding from National Institute for Health and Care Research to advance digital inclusion. This work is being delivered in partnership with:

- Essex County Council
- Southend Association of Voluntary Services
- Mid and North East Essex Mind
- Multicultural Essex Women's Association (MEWA)

This collaboration supports the Department of Health and Social Care's 10-year strategy to move from analogue to digital services, including increased use of the NHS App.

Investment in digital skills and the training of digital champions will help ensure that people across Essex can access engagement opportunities regardless of their digital confidence or connectivity.

Looking Ahead: 2026/27

As we transition to the new Essex ICB, we will:

- Expand the REN programme to include North East and West Essex
- Extend the Virtual Views platform to serve the whole Essex footprint
- Support engagement delivery across the new ICB structure
- Develop and submit a strong 2026/27 REN funding bid of £185,000, essential to sustaining and scaling the REN programme across Essex

Through these actions, we will continue to embed meaningful engagement at the heart of our system ensuring that research, service design and commissioning are shaped by the voices of the communities we serve.

Supporting our workforce and social value

ICB workforce

On 13 March 2025 NHS England announced changes to the ICB operating model, including a requirement to reduce operating costs by 50%. During 2025/26, the ICB focused on implementing these changes while bringing together services and functions previously delivered across three separate organisations into a single, county-wide ICB.

To support this transition, new organisational structures and roles were developed and consulted on with staff, ensuring the ICB is appropriately configured to deliver its statutory functions and future priorities. Staff were supported throughout the change programme through a structured programme of engagement, including weekly all-staff briefings and directorate meetings. In line with national guidance, staff were also given the opportunity to apply for voluntary redundancy.

During the year, a review and consultation were undertaken regarding the location of the ICB headquarters and the approach to office-based working, reflecting the changing organisational model and operational needs.

Looking ahead, as the new ICB becomes fully established, an organisational development plan will be implemented. This will be co-led with staff and will focus on embedding the new structure, supporting culture and leadership development, and strengthening staff engagement. Further detail on staff engagement activity during the year is set out in the Staff Report.

System workforce planning

During 2025/26, workforce planning has continued to evolve, with strengthened collaboration between the ICB and NHS provider colleagues. Workforce plans have been closely aligned and triangulated with financial and activity performance, ensuring a more integrated and sustainable approach. There has been an increased focus on

optimising skill mix and transforming service delivery models to support medium- and long-term workforce requirements.

The People Board has maintained oversight of this work through its key workforce workstreams:

- Clinical capacity, education and training
- Colleague experience, wellbeing and retention
- Culture

These workstreams are underpinned by a shared commitment to support and develop the workforce across mid and south Essex. Partnership working remains central to this approach, with continued collaboration across the ICS, including partners from education, health, social care and the hospice sector.

This collaborative model has enabled stronger system-wide alignment and a more coordinated response to workforce challenges. It has also supported the development of innovative approaches to workforce supply and development.

The following case studies led by the ICB, demonstrate how the ICS has worked in partnership with providers and the Department for Work and Pensions (DWP) to support local residents into sustainable careers in health and social care.

Case Study 1: Widening Access Demonstrator Success

In June 2025, the ICB was selected by NHS England as one of ten national *Widening Access Demonstrator* sites. This programme supported young people and individuals from disadvantaged communities into pre-employment pathways, enabling progression into substantive entry-level roles and training opportunities across local health and care providers.

During the last year, through its Health & Care Academy and Anchor Programme, mid and south Essex successfully mobilised and delivered this initiative. The programme has enabled residents to develop key skills, build confidence, and access meaningful employment opportunities within the health and care system.

This work is contributing to the development of a more inclusive and sustainable workforce, better reflecting the diverse communities served across MSE, while also supporting wider system priorities of workforce supply and reducing health inequalities.

Case Study 2: Healthcare Assistant Academy recruitment and retention success

The Academy supported 362 Health Care Assistants through induction increased the retention rate from 68% to 94%, reduced the vacancy rate from 22% to 8%, supported 25 recruitment and engagement events and provided virtual reality training at induction and recruitment events.

The system workforce teams continued to support the ICB and Trusts to provide the best opportunities for all staff, as showcased in the following case study.

Case Study: Learning Disability Support Offer

Supporting our workforce: 'Life changing' Learning Disability support

In June 2025 Mid and South Essex NHS Foundation Trust heard from a member of staff at Broomfield Hospital talk positively about the impact that the Supported Internship Programme has had on his life.

Oliver Henson-Webb, 23, from Maldon, has autism and joined the hospital through the Supported Internship Programme at the Trust. He now works as a Healthcare Assistant on the Stroke Unit and has gone from strength to strength, helping to run the Stroke Ambulatory Pathway (SAP) clinic four days a week, taking patients to scans and supporting others on the ward where he can.

Annie Pateman, Senior Ward Sister on the Stroke Ward and his supervisor, said: "Ollie has come such a long way since joining us. His confidence has really grown. He's passed his driving test, chats easily with colleagues and takes real pride in what he does. The SAP clinic feels like his space now and we honestly couldn't be prouder."

Ollie Said: "I was very lucky to meet Annie and my other colleagues. They have been amazing. Annie has supported me from the start and helped me to believe in myself.

Clinical and professional leadership (Stewardship)

The MSE ICS Stewardship Programme has been in place since 2021 and continues to provide a platform for clinical and professional leadership across the system. During 2025/26, ten stewardship groups were active, covering Ageing Well, Babies, Children and Young People, Cancer, Diabetes, Dermatology, Eye Care, Mental Health, Musculoskeletal, Stroke, and Urgent and Emergency Care. Collectively, these groups engaged around 80 frontline staff, supporting system-wide improvement through clinically led collaboration.

An evaluation undertaken in summer 2025, covering the previous two years, demonstrated significant impact. More than 61,700 patients benefited from stewardship led initiatives, with an estimated 7,580 GP appointments avoided, 14,000 acute bed days saved, and £5.1 million released. A wide range of additional quality, access and experience benefits were also delivered.

In recognition of this impact, the Stewardship Programme was shortlisted in November 2025 for the HSJ Integrated Care Programme of the Year Award.

Selected Highlights from 2025/26

<u>Cancer Stewardship</u>

The Cancer Stewardship Group identified challenges within the skin cancer pathway, including poorer than expected patient experience and delays in diagnosis and treatment. By challenging existing ways of working and bringing system partners together, the group supported the introduction of a systemwide tele-dermatology pathway. As a result, performance against the Faster Diagnosis Standard for skin cancer improved from 22% in 2022 to 76%, with only 33% of patients remaining on the urgent suspected cancer skin pathway.

Babies, Children and Young People

The Babies, Children and Young People (BCYP) Stewardship Group worked with children's commissioning colleagues to develop a targeted winter plan focused on improving vaccination uptake. Funding was directed towards a child friendly communication campaign, *Super Bodies*, designed to build confidence among parents and carers and address common myths. The group also led a systemwide vaccination summit, bringing together professionals to explore innovative approaches to improving vaccination uptake across mid and south Essex.

Diabetes

The Diabetes Stewardship Group designed and delivered a patient survey, receiving over 100 responses from residents. This provided valuable insight into patient reported barriers and challenges, enabling priorities to be more closely aligned with patient need and experience.

Dermatology

Variation in the availability of emollients across different localities created challenges for patients receiving care across mid and south Essex. The Dermatology Stewardship Group worked with clinicians across primary, community and secondary care to develop a single, system-wide emollient formulary. The formulary, now published on the ICB website, supports consistent prescribing, patient self-care and improved continuity of treatment.

Eye Care

The Eye Care Stewardship Group addressed inconsistencies in the school vision screening pathway, particularly around follow-up assessment and referral. Working with local authority partners, the group mapped the pathway across all school settings, identifying inequalities in access and safeguarding risks. This work led to:

- Southend Council commissioning screening for independent schools and funding use of the OPERA IT platform to ensure follow-up sight tests were completed and recorded
- Improved access to neurodiversity accredited optometrists through shared provider lists
- An audit of late presentations to hospital eye services to inform future prevention and pathway improvement

Environmental matters (Sustainability)

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

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

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

The phased approach incorporates the disclosure requirements of the following 'pillars': Governance, Strategy, Risk Management, and Metrics and targets. These disclosures are provided below.

Sustainability Governance

Mid and South Essex ICS Greener Plan Programme Board provides oversight and assurance that the ICB and system providers are delivering against the ICS Green Plan and key priority areas outlined below.

Sustainability Risk Management

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

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

Metrics and Targets

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

Our Five Key Priorities:

1. **Reduce Carbon Emissions:**

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

2. **Decrease Pollution:**

    - Minimising waste and eliminating single-use plastics
    - Reducing air pollution across the system
    - Prioritising low/no-carbon product procurement

- Implementation of electric car charging points, sustainable office supplies, reusable cup schemes, enhanced recycling, solar panels and energy-efficient lighting at headquarters

3. **Improve Health and Wellbeing:**

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

4. **Increase Financial Efficiency:**

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

5. **Enhance Reputation:**

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

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

Progress against the MSE ICB Green Plan 2025/26

The following key deliverables were delivered by MSE ICB during 2025/26:

- ICB Greener NHSE Staff Network established, and green champions identified
- Greener NHS intranet page developed for ICB staff
- Cycle to work and lease car schemes introduced, supported by showers and electric car charging points available on site within the ICB headquarters site
- Sustainability Impact Assessment introduced into ICB commissioning processes
- Gloves off campaign introduced by secondary care and community providers launched within primary care
- Greener prescribing programme established which includes:
    - Inhaler disposal scheme

    - Reduction of medicines waste
    - Prescribing of lower carbon inhalers
    - Optimisation of medical gases, including the reduction of nitrous oxide waste
- Sustainability statement included in all job descriptions
- MSE ICB Commissioning Intentions include sustainability compliance measures.

Financial review

Our full statutory financial accounts are included from page 111. This section provides a summary of our 2025/26 12-month financial position. Our Head of Internal Audit offers an opinion on Financial Systems Key Controls and other matters which can be found on page 86. 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 28 of the Annual Accounts section for their full audit opinion).

ICB funding

The MSE ICB in-year total healthcare funding was £3,357.14m and funding for running the ICB (called “running cost expenditure”) was £29.07m, resulting in total overall funding of £3,386.21m. ICB expenditure was £3,386.09m, resulting in £0.12m surplus for the financial year.

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

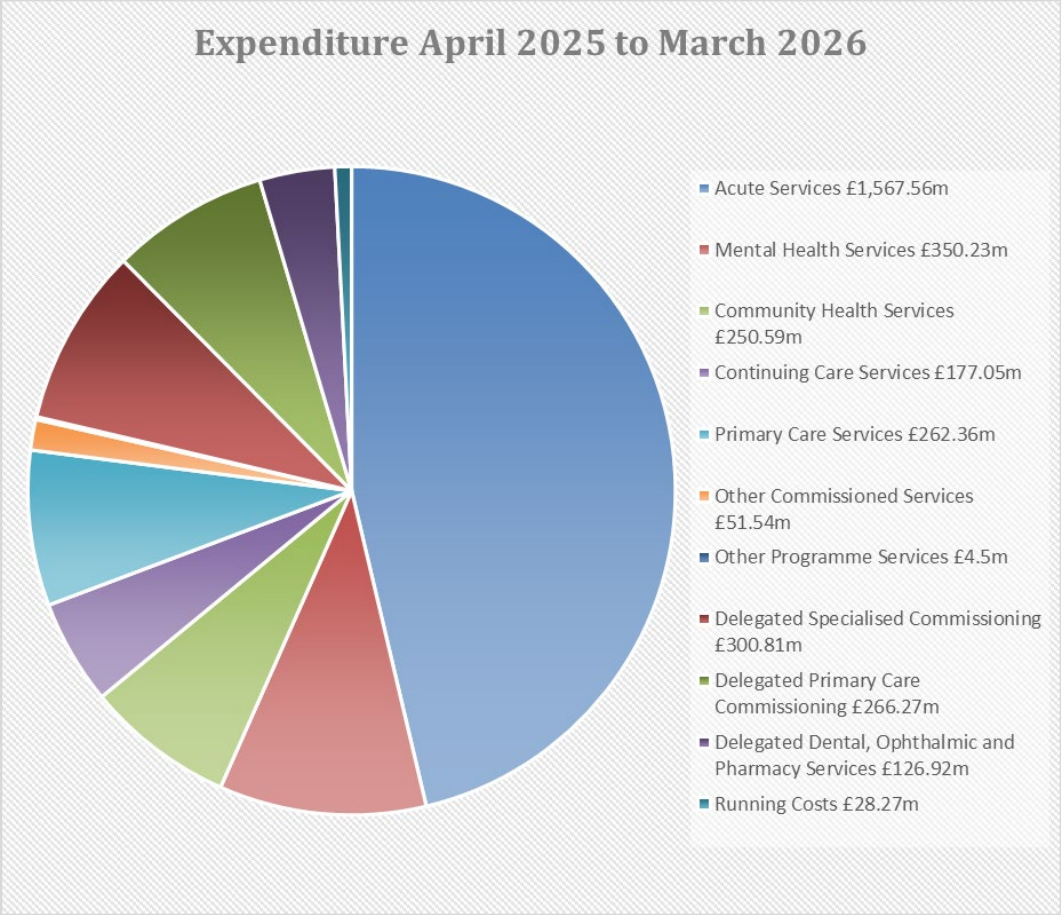
The ICB has a delegated primary medical services budget of £259.4m which included additional funding for Additional Roles Reimbursements (ARRS) for PCNs for commissioning general practice and a delegated budget for commissioning pharmacy, optometry and dentistry of £123.1m. In addition, the ICB has a delegated specialised commissioning budget of £312.8m.

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 2025/26 the ICB has achieved the MHIS by increasing all mental health related expenditure by 4.93%.

How your money was spent

In 2025/26 we spent £3,357.8m on healthcare services and a further £28.3m on running costs, totalling £3,386.1m.

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



Capital spending

The ICB did not receive an individual capital allocation for 2025/26 but accessed primary care capital held by NHSE on behalf of the ICB towards GP IT and primary care estates projects including through the Utilisation and Modernisation Fund.

The ICB did receive a further capital allocation of £0.3m in year reflecting changes to leases for corporate estate in Essex in line with the accounting treatment required under International Financial Reporting Standards – IFRS16 leases.

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 2025/26 the ICB met all four targets (based on invoice numbers and value of expenditure) for NHS and non-NHS invoices (see note 6 of the financial statements for details).

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

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

On the 1 October 2025, ISFE2, a new national finance and accounting system for the ICB, went live replacing ISFE1.

2026/27 financial plans and looking to the future

From April 2026, Mid and South Essex ICB formed Essex ICB together with the geographical areas of north east Essex and west Essex. The change is part of a wider NHS transformation in response to challenging public finances. The reorganisation aims to reduce administrative costs by around 50 per cent while refocusing ICBs on their core role as strategic commissioners.

Existing ICB finance ledgers have been merged to form a newly established Essex ICB ledger from the 1 April 2026.

In line with the NHSE planning process, the 2026/27 Financial Plan was submitted on 31 March 2026 with a breakeven position for Essex ICB. Essex ICB budgets have been built from the consolidated outturn of Mid and South Essex ICB, and the Essex apportionment of Suffolk and North East Essex ICB and Hertfordshire and West Essex ICB. It is expected that Essex ICB will achieve its control total noting any risks and mitigations.

ACCOUNTABILITY REPORT

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

18 June 2026

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026, 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 2026, the composition of the ICB Board was as follows:

- Professor Michael Thorne CBE, Chair
- Tom Abell, Chief Executive Officer
- Dr Giles Thorpe, Executive Chief Nursing Officer
- Dr Matthew Sweeting, Executive Medical Director
- Jennifer Kearton, Executive Director of Finance and Commercial
- 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
- Dawn Scrafield, Mid and South Essex NHS Foundation Trust
- Sarah Muckle, Essex County Council
- Mark Harvey, Southend City Council

- Robert Persey, Thurrock Council
- Dr Anna Davey, Primary Care Partner Member

As at 31 March 2026, the following officers and Associated Non-Executive Members also attended and/or contributed to the Board:

- Prof Shahina Pardhan, Associate Non-Executive Member
- Dr Geoffrey Ocen, Associate Non-Executive Member
- Mark Bailham, Associate Non-Executive Member
- Prof. Sanjiv Ahluwalia, Associate Non-Executive Member
- Emily Hough, Executive Director of Strategy
- Michael Watson, Executive Director of Corporate Services
- Beverley Flowers, Executive Director of Neighbourhood Health
- Sam Goldberg, Executive Director of Planning

Committee(s), including Audit Committee

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

Register of Interests

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

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

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

Oversight of conflicts of interest arrangements during 2025/26 was further supported through independent review activity, which confirmed that the framework in place remained effective and consistent with the previous year.

Personal data related incidents

There are processes in place for incident reporting and investigation of serious incidents. One serious incident requiring investigation involving personal data was reported to the Information Commissioner in 2025/26. The Information Governance section of the report provides further detail regarding how this was managed.

Modern Slavery Act

The ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Modern Slavery Act statement for the period ending 31 March 2025 is published on the website at Modern Slavery Act statement — Mid and South Essex Integrated Care System (ics.nhs.uk) [hyperlinks] Our statement for 31 March 2026 is published on the Essex ICB website Modern slavery act statement - NHS Essex Integrated Care Board.

Statement of Accountable Officer's responsibilities

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

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

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

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

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of the Mid and South Essex Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public

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

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

Tom Abell
Chief Executive of Mid and South Essex Integrated Care Board
18 June 2026

Governance Statement

Introduction and context

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

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

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

Between 1 April 2025 and 31 March 2026, the ICB was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The ICB's Constitution, which is based upon the NHS England ICB model constitution template, was approved by the Board at its inaugural meeting on 1 July 2022. Updates to the Constitution included changes to reflect organisational change and a new Executive Team structure, and a revision approved in December 2025 to account for changes required by NHS England. 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 59, within the Members Report.

The Board met in public on five occasions during 2025/26. Four of these meetings were held at different venues across MSE as well as being livestreamed, with the recording published on the ICB website. The fifth, an extraordinary meeting of the Board in October 2025, was held online, but remained open to the public to attend. Members' attendance at Board meetings is recorded. Each meeting was well attended and was quorate.

The Board also held one extraordinary meeting in private in April 2025 to approve the Operational Plan.

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

There were no urgent decisions required between scheduled Board meetings.

Board seminars were held to further the development of the Board, undertake training, and discuss topical and emerging issues, such as the restructuring of the Safeguarding Team, the organisational change process, risk management, primary care provider collaboration, ICB transitional governance, developing the proposed Essex ICB strategy, development of neighbourhood health in Essex, and the future role and responsibilities of ICBs, particularly in relation to quality.

Board development sessions included a focused seminar on risk appetite and risk management in July 2025, alongside sessions on transitional governance arrangements and the future role of the ICB, supporting the Board to strengthen its oversight and preparedness for organisational change.

The Board formally reported the outcome of its self-assessment of effectiveness undertaken in the early part of 2025 at its Part I meeting in September 2025. The review identified areas of strength and opportunities for further development, particularly in relation to system leadership, risk oversight and supporting organisational transition. A review of effectiveness for the current year was not carried out because of the organisational change process and the Mid and South Essex ICB ceasing to exist from 31 March 2026.

Learning from the Board effectiveness review informed the Board's approach to transition and governance arrangements during 2025/26 and will be carried forward into the development of the new Essex ICB Board. A Board development plan for the new Essex ICB will reflect on any lessons from the three Boards operating across Essex.

ICB Committees

To support the Board in carrying out its duties effectively, committees reporting to the Board are formally established to provide assurance on matters within each

committee's remit as set out in their terms of reference. The current committee structure is set out below.

Essex Joint Committee

To support transitional governance arrangements in preparation for the establishment of Essex ICB from 1 April 2026, the three Essex ICBs agreed to establish the Essex Joint Committee (EJC) with delegated responsibility for discharging certain commissioning functions across the Essex geography.

The EJC's primary purpose was to enable collaborative decision-making across the three ICBs on services spanning the Essex footprint. While the EJC facilitated joint working, each sovereign ICB remained fully accountable for its statutory responsibilities, including the delivery of its agreed 2025/26 financial plans.

The EJC first met in public on 20 November 2025 and held two further meetings in public. These meetings replaced the usual MSE Board meetings from January 2026. The EJC also held two extraordinary confidential meetings in December 2025 and February 2026, with planning for 2026/27 discussed at both meetings and the draft Population Health Improvement Plan at the latter.

Three associated Joint Essex sub-committees (Executive; Quality; and Finance and Performance) were established to further support Essex-wide decision making during the transition period. Further information on the work of these sub-committees is detailed under each respective MSE ICB Committee section below.

Audit Committee

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

As of 31 March 2026, the committee comprised of three members (with the fourth partner member position being vacant). The committee was chaired by George Wood, Non-Executive Member of the Board.

During 2025/26, the committee met on six occasions. Decisions were quorate in line with the committee's terms of reference (minimum of two members) on all occasions. There were two urgent decisions taken between meetings, relating to the Provider Selection Regime Annual Report (to meet the required timescales for publication) and to approve changes to the ICB's Information Governance Policy and Framework prior to the annual Data Security Protection Toolkit submission.

The committee continued to focus upon ensuring the review of the systems, policies, procedures, and processes fundamental to the governance of the organisation. Minutes

of ICB sub-committees reporting to the Audit Committee were also received to provide the committee with oversight of established governance.

The committee reviewed the ICB's draft accounts and approved the final accounts and management response to the auditor for 2024/25 on behalf of the Board. The committee also received assurance from internal audit of key systems and processes and, in addition to routine reporting, received updates on counter-fraud initiatives and investigations and implementation of audit recommendations.

The committee regularly reviewed the ICB's Board Assurance Framework (BAF), including undertaking 'deep dives' of several BAF risks, including those associated with ICB transition, and maintained oversight of associated risk management processes and procedures.

In line with NHS England guidance on the management of conflicts of interest, the Chair of the Audit Committee acts as the ICB's Conflicts of Interest Guardian and Freedom to Speak Up Guardian. Assurance that the ICB was adhering to NHS England mandatory guidance on the management of conflicts of interest was received via the annual internal audit of conflicts of interest for 2025/26 which supported the previous year audit opinion of 'substantial' assurance.

The committee undertook a review of its effectiveness during 2025/26. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference.

Remuneration Committee

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

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

As of 31 March 2026, the committee comprised of three members. The committee was chaired by Joe Fielder, Non-Executive Member of the Board.

During 2025/26 the committee met on eleven occasions. Decisions were quorate in line with its terms of reference (minimum of two members) on all occasions, except one meeting, following which arrangements were implemented to ensure that all decisions taken were quorate. The work of the committee focussed upon approval of new and revised people policies, approval of very senior managers' remuneration, review of ICB workforce key performance indicators, off-payroll contracts, oversight of the Executive consultation process, review of the outcome of the Fit and Proper Persons Test, the

ICB's Workforce and Disability Race Equality Standard reports and Gender, Ethnicity and Disability Pay Gap reports, approval of voluntary/compulsory redundancies and ratification of any urgent decisions taken between meetings.

The committee undertook a review of its effectiveness during 2025/26. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference.

Quality Committee

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

Key areas reviewed by the committee included arrangements for monitoring the quality of provider contracts; quality and patient safety policies and procedures; review of provider Quality Accounts 2024/25; updates on patient safety; special educational needs and disabilities (SEND) and learning disabilities services; infection prevention and control; safeguarding; all age continuing care; review of patient safety and quality risks; medicines optimisation; mental health services (including an update relating to action taken by providers following the Greater Manchester Mental Health Report and the independent review following tragic circumstances in Nottingham in June 2023); babies, children and young people; community services; maternity services; palliative and end of life care; and patient experience/complaints.

Deep-dive reviews into maternity services, drugs of dependency, children's vision screening programme and community pharmacy, were also discussed by the committee.

The committee is also notified of escalations from the System Quality Group and emerging concerns, for example inspections undertaken by regulatory bodies, such as the Care Quality Commission (CQC), and the outcome of inquests and inquiries, The committee considers if further action is required and/or if any matters need to be escalated to the Board at each meeting.

No urgent decisions were taken outside of formal committee meetings during 2025/26.

The Quality Committee met on four occasions between April and November 2025, following which Essex-wide quality related business was conducted by the Essex Joint Quality Sub-committee (EJQSC) as detailed below.

Decisions were quorate in line with the committee's terms of reference (minimum of six members) on all occasions.

The committee comprised of fifteen members, including representation from main provider organisations and the ICB's Patient Safety Partner. The committee was chaired by Dr Neha Issar-Brown, Non-Executive Member of the Board, with Prof. Shahina Pardhan, Associate Non-Executive Committee acting as Deputy Chair.

The committee undertook a review of its effectiveness during 2025/26, which also took account of the work of the EJQSC. This assessment identified both had effectively discharged their duties as set out in their terms of reference.

Essex Joint Quality Sub-committee

To further support transitional governance arrangements, the EJQSC was established as a sub-committee of Essex Joint Committee.

The sub-committee first met in December 2025 and again in February 2026. The sub-committee's workplan followed that of the MSE ICB Quality Committee, with the addition of updates on quality priorities within west and north east Essex.

As of 31 March 2026, the sub-committee comprised of fifteen members, including representation from west and north east Essex, main provider organisations across the whole of Essex, local authority and Health Watch representation and the ICB's Patient Safety Partner. The committee was chaired by Dr Neha Issar-Brown, Non-Executive Member of the MSEICB Board, with Prof. Shahina Pardhan, Associate Non-Executive Member (MSEICB) acting as Deputy Chair.

Decisions were quorate in line with the committee's terms of reference (minimum of six members) on all occasions.

Finance and Performance Committee

The Finance and Performance 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 undertook 'deep dive' sessions on areas of performance and financial risk, this included sessions focusing on referral to treatment waiting times; urgent and emergency care, all age continuing care; and cancer; and supported transitional arrangements in preparation for the new Essex ICB.

The committee met on nine occasions during the year, with one planned meeting being cancelled because required business related to Essex rather than MSE. The committee itself was however operational throughout the year to monitor the finance and performance of the ICB. Decisions were quorate in line with the committee's terms of reference (minimum of four members) on all occasions. There were no urgent decisions taken between meetings. From December 2025 Essex-wide finance and performance related business was conducted by the Essex Joint Finance & Performance Sub-committee (EJFPSC), as detailed below.

The committee undertook a review of its effectiveness during 2025/26, which also took account of the work of the EJFPSC. This assessment identified both committees had effectively discharged their duties as set out in their terms of reference.

Essex Joint Finance & Performance Sub-Committee

To further support transitional governance arrangements, the EJFPSC was established as a sub-committee of Essex Joint Committee.

From December 2025, the sub-committee met on three occasions and in addition, on one occasion provided approval of papers virtually via email. The sub-committee's workplan followed that of the MSE ICB Finance & Performance Committee, with the addition of updates on finance and performance issues from west and north east Essex. All decisions made by the committee were quorate, with some business being conducted outside of the meeting to facilitate timely decision-making.

As of 31 March 2026, the sub-committee comprised of nine members, including Non-Executive Member representation from west and north east Essex. The committee was chaired by Joe Fielder, Non-Executive Member of the Board (MSEICB), with Mark Bailham (MSEICB), Associate Non-Executive Member acting as Deputy Chair.

System Oversight and Assurance Committee

The primary purpose of the System Oversight and Assurance Committee was to bring partners together for mutual accountability of system overall performance according to the requirements of relevant legislation, the NHS Constitution and NHS England (assessed through the NHS England Oversight Framework). To support this, deep dive reviews of significant system risks were undertaken. During 2025/26 these related to: mental health risks, primary care access, and All Age Continuing Care and Discharge to Assess.

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

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

The committee met on three occasions between April and September 2025. All meetings were quorate. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

The committee also held separate confidential meetings, chaired by the Regional Director of Finance, NHS England, specifically to provide oversight of MSEFT's progress with delivery of its agreed National Oversight Framework Level 4 (NOF4) exit criteria. Between April 2025 and September 2025 five confidential meetings were held.

Due to transitional governance arrangements implemented in preparation for the establishment of Essex ICB and other changes within the wider NHS, the committee was dis-established in late 2025, with monitoring of MSEFT's progress against its agreed NOF4 exit criteria undertaken via meetings between the Trust and NHSE.

A desktop review of the committee's effectiveness during 2025/26 was undertaken which confirmed that the committee had met its responsibilities as set out in its terms of reference.

Primary Care Commissioning Committee

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

The committee received reports on primary care contracts, proposed branch closures and mergers, the quality and safety of primary care services, primary care finance including the implications of the ICB's running costs reduction programme, Integrated Neighbourhood Team development, and primary care workforce. Issues relating to primary care premises and information and technology were also considered by the committee.

Virtual approval of three urgent decisions between meetings was also sought regarding: approval of the outcome of the Local Dispute Resolution Panel – Dental Contract Dispute; approval of proposed changes to the operational hours of North Chelmsford Healthcare Centre, and approval of the proposed relocation of Westcliff Medical Centre surgery.

As of 31 March 2026, the committee had eight members. The committee was chaired by Professor Sanjiv Ahluwalia, Associate 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 twelve occasions during 2025/26, with two meetings held in the latter part of the financial year including representation from west and north east Essex. Decisions were quorate in line with the committee's terms of reference (minimum of four members) on all occasions, including virtual decisions which were ratified at subsequent meetings.

The committee undertook a review of its effectiveness during 2025/26. This assessment identified that the committee had effectively discharged its duties as set out in its terms of reference.

Clinical and Multi-Professional Congress

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

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

During 2025/26 the work of Congress included reviewing and endorsement of several service restriction policies, provision of feedback on the approach to the National Institute for Health and Care Excellence Technology Appraisals and on the Scans and

Guided Injections for Shoulder Pain Service Restriction Policy. The Committee also received updates on the Community Services Decision Making Business Case and the elective care specifications.

As of 31 March 2026, the Committee's terms of reference state that its membership may comprise of up to 15 members. Congress was chaired by Dr Matt Sweeting, Executive Medical Director. Meetings were also attended by other senior managers with specific responsibility for areas within the Committee's remit.

Congress met on five occasions during 2025/26 and also considered several SRPs and a review of the Assertive Outreach Service virtually. Quorum was not achieved at all meetings; however, papers were circulated to give all members an opportunity to comment on proposals and achieve quorate decisions.

Congress undertook a review of its effectiveness during 2025/26. This assessment identified that it had effectively discharged its duties as set out in its terms of reference, although attendance at meetings had been challenging.

Executive Committee

The Executive Committee provides oversight and assurance regarding the operational management of the ICB, including scrutiny of proposed business cases, making recommendations regarding strategic direction, providing support for investment in line with the ICB Scheme of Reservation and Delegation, and identification of key issues and risks requiring discussion by or escalation to the Board.

Membership of the committee as of 31 March 2026 comprised of the seven executive ICB Board members.

During 2025/26, committee business focussed on oversight of the ICB's 'Triple Lock' process to ensure robust scrutiny of expenditure; review of business cases and commissioning decisions; introduction of the ICBs 'goal pack' programme, which included oversight of the internal performance of the ICB; oversight of internal performance and workforce figures; and development of the ICB's transition programme, structures and staff change process to achieve the nationally mandated reduction in its running costs.

Decisions taken by this committee were routinely reported within the Chief Executive's report to public Board and Essex Joint Committee meetings.

The committee undertook a review of its effectiveness during 2025/26. This assessment identified that it had effectively discharged its duties as set out in its terms of reference.

<u>Essex Joint Executive Sub-Committee</u>

To further support transitional governance arrangements, the Essex Joint Executive Sub-Committee was established as a sub-committee of Essex Joint Committee to perform the same functions as the MSE Executive Committee when discussing Essex-wide issues. The sub-committee's membership included colleagues from west and north east Essex. Meetings were held fortnightly and all decisions made by the committee were quorate.

Digital, Data and Technology Board

The Digital Data and Technology (DDaT) Board provides oversight and assurance to the Board in the development and delivery of relevant IT related/Digital services commissioned by the ICB, mitigating risk as appropriate in the context of system working.

The Committee's key achievements included: oversight and assurance on delivery of development and approval of a revised Digital Strategy for 2025-28; oversight of the successful completion of the Digital Social Care Record programme; continued oversight of the Shared Care Record, Patient Knows Best, NOVA programmes and the HSCN CoIN procurement; the amalgamation of the IG and Cyber Security Steering Groups; oversight of Cyber Assessment Framework (CAF) aligned Data Security Protection Toolkit (DSPT) submission; and holding collaborative discussions to establish a system-wide strategic digital transformation proposal for the future of Essex digital services post 1 April 2026.

As of 31 March 2026, the committee had 17 members. The Committee was chaired by Paul Scott, Chief Executive Officer of EPUT. Committee meetings were also attended by other senior managers with specific responsibility for areas within the committee's remit.

DDaT Board met on five occasions during 2025/26 Decisions were quorate in line with the committee's terms of reference (minimum of five members). No urgent decisions were taken between meetings.

The Committee undertook a review of its effectiveness during 2025/26. This assessment identified that the Committee had effectively discharged its duties as set out in its terms of reference.

People Board

The purpose of the People Board (a sub-committee of the ICB Board) is to provide the ICB with assurance that it is delivering its functions and undertaking its responsibilities to deliver workforce related activities carried out by the ICB as an employer, and to collaborate with partner organisations to build and develop the system's workforce.

During 2025/26 the People Board focussed on: implementing a robust governance structure with workstreams and subgroups working to remits stated in the workplan; improved attendance from strategic leaders across the system; regularly receiving assurances from our providers; development of the workforce dashboard; improved partnership working with whole system; improvement as a system regionally.

As of 31 March 2026, the Committee had 16 members. The Committee was chaired by Joe Fielder, Non-Executive Member of the Board. Committee meetings were also attended by other senior managers with specific responsibility for areas within the Committee's remit.

The Committee met on five occasions during 2025/26. Decisions were quorate in line with the Committee's terms of reference (minimum of four members) on all occasions. There were no urgent decisions taken between meetings.

The Committee undertook a review of its effectiveness during 2025/26. This assessment identified the Committee had effectively discharged its duties as set out in its terms of reference.

Alliance Committees

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

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

Better Care Fund (including Improved Better Care Fund) governance

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

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

Utilisation of the BCF funds (including discharge fund) was in line with national guidance and as detailed within the section 75 agreements. Reporting focused on expenditure on the approved services and performance against the nationally defined metrics and was delivered both to the Alliance Committees within the ICB for internal governance and to the relevant Health and Wellbeing Board as required under the national BCF policy Framework.

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

Discharge of Statutory Functions

The ICB has reviewed the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

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

The ICB's Risk Management Policy, which encompasses clinical and non-clinical risks, is based on the Australia/New Zealand risk management model, is compliant with the principles of 'The Orange Book: Management of Risk' and sets out the risk management system, supporting processes and reporting arrangements which aim to protect patients, the public, staff and the ICB's assets and reputation.

The Policy includes the ICB's Risk Appetite Statement, which assists managers to identify when risk levels are tolerable or where further action is required to reduce risk ratings to an acceptable level. The Board reviewed its risk appetite in July 2025.

Risks recorded on the ICB's risk management database are mapped against the ICB's Strategic Objectives, updated and approved by the ICB Board in July 2025, along with responsible directorates, risk leads and committees.

The ICB identified its top strategic areas of risk which are monitored via the ICB's Board Assurance Framework (BAF). During 2025/26, these risk areas were:

- **Workforce** – risks associated with the ICB and partner organisations not taking effective action to improve recruitment and retention of permanent staff to reduce reliance on bank / agency staff; and not taking effective action to ensure there is a reliable pipeline of staff to fill future vacancies.
- **Primary care** – risk that the intentions of the Primary Care Strategy and development of Primary Care Networks will not be realised.
- **Primary Care Estates (Capital)** – risks associated with insufficient capital to support all system needs, reducing our ability to invest in new opportunities, for transformational impact.
- **Quality Assurance of Services** – risk that people experience poor quality of services, have a poor experience and negative outcomes of harm.

- **Access to Services** – risk of not meeting relevant NHS constitutional or operational performance standards.
- **System financial performance** – risk that organisations within the MSE system control total do not deliver the required financial plans / efficiency savings.
- **Transition Risks** – risk that the creation of a new ICB geography and organisation at reduced cost will not be able to deliver core functions and transformational changes in the Medium-Term Plan.

The BAF is reviewed by the Audit Committee and by the ICB Board / Essex Joint Committee at publicly held meetings. The Executive Committee regularly reviews the BAF and all red-rated risks. Other ICB committees also maintain oversight of risks on the BAF that link to their terms of reference and underlying risks within their remit.

The ICB participated in an NHS England pilot for assessing and managing risks across integrated care systems in line with guidance issued by the National Quality Board. This involved bringing partner organisations together in early 2025/26 to assess two specific service areas where the patient pathway cut across different system partners, these being Palliative and End of Life Care and the Mental Health Urgent Emergency Care pathway.

While the changing role of ICBs moves away from system working, the pilot will inform a new approach to the risk framework of Essex ICB ensuring the principles set out by the National Quality Board are used to address risks that sit across organisations as well as the ICB.

Capacity to handle risk

During 2025/26 the ICB had the following arrangements in place:

- A risk management database (Datix) which records clear ownership of risks, with responsible directors and lead officers identified.
- Training and readily accessible support for staff in the use of the Datix database, supplemented by a risk management session delivered at an ‘all staff’ briefing.
- Regular reporting to committees regarding risks within their remit.
- Escalation arrangements in place to the ICB Board and/or other appropriate forums.
- A Board Assurance Framework within which the latest updates from lead officers were recorded and reported to relevant committees and the Board.
- Recording and investigation processes for incidents, including identification of learning.
- Triangulation of learning from incidents, complaints, and claims (should they arise) via reporting to Quality Committee.
- Monitoring of completion of Equality and Health Inequality Impact Assessments, Quality Impact Assessments and Privacy Impact Assessments.

- Regular review of anti-fraud, bribery, and security arrangements by the Audit Committee.
- Emergency planning, resilience and response and business continuity management policies and procedures.
- Health & Safety Working Group and associated policies and procedures.

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

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

Stakeholders, including staff, patients and the public are involved in the risk management process, for example by ensuring that relevant staff are identified to input into any risk assessments in their function or area of work and reviewing risks at both committee and Board level to encourage maximum input from stakeholders. ICB staff and contractors are made aware of agreed risk reporting procedures and contracts clearly stated the responsibilities of contracted personnel about risk identification, reduction, mitigation, and reporting. Feedback on risk issues is encouraged via the ICB's complaints and enquiries services and through its public engagement and consultation mechanisms, for example, patient stories at Quality Committee meetings, engagement with the public and other stakeholders on the ICB's plans for services, such as the public consultation on community beds.

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

Risk assessment

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

- Commitment to identifying the underlying or root causes of incidents, complaints, and claims (should they arise).
- Promoting an open, just, and non-punitive culture.

- Driving an ongoing information and education programme which empowers and supports Board members and staff in the risk management process generally, and in relation to specific areas of risk.
- All staff being familiar with the anti-fraud, anti-bribery, and security policies and through training and raising awareness via the issuing of fraud alerts, guided by the ICB counter-fraud services.
- All staff being familiar with the terms of the Conflicts of Interest, Gifts and Hospitality and Standards of Conduct Policies.
- Registers of Interests being produced for Board and committee meetings and those sub-committees with decision-making powers, or capacity to influence decisions made by the ICB, so that the relevant Chair can ensure that potential, perceived or real conflicts of interest are managed appropriately.

Other sources of assurance

Internal control framework

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

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

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

Annual audit of conflicts of interest management

An independent review of Conflicts of Interest arrangements was undertaking during 2025/26 by the Counter Fraud Service. This review confirmed that established policies, procedures and controls remained in place and were operating as intended, with no significant issues identified.

The review provided assurance that the ICB continues to maintain a robust framework for the identification, declaration and management of conflicts of interest, consistent with NHS England guidance and the ICB's Conflicts of Interest Policy.

Data Quality

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

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Cyber Assurance Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The ICB submitted a "Standards Met" Data Security and Protection Toolkit (DSPT), which was supported by a very Low risk and High confidence level in the internal audit of the DSPT submission.

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 information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for the reporting, investigation and management of information governance incidents. One incident involving personal data was notified to the Information Commissioner's Office (ICO) during 2025/26. While the DSPT reporting tool did not consider the incident to meet the statutory reporting threshold to raise it with the ICO, the ICB chose to report it proactively in light of the wider context. The incident has been investigated, actions were taken to reinforce existing controls, and learning was shared to reduce the risk of recurrence. We are awaiting further correspondence from the ICO.

The Freedom of Information (FOI) Act 2000 gives a general right of access to recorded information held by public authorities, subject to certain conditions and exemptions.

The ICB received 453 FOI requests during 2025/26. The ICB responded to 98% of these within the statutory timescale of 20 working days.

We certify that we have complied with HM Treasury's guidance on setting charges for information.

Complaints and Patient Experience

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

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

From April 2025 to March 2026, there was a total of 1,862 new complaints, concerns and enquiries opened, and 1,897 closed, excluding those carried forward from 2024/25.

Current Trends

Analysis of themes arising from complaints, concerns, and enquiries indicates that the most frequently raised issues during the reporting period related to the following areas:

1. Access to treatment or drugs
2. Patient care
3. Appointments
4. Communications
5. Values and behaviours (staff)

It should be noted that there was a marked increase in concerns relating to Shared Care Arrangements for ADHD medication, largely associated with GP collective action. However, when this factor is excluded, access to treatment or drugs would remain the most commonly reported concern.

These themes broadly reflect the pressures experienced across health services during the year, particularly in relation to service demand, waiting times, and communication with patients and families. While many concerns relate to access and coordination of care, the data also highlights the continued importance of maintaining high standards of patient experience, staff professionalism, and clear communication.

In 2025/26, 8 complaints were referred to the Parliamentary and Health Services Ombudsman (PHSO). Open cases as at 31 March 2006 will be tracked and closed by the new Essex ICB.

Business critical models

The ICB supports the principles of the Macpherson Report and is committed to embedding best practice in relation to quality assuring our prioritised business critical models and other functions. Work will be on-going in 2026/27 to fully identify all business-critical models used by the ICB to gain assurance over their use in accordance with NHSE guidance.

Third party assurances

The ICB relies on several third-party providers for the provision of payroll and pension services, procurement advice and commissioning support (highlighted below). All service auditor reports summarised below were issued on the basis of providing assurance limited to the scope of their review according to the testing undertaken.

Attain – Procurement advisors

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

NHS Business Services Authority – Electronic Staff Record (ISAE 3000 Type II)

A Type II ISAE 3000 report was received for the Electronic Staff Record system covering the period 1 April 2025 to 31 March 2026. The independent service auditor, *Grant Thornton LLP* concluded that the system was fairly presented and that controls were suitably designed and operating effectively to meet the control objectives throughout the period, where complementary controls were applied.

NHS England – GP Data Services (ISAE 3000 Type II)

The Integrated Care Board received a Type II ISAE 3000 controls assurance report from NHS England in respect of the extraction and processing of General Practitioner data services for the period 1 April 2025 to 31 March 2026. The independent service auditor, *PriceWaterhouseCoopers LLP* concluded that, except for specific control deficiencies, the system was fairly presented, and controls were suitably designed and operating effectively to achieve the stated control objectives. The report identified weaknesses relating to user access management controls and segregation of duties between development and production environments, resulting in a qualified opinion.

NHS Commissioning Support Units – Payroll and Non-Clinical Procurement (ISAE 3000/3402 Type II)

A Type II service auditor report was received covering payroll and non-clinical procurement services delivered by the NHS Commissioning Support Units for the period 1 April 2025 to 31 March 2026. The independent service auditor report from *Deloitte LLP* confirmed that controls were, in all material respects, suitably designed and operating effectively throughout the period. One control exception relating to late processing of a payroll recovery action was identified, which was attributed to human error and was not considered indicative of wider control failure.

NHS Commissioning Support Units – CQRS (ISAE 3000/3402 Type II)

The Integrated Care Board received a Type II report covering the Calculating Quality Reporting Service (CQRS), primarily an approval, reporting and payments calculation

system for General Practitioner (GP) Practices, for the period 1 April 2025 to 31 March 2026. The independent service auditor, *Deloitte LLP* provided a report that confirmed controls supporting change management, access management and data processing were suitably designed and operating effectively, with no management control failures identified during the reporting period.

Capita Primary Care Support England – Payments and Pensions (ISAE 3402 Type II)

A Type II ISAE 3402 report was received from Capita in respect of Primary Care Support England services for the period 1 April 2025 to 31 March 2026. The independent service auditor, *Forvis Mazars LLP* issued a qualified opinion due to isolated control exceptions relating to data accuracy in pension records and insufficient validation of changes to bank details in a small number of cases. Subject to these matters, the report concluded that the system was fairly presented and that controls were suitably designed and operating effectively.

NHS Shared Business Services – Finance and Accounting (ISAE 3402 Type II)

The Integrated Care Board received a Type II ISAE 3402 report from NHS Shared Business Services covering finance and accounting services for the period 1 April 2025 to 31 March 2026. The independent service auditor, *PriceWaterhouseCoopers LLP* concluded that the system was fairly presented and that controls were suitably designed to provide reasonable assurance and were operating effectively to achieve the stated control objectives throughout the period, subject to the operation of complementary user controls.

NHS Business Services Authority – Prescription Payments (ISAE 3402 Type II)

The Integrated Care Board received a Type II ISAE 3402 report from the NHS Business Services Authority covering the Prescription Payments Process System for the period 1 April 2025 to 31 March 2026. The independent service auditor, *Grant Thornton LLP* issued an unqualified opinion, concluding that the system was fairly presented and that controls were suitably designed and operating effectively to meet the relevant control objectives throughout the period, where complementary controls were also in place.

NHS Business Services Authority – Dental Payments (ISAE 3402 Type II)

The Integrated Care Board received a Type II ISAE 3402 report from the NHS Business Services Authority in respect of the Dental Payments Process System for the period 1 April 2025 to 31 March 2026. The independent service auditor, *Grant Thornton LLP* concluded that the description of the system was fairly presented and that the controls were suitably designed and operating effectively to achieve the stated control objectives throughout the period. The report provides reasonable assurance over the completeness and accuracy of payments and the integrity of the control environment, subject to the operation of complementary controls by user entities and subservice organisations.

Control issues

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

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

Performance against cancer constitutional standards – oversight of cancer performance was via the national fortnightly tier one meetings and the MSE Cancer Oversight and Assurance Board, with escalations via the System Oversight and Assurance Committee (SOAC), with a focus on recovery of both the faster diagnosis standard and 62-day standards. The cancer alliance pathway analyser tool was used to identify actions to support recovery of cancer pathways and to identify where actions can be taken to improve performance by reducing delays in the pathway. Task force groups for urology, skin, breast and gynae pathways have been operating to focus on pathway interventions. Harm reviews, workforce reviews, patient tracking list management, multi-disciplinary team and diagnostic improvements have been the focus to improve performance.

Elective recovery – Performance against elective recovery and referral to treatment standards is being actively managed through robust system-level oversight and targeted improvement actions. Oversight is provided via the National Fortnightly Tier One Meetings, MSE ICB Elective Oversight and Assurance Board and escalation to the System Oversight and Assurance Committee, with a clear focus on reducing 65+ week waits, improving referral to treatment (RTT) performance and moderating waiting list growth. Key mitigations include large-scale patient transfers to independent sector and community pathways, commissioning additional mutual aid capacity from Elective Orthopaedic Centres, and focused task-and-finish work with providers to improve Advice and Guidance responsiveness. Further actions include commissioning new community dermatology and MSK/pain services, pathway redesign for ENT (Ear, Nose and Throat) and Audiology, maintaining GP direct access diagnostics during the transition to Community Diagnostic Centres, and implementing the MSE Patient Choice Policy to improve access and patient flow

Diagnostics – The risk to delivery of the DM01 diagnostic standard is being actively managed through strengthened system governance, close partnership working and focused mitigation of capacity and infrastructure constraints. Oversight of diagnostic performance and community diagnostic centre (CDC) delivery is provided through the MSEFT CDC Programme Board, reporting into the MSE ICB System Diagnostic Board, with issues escalated to the ICB Executive as required. The ICB and Trust continue to work jointly with NHS England on CDC funding, build timelines and performance, ensuring regular assurance on actions to mitigate delays arising from workforce shortages, constrained diagnostic capacity and slower-than-planned infrastructure development. This approach is intended to protect patient outcomes, manage financial impact and support recovery of diagnostic performance to national standards.

Transition – The transition of commissioning and oversight functions under the ICB Operating Model Blueprint carries inherent risk due to uncertainty over the timing, sequencing and scale of function transfer, alongside the ICB's requirement to reduce its workforce in line with mandated running cost limits. This creates a risk that, during the transition period, the ICB may retain responsibility for critical functions with reduced capacity and reduced corporate memory, potentially impacting assurance and delivery. This risk is being mitigated through strengthened due diligence and assurance arrangements, structured transition and handover planning, and proactive capture and transfer of specialist knowledge. The ICB is prioritising its most critical statutory and strategic functions during the transition period and using a central programme management approach to track risks, oversee capacity and dependency management, and maintain continuity of essential commissioning, quality and performance oversight as responsibilities evolve across the system.

Accident and Emergency – Urgent and Emergency Care (UEC) performance across Mid and South Essex remains under pressure due to system-wide patient flow constraints, impacting emergency department flow and ambulance handover performance. This risk is being addressed through a coordinated, system-wide improvement programme led by the ICB with MSEFT and EEAST, overseen through the UEC Oversight and Assurance Board. Key actions include pathway redesign, strengthened contract and performance management, workforce optimisation and improved digital support. Targeted initiatives focus on diverting appropriate demand through the Unscheduled Care Coordination Hub, implementing a system-wide single point of contact for ambulance crews, and applying the ambulance handover escalation policy via the System Control Centre. Progress and assurance are monitored by senior ICB leaders and reported through NHS England, the Board Assurance Framework and the Audit Committee

All Age Continuing Care (AACC) – The ICB has identified a backlog of potential Court of Protection and Deprivation of Liberty (CoPDoL) applications following a comprehensive Continuing Healthcare (CHC) caseload review, which presents residual legal, reputational and patient experience risks. This risk is being mitigated through the implementation of a new AACC Operating Model in 2026/27, moving to a workstream-based approach, alongside the establishment of a dedicated CHC CoPDoL team supported by legal expertise. These actions will strengthen case management, improve oversight and provide a more sustainable approach to meeting statutory responsibilities.

Patent Safety (Maternity and Paediatrics) – Quality risks within maternity and paediatric services are being actively managed through strengthened governance, external oversight and targeted improvement arrangements. The Section 31 Notice for Basildon maternity services has now been lifted, while improvement actions for Broomfield maternity services, where a Section 31 Notice remains in place, are overseen through enhanced reporting to the Local Maternity and Neonatal System (LMNS) and associated safety forums, with the ICB Chief Nursing Officer acting as Senior Responsible Officer (SRO). Trust-wide maternity improvement is supported through the MSEFT Perinatal Assurance Group with external stakeholder involvement.

In paediatrics, following a Section 29a Notice and earlier ICB-initiated Rapid Quality Review, a sustained programme of quality improvement is now embedded within NHS England-chaired Quality Summit Review meetings, providing ongoing assurance that governance and care quality improvements are being delivered and sustained across all sites.

Mental health and Dementia – There is an ongoing risk that delays in managing mental health patients in crisis could result in prolonged accident and emergency (A&E) attendances or inappropriate out-of-area placements, impacting patient experience, safety and system cost. This risk is being mitigated through ICB investment in dedicated mental health input to the Integrated Transfer of Care Hub to support patient flow, alongside joint working with EPUT to implement the Time to Care programme to reduce length of stay and reliance on out-of-area placements. Quality and performance are overseen through the monthly Quality, Contracting and Performance Meeting across the Essex footprint, with escalation to the Executive as required. While regulatory requirements and ongoing improvement actions identified through CQC inspections continue to present delivery challenges, remedial action plans are in place and monitored through established governance to support sustained service improvement and assurance.

System financial performance - The system entered 2025/26 with an agreed £106m deficit plan, supported by NHS England deficit funding to achieve breakeven. At month 9 MSEFT revised its forecast outturn. The system continued to operate under enhanced financial oversight arrangements, including the national “triple lock”, with the acute trust in National Oversight Framework level 4 and a Financial Intervention Programme in place. Key cost pressures, particularly workforce and delivery of efficiency plans, are subject to robust recovery governance, with oversight through the People Board, CEO Forum and the ICB Board to support financial control and recovery.

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

The ICB reported a £0.12million surplus for the year, whereas the system reported a deficit of £63.4million. The ICB’s Finance and Performance Committee and the Board each received regular financial reporting during the year and had the opportunity for detailed review of the financial position.

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

The ICB’s 2025/26 running (management) costs were within nationally permitted expenditure limits.

The internal auditor reviewed the ICB’s financial systems and processes, including the arrangements for financial reporting and confirmed that the ICB had substantial arrangements in place. The external auditor’s comments on arrangements for securing economy, efficiency, and effectiveness in use of resources in 2025/26 are included in

their report immediately after the annual accounts (see page 28 onwards of the accounts section).

Commissioning of delegated specialised services

Mid and South Essex ICB has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of functions

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

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

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

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

Counter fraud arrangements

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

There was executive support and direction from the Executive Director of Finance and Commercial for a proportionate proactive work plan to address identified risks. The Executive Director of Finance and Commercial was the identified member of the

executive team named within the Anti-Fraud, Bribery and Corruption Policy who was proactively and demonstrably responsible for tackling fraud, bribery, and corruption.

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

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

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2025 to 31 March 2026 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that, for the areas reviewed during the year, the ICB had reasonable and effective risk management, control and governance processes in place.

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

Assignment	Assurance Opinion
CIC Referrals	Limited
Special Educational Needs and Disabilities (SEND)	Limited
Financial Management	Substantial
Provider Quality Assurance	Reasonable
Risk Management & Board Assurance Framework	Reasonable
All Age Continuing Care – Core Functions	Limited
Key Financial Controls	Reasonable
Commissioning – Independent Sector	Reasonable
Conflicts of Interest (Counter Fraud Report)	Confirmed controls in place
Cyber Assessment Framework (Data Security and Protection Toolkit)	Very Low Risk, High Confidence
Review of transition governance	Advisory Report - arrangements fit for purpose

Action plans have been agreed for areas given limited assurance; with follow-up reviews planned under the Essex ICB Internal Audit plan. The reports did not however identify any control deficiencies that would impact on the annual report and indeed there was no change in the annual audit opinion.

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

My review of the effectiveness of the system of internal control was informed by the work of the internal auditors, executive managers, and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review was also informed by comments made by the external auditors in their annual audit letter and other reports.

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

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

- The Board and Essex Joint Committee
- The Audit Committee and Remuneration Committees.
- Quality (and Essex Joint Quality) Committee, Finance and Performance (and Essex Joint Finance and Performance) Committee
- System Oversight and Assurance Committee.
- Primary Care Commissioning Committee.
- Clinical and Muti-professional Congress.
- Executive Committee / Essex Joint Executive Sub-Committee
- People Board and Digital, Data and Technology Board
- Alliance Committees
- Internal and External Audit.

Conclusion

I concur with the Head of Internal Audit Opinion that during 2025/26 there were reasonable and effective risk management, control and governance processes in place, and that controls have been generally applied consistently.

Action plans to implement any outstanding recommendations from audits were in place and will continue to be monitored during the 2026/27 financial year.

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

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

18 June 2026

Remuneration and Staff Report

Remuneration Report (subject to audit)

Remuneration Committee

For 2025/26 the membership of the remuneration committee was as follows:

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

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

HR and remuneration advice was provided by the Interim People Director and HR business partners, and the committee was informed by local and national guidance on remuneration matters.

Percentage change in remuneration of highest paid director

2025-26	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	7%	n/a*
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	12%	n/a*

The ICB has undertaken a restructure during 2025-26, reducing staff numbers significantly, resulting in an overall reduction in average staff costs. The basis of calculation has been revised to exclude non-exec roles at 31 March 2026 in line with the revised DHSC Group Accounting Manual (GAM).

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

*The ICB has not paid any performance pay or bonuses in 2025-26 or 2024-25.

During 2024-25 the pay ratios increased broadly in line with the NHS pay rise for 2024-25.

Pay ratio information

The purpose of including pay ratios is to provide transparency and accountability. Pay ratios help to demonstrate the fairness and effectiveness of the remuneration policy, particularly for the highest paid director.

They also serve as a benchmark for comparison with the median salary of the workforce, ensuring that the remuneration structure is competitive and just. The pay ratios are calculated using the total remuneration of the highest paid director and the median salary of the workforce.

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

The banded annualised remuneration of the highest paid director/member in Mid and South Essex ICB in the financial year 2025-26 was £235k-£240k (2024-25: £220k-£225k), and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay Ratio information table:

2025-26	25th percentile	Median	75th percentile
Total remuneration (£)	£40,616	£56,908	£70,974
*Salary component of total remuneration (£)	£40,616	£56,908	£70,974
Pay ratio information	5.8 : 1	4.2 : 1	3.3 : 1

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

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

In 2025-26: 0 employees received annualised remuneration in excess of the highest-paid director (2024-25: 0).

During the reporting period 2025-26, remuneration ranged from £26k to £239k (2024-25: £2k to £223k) 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 (AfC) terms and conditions, except for those roles which are subject to the VSM (Very Senior Managers) framework. The salaries of governing body members are determined by remuneration committee with national and local guidance (provided by the Executive Director of Finance and Commercial and Director of Corporate Services (responsible for Human Resources) being considered in all decisions.

Remuneration of Very Senior Managers

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

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

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

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

The ratio is believed to be consistent due to the below:

Nationally Negotiated Frameworks: Because standard NHS salaries are bound by structured, transparent AfC pay bands, the median and lower quartile points of the workforce reflect standardized job evaluations rather than arbitrary pay awards.

Equitable Progression: Pay progression is not automatic; it is conditional upon workers meeting national standards and competencies, ensuring a link between reward and delivery.

Senior manager remuneration (including salary and pension entitlements)

ICB remuneration reports 2025-26

This ICB remuneration report for 2025-26 is shown in two sections, representing the salary and allowances and pension entitlements of the senior leadership of the ICB.

ICB salary and allowances table:

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

ICB pension table:

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

Mid and South Essex ICB Remuneration Report 2025-26

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

Notes	Name	Title	2025/26					Date served	
			Salary (bands of £5,000) £000	Taxable benefits / expenses (nearest £100) £	Other Remuneration (bands of £5,000) £000	All Pension Related Benefits[7] (bands of £2,500) £000	Total (bands of £5,000) £000	Commenced	Ceased
	Executive Directors								
	Tom Abell	Chief Executive Officer	230-235	0	0	0	230-235	08-Aug-24	
1	Jennifer Kearton	Executive Chief Finance Officer	150-155	1600	0	80-82.5	235-240	10-Oct-22	
1	Dr Giles Thorpe	Executive Chief Nursing Officer	160-165	5900	0	0-2.5	165-170	14-Aug-23	
	Dr Matt Sweeting	Executive Medical Director	160-165	0	0	57.5-60	220-225	14-Aug-23	
2	Dr Kathy Bonney	Interim Executive Chief People Officer	0-5	0	0	0	0-5	01-May-24	11-Apr-26
	Governing Body Members								
	Professor Michael Thorne CBE	Chair	65-70	0	0	0	65-70	01-Jul-22	
	Dr Neha Issar-Brown	Non-Executive Member	15-20	0	0	0	15-20	01-Jul-22	
	George Wood	Non-Executive Member	15-20	100	0	0	15-20	01-Jul-22	31-Mar-26
	Joseph Fielder	Non-Executive Member	15-20	0	0	0	15-20	01-Jul-22	
3	**Partner Members**								
4	Dr Anna Davey	Primary Care Partner Member	10-15	0	0	0	10-15	01-Jul-22	
	Paul Scott	Partner Member, Essex Partnership University NHS FT	0	0	0	0	0	01-Jul-22	
	Matthew Hopkins	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Aug-23	31-Oct-25
	Dawn Scrafield	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Nov-25	
	Peter Fairley	Partner Member, Essex County Council	0	0	0	0	0	01-Jul-22	22-Apr-25
	Sarah Muckle	Partner Member, Essex County Council	0	0	0	0	0	24-Apr-25	
7	Robert Persey	Partner Member, Thurrock Council	0	0	0	0	0	13-Jan-25	
	Mark Harvey	Partner Member, Southend City Council	0	0	0	0	0	13-Mar-23	

Notes:

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

2 Dr Kathy Bonney left th post of Interim Executive Chief People Officer on 10 April 2025.

3 Partner Members are paid by their respective partner organisations and are not paid by the ICB, with the exception of Dr Anna Davey, who is engaged by the ICB on a sessional basis.

4 In addition to the Partner Member role, Dr Anna Davey filled a Clinical Lead role. Remuneration for this role was in the £40k-£45k band and is in addition to the figure quoted above.

5 Dawn Scrafield became the Partner Member for Mid and South Essex NHS FT on 01/11/25, with Matthew Hopkins ceasing to be the Partner Member for Mid and South Essex NHS FT on 31/10/25.

6 Sarah Muckle became the Partner Member for Essex County Council on 24/04/25, with Peter Fairley ceasing to be the Partner Member for Essex County Council on 22/04/25.

7 The pension-related benefit figures do not represent cash payments made to an individual's pension provider. The quoted figures provided by NHS Pensions Agency are an estimate of the increase in the accrued pension over their estimated pensionable life. Each organisation reports a disclosure value appropriate to the length of time the senior manager was employed by their organisation.

Mid and South Essex ICB Remuneration Report 2024-25

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

Notes	Name	Title	2024/25					Date served	
			Salary (bands of £5,000) £000	Taxable benefits / expenses (nearest £100) £	Other Remuneration (bands of £5,000) £000	All Pension Related Benefits[8] (bands of £2,500) £000	Total (bands of £5,000) £000	Commenced	Ceased
	Executive Directors								
1	Tom Abell	Chief Executive Officer	140-145	0	0	0	140-145	08-Aug-24	
1	Tracy Dowling	Interim Chief Executive Officer	75-80	0	0	7.5-10	80-85	20-Nov-23	07-Aug-24
2	Jennifer Kearton	Executive Chief Finance Officer	140-145	1100	0	0	140-145	10-Oct-22	
2	Dr Giles Thorpe	Executive Chief Nursing Officer	155-160	6400	0	0	160-165	14-Aug-23	
3	Dr Matt Sweeting	Executive Medical Director	145-150	0	0	72.5-75	220-225	14-Aug-23	
4	Dr Kathy Bonney	Interim Executive Chief People Officer	125-130	0	0	0	125-130	01-May-24	
4	Lisa Adams	Interim Executive Chief People Officer	5-10	0	0	0-2.5	5-10	28-Jun-23	21-Apr-24
	Governing Body Members								
	Professor Michael Thorne CBE	Chair	65-70	0	0	0	65-70	01-Jul-22	
	Dr Neha Issar-Brown	Non-Executive Member	15-20	0	0	0	15-20	01-Jul-22	
	George Wood	Non-Executive Member	15-20	100	0	0	15-20	01-Jul-22	
	Joseph Fielder	Non-Executive Member	15-20	100	0	0	15-20	01-Jul-22	
5	**Partner Members**								
6	Dr Anna Davey	Primary Care Partner Member	10-15	0	0	0	10-15	01-Jul-22	
	Paul Scott	Partner Member, Essex Partnership University NHS FT	0	0	0	0	0	01-Jul-22	
	Matthew Hopkins	Partner Member, Mid and South Essex NHS FT	0	0	0	0	0	01-Aug-23	
	Peter Fairley	Partner Member, Essex County Council	0	0	0	0	0	01-Jul-22	
7	Robert Persey	Partner Member, Thurrock Council	0	0	0	0	0	13-Jan-25	
7	Ian Wake	Partner Member, Thurrock Council	0	0	0	0	0	May 23	05-Jan-25
	Mark Harvey	Partner Member, Southend City Council	0	0	0	0	0	13-Mar-23	

Notes:

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

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

3 Dr Matt Sweeting became Interim Medical Director on 14th August 2023. He was employed by Mid & South Essex NHS FT and was seconded to the ICB. He has subsequently been appointed as permanent Executive Medical Director from 1st May 2024.

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

5 Partner Members are paid by their respective partner organisations and are not paid by the ICB, with the exception of Dr Anna Davey, who is engaged by the ICB on a sessional basis.

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

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

8 The pension-related benefit figures do not represent cash payments made to an individual's pension provider. The quoted figures provided by NHS Pensions Agency are an estimate of the increase in the accrued pension over their estimated pensionable life. Each organisation reports a disclosure value appropriate to the length of time the senior manager was employed by their organisation.

Pension entitlements of directors and senior managers 2025-26

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 2026 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2026 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2025 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2026 £000	Employers contribution to stakeholder pension £000
Executive Directors									
Jennifer Kearton	Executive Chief Finance Officer	2.5-5	5-7.5	45-50	105-110	767	67	866	0
Dr Giles Thorpe	Executive Chief Nursing Officer	0-2.5	0	40-45	105-110	874	0	908	0
Dr Matt Sweeting	Executive Medical Director	2.5-5	0-2.5	40-45	95-100	752	46	832	0

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

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

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

Pension entitlements of directors and senior managers 2024-25

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

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2025 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2024 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2025 £000	Employers contribution to stakeholder pension £000
Executive Directors									
Tracy Dowling	Interim Chief Executive Officer	0-2.5	0	5-10	0	122	0	158	158
Jennifer Kearton	Executive Chief Finance Officer	0-2.5	0	40-45	95-100	721	0	767	767
Dr Giles Thorpe	Executive Chief Nursing Officer	0	0	40-45	105-110	841	0	874	874
Dr Matt Sweeting	Executive Medical Director	2.5-5	2.5-5	35-40	90-95	631	60	752	752
Lisa Adams	Interim Executive Chief People Officer	0-2.5	0	0-5	0	12	0	16	16

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

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

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

Public Service Pensions Remedy

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy

period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

Cash equivalent transfer values

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Compensation on early retirement for loss of office

For the 2025/26 accounting period there were none.

Payments to past directors

For the 2025/26 accounting period there were none.

Staff Report

Number of senior managers

In 2025/26, the ICB had 74 senior managers.

Staff numbers and costs (subject to audit)

EMPLOYED STAFF		
Employee category	Headcount	WTE
Permanent	352	324.80
Fixed-term	25	15.00
TOTAL	377	339.80
AGENCY & INTERIM		
TOTAL	76	26.43
GRAND TOTAL	**453**	**366.23**

Staff composition

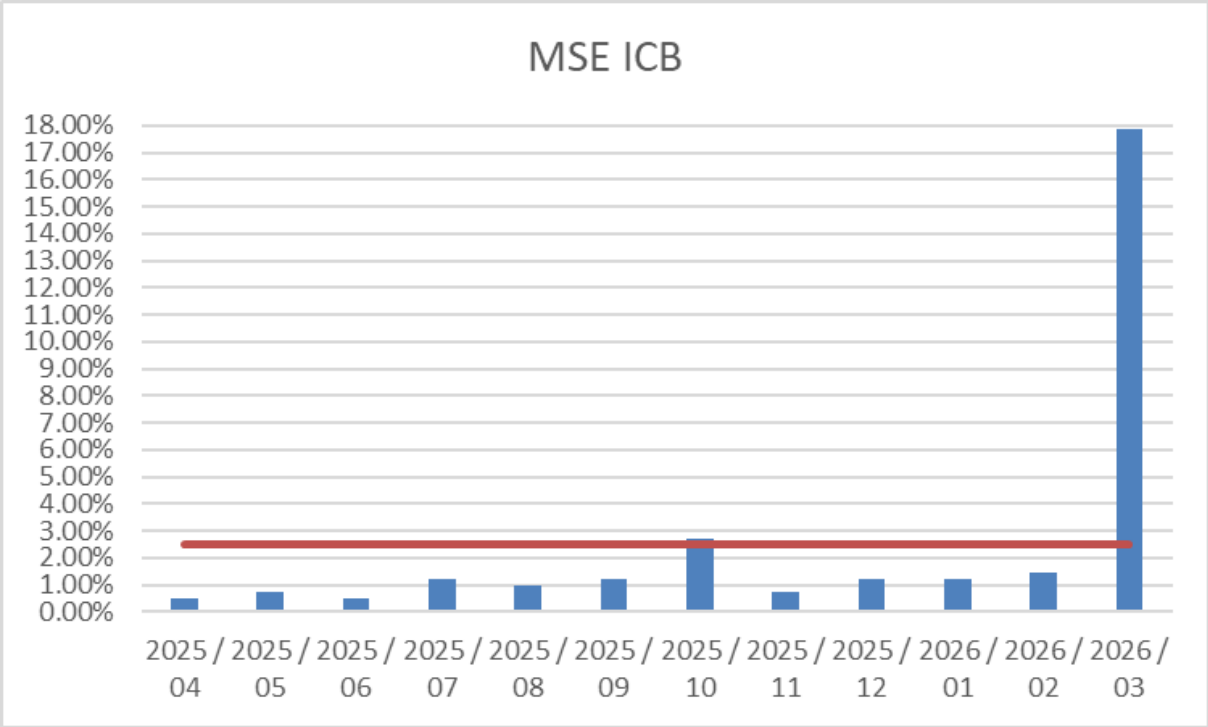
Pay Band	2	3	4	5	6	7	8a	8b	8c	8d	9	VSM	Other	Grand Total
									Senior Managers					
Female	1	3	35	34	68	42	45	33	21	17	6	5	43	350
Male	1		8	4	10	9	6	6	6	11	4	4	32	100
Grand Total	**2**	**3**	**43**	**38**	**78**	**51**	**51**	**39**	**27**	**28**	**10**	**9**	**75**	454

Sickness absence data

Average FTE	Average Sick Days per FTE	FTE-Days recorded Sickness Absence	FTE-Days Available
379.72	13.47	5,116.29	138,596.94

Sickness absence data can be found here: [Sickness and Absence Rates [hyperlinks]]

Staff turnover percentages



NB: national NHS reorganisation of Integrated Care Board boundaries March/April 2026.

Staff engagement

During 2025/26, the ICB underwent a significant organisational change programme. As a result, it did not participate in the annual NHS staff survey for 2025/26. A staff survey is planned for 2026, once the new organisational arrangements are fully embedded.

Staff engagement remained a priority throughout the change process. Weekly all-staff briefings were held to provide updates on organisational developments, and staff were actively involved in formal consultations, including those relating to the new organisational structure and working in the office of the new ICB headquarters.

The ICB has an established staff engagement group, led by staff and open to all colleagues. In addition, a range of staff networks operate across the organisation, including LGBTQIA+, women's, diversity, neurodiversity and positive ways to wellbeing networks. Each network is supported by an Executive Director sponsor, helping to ensure that staff voices inform leadership discussions and organisational decision-making.

The ICB also participated as a partner member in system-wide Staff Colleague Experience, Wellbeing and Retention, and Culture and Diversity Groups. These forums considered shared priorities across the system, including health and wellbeing, engagement, equality, diversity, and inclusion.

Together, these arrangements supported staff engagement and involvement during a period of significant organisational change and will continue to inform the development of the organisation as it moves forward.

Staff policies

The ICB maintains a comprehensive set of HR policies to support managers and staff through this employment journey. An in-depth review of several polices including grievance and disciplinary were undertaken during the year, to ensure they were in line with legislation and fit for purpose following learning from employee relations work.

Health and wellbeing

The ICB has continued to support staff through our external Occupational Health provider and Employee Assistance Programme (EAP). Support sessions have also been provided to staff on several topics including Menopause, Breast Cancer, Mental Health – including stress reduction and dealing with organisational change and financial support including retirement.

Equality, Diversity, and Inclusion (ED&I)

In November 2024, the ICB Board met to review the system position in relation to the national ED&I High Impact Actions and has since been working on areas of improvement to evidence progress against the six prescribed areas:

- Chief executives, Chairs and Board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

- Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
- Develop and implement an improvement plan to eliminate pay gaps.
- Develop and implement an improvement plan to address health inequalities within the workforce.
- Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.
- Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

The ICB successfully worked internally and with partners to create a comprehensive data set to evidence progress both as a system and as an ICB. The system ED&I group provided an opportunity to share best practice and to hold each other to account for delivery. The People Board has continued to receive highlight reports from the system Culture group and staff networks across the system have created space for us to understand the lived experience of those staff that have protected characteristics acknowledging the intersectionality of all staff. Network chairs from across the system met to share their experiences and both a Reciprocal mentoring programme and a Rise and Thrive Programme to support staff from the Global Workforce Majority to progress their careers.

The ICB continued its compliance with the Public Sector Equality Duty. The ICB also completed and submitted evidence against the Equality Delivery System domains 2 & 3.

The ICB updated and published a Workforce Race Equality Standard (WRES) report and action plan. These will be regularly monitored to ensure progress against agreed objectives.

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

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

The ICB has made a solid commitment to try and turn the dial on this area of staff experience noting the particularly static nature of reporting in this area, both in the system and in the NHS as a whole, agreeing to a zero-tolerance approach to any form of discrimination.

Health and safety

The ICB's Health and Safety Policy sets out responsibilities of the ICB and those of employees under the Health and Safety Work Act 1974. Health and safety, fire safety, and moving and handling were included in the mandatory training programme for all ICB staff, and conflict resolution training was mandated for specific groups of staff.
The policy was updated in September 2025.

The ICB's Health and Safety Working Group (HSWG), which reports to the Audit Committee, was originally chaired by the Executive Director of Digital and Business Intelligence. Following the appointment of a new ICB Executive Team, the Director of Corporate Services assumed executive responsibility for health and safety.

The designated Health & Safety Lead regularly attended Staff Engagement Group meetings to provide staff the opportunity to raise any concerns they might have and to provide them with an update on H&S issues.

Regular health and safety checks including security, building system tests and maintenance of the ICB's headquarters continued throughout the year.

ICB staff continue to work in a hybrid way and are required to complete a display screen equipment and working from home risk assessment.

The ICB vacated its previous headquarters (HQ) during the latter part of 2025. Significant work has been undertaken by ICB Estates and other relevant staff to set up the new HQ at Seax House, and other office accommodation, following a decision to require office-based staff to work from an ICB office, or from a partner organisation's premises, at least two days a week from April 2026.

Following the organisational change process and in preparation for the establishment of Essex ICB from 1 April 2026, a review of H&S and Security policies and procedures commenced in early 2026.

To support the wellbeing of ICB staff, a series of events was held throughout 2025/26, commencing with three staff information sessions during 'stress awareness' month in April 2025. Further events provided information on suicide prevention including LGBTQ+ mental health/suicide prevention, Men's health week in June, a summer walking challenge, International Stress Awareness Week in November focussing on winter welling, and a 'healthy dose of humour' in February.

Expenditure on consultancy

Administrative	£110k
Programme	£338k

Off-payroll engagements

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

For all off-payroll engagements as at 31 March 2026, for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2026	5
Of which, the number that have existed:	
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

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

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

For all off-payroll engagements between 1 April 2025 to 31 March 2026, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026	19
Of which:	
No. not subject to off-payroll legislation[2]	18
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	1
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

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

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

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “Board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	17

Losses and Special Payments

There was one loss in 2025/26 as follows:

Losses	Total number of cases 2025-26 Number		Total value of cases 2025-26 £'000
Administrative write-offs	1		9
Total	**1**		**9**

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

Table 1: Exit Packages 2025/26

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£	Whole numbers only	£	Whole numbers only	£	Whole numbers only	£
Less than £10,000	1	8,000	4	21,762	5	29,762	0	0
£10,001 to £25,000	7	125,628	25	411,256	32	536,884	0	0
£25,001 to £50,000	6	239,573	25	809,714	31	1,049,288	0	0
£50,001 to £100,000	8	542,377	15	1,131,647	23	1,674,024	0	0
£100,001 to £150,000	2	281,658	13	1,505,959	15	1,787,617	0	0
£150,001 to £200,000	2	320,000	4	621,709	6	941,709	0	0
Over £200,001	0	0	0	0	0	0	0	0
Total	26	1,517,237	86	4,502,047	112	6,019,284	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. Other departures related to Voluntary Redundancies as shown below.

Table 1: Exit Packages 2024/25

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£	Whole numbers only	£	Whole numbers only	£	Whole numbers only	£
Less than £10,000	0	0	0	0	0	0	0	0
£10,001 to £25,000	2	45,114	0	0	2	45,114	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	1	160,000	0	0	1	160,000	0	0
Over £200,001	0	0	0	0	0	0	0	0
Total	3	205,114	0	0	3	205,114	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. Other departures related to Voluntary Redundancies as shown below

Table 2: Analysis of Other Departures 2025/26

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	65	4,101,498
Contractual payments in lieu of notice	21	400,549
TOTAL	86	4,502,047

Parliamentary Accountability and Audit Report

MSE ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the financial statements of this report at page 26 of the Annual Accounts. An audit certificate and report is also included in this Annual Report.

ANNUAL ACCOUNTS

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

18 June 2026

Entity name:	NHS Mid and South Essex Integrated Care Board
	Statutory Accounts
This year	**2025-26**
Last year	2024-25
This year ended:	**31-Mar-26**
Last year ended:	31-Mar-25
This year commencing:	**01-Apr-25**
Last year commencing:	01-Apr-24

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(44,429)	(40,125)
Other operating income	2	(119)	(228)
Total operating income		**(44,548)**	**(40,353)**
Staff costs	4	39,790	30,743
Purchase of goods and services	5	3,385,925	3,176,389
Depreciation and impairment charges	5	500	332
Provision expense	5	4,135	2,200
Other operating expenditure	5	158	1,171
Total operating expenditure		**3,430,508**	**3,210,835**
Net operating expenditure		**3,385,960**	**3,170,482**
Finance expense	7	144	27
Other gains & losses	8	(12)	-
Net expenditure for the year		**3,386,092**	**3,170,509**
Total net expenditure for the financial year		**3,386,092**	**3,170,509**

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

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Right-of-use assets	9	3,899	4,115
Total non-current assets		**3,899**	**4,115**
Current assets:			
Trade and other receivables	10	7,213	15,679
Cash and cash equivalents	11	7,526	-
Total current assets		**14,739**	**15,679**
Total assets		**18,638**	**19,794**
Current liabilities			
Trade and other payables	12	(154,105)	(131,821)
Lease liabilities	9	(342)	(469)
Borrowings (book overdraft)	13	-	(3,626)
Provisions	14	(7,331)	(3,738)
Total current liabilities		**(161,778)**	**(139,654)**
Total assets less total current liabilities		**(143,140)**	**(119,860)**
Non-current liabilities			
Lease liabilities	9	(3,915)	(3,906)
Provisions	14	(4,386)	(5,687)
Total non-current liabilities		**(8,301)**	**(9,593)**
Assets less Liabilities		**(151,441)**	**(129,453)**
Financed by taxpayers' equity			
General fund		(151,441)	(129,453)
Total taxpayers' equity:		**(151,441)**	**(129,453)**

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

The financial statements on pages 3 to 6 were approved by the Governing Body on 18th June 2026 and signed on its behalf by:

Chief Accountable Officer
Tom Abell

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	(129,453)	**(129,453)**
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Net operating expenditure for the financial year	(3,386,092)	**(3,386,092)**
Net Recognised NHS Integrated Care Board expenditure for the Financial year	**(3,386,092)**	**(3,386,092)**
Net funding	3,364,104	**3,364,104**
Balance at 31 March 2026	**(151,441)**	**(151,441)**

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

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

Statement of Cash Flows for the year ended 31 March 2026

	Note	**2025-26 £'000**	2024-25 £'000
Cash flows from operating activities			
Net expenditure for the year		(3,386,092)	(3,170,509)
Depreciation charges	5	500	332
Other gains & losses	8	(12)	-
Decrease in trade & other receivables	10	8,465	2,057
Increase/(decrease) in trade & other payables	12	22,284	(11,494)
Provisions utilised	14	(1,843)	(1,555)
Increase in provisions	14	4,135	2,200
Net cash outflow from operating activities		**(3,352,563)**	**(3,178,969)**
Cash flows from investing activities			
Interest paid	7	144	27
Net cash inflow from investing activities		**144**	**27**
Net cash outflow before financing		**(3,352,419)**	**(3,178,942)**
Cash flows from financing activities			
Grant in Aid funding received		3,364,104	3,178,154
Repayment of lease liabilities	9	(533)	(315)
Net cash inflow from financing activities		**3,363,571**	**3,177,839**
Net increase/(decrease) in cash & cash equivalents	11	**11,152**	**(1,103)**
Cash & cash equivalents at the beginning of the financial year		(3,626)	(2,523)
Cash & cash equivalents (including bank overdrafts) at the end of the financial year		**7,526**	**(3,626)**

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 (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
The financial statements for ICBs are prepared on a Going Concern basis as the services will continue to be provided in the future. With effect from 1 April 2026, Mid and South Essex ICB formed the Essex ICB together with the geographical areas of north east Essex and west Essex. The Essex ICB has been built from the consolidated outturn of Mid and South Essex ICB, and the Essex apportionment of Suffolk and North East Essex ICB and Hertfordshire and West Essex ICB. All of the assets and liabilities of NHS Mid and South Essex ICB transferred to NHS Essex ICB.

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, inventories and certain financial assets and financial liabilities.

1.3 Joint Arrangements

The ICB has not been part of any pooled budget arrangements in 2025-26. The ICB has operated Better Care Funds during 2025-26 under Section 75 agreements with Essex County Council, Southend City Council and Thurrock Council. The arrangements under which the Better Care Funds operated in 2025-26 do not constitute pooled budgets as the risks of each scheme remained with the respective commissioners. See Note 20 for further information.

1.4 Operating Segments

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

1.5 Revenue

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

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

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

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

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

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

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

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. See note 4.5
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other Expenses

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

1.8 Grants Payable

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

1.9 Leases

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

1.9.1 The ICB as Lessee

A Right-Of-Use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the Right-Of-Use asset, to reflect any reassessment of or modification made to the lease.
The Right-Of-Use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the Right-Of-Use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, Right-Of-Use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-Of-Use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the Right-Of-Use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The Right-Of-Use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.10 **Cash & Cash Equivalents**

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

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

1.11 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate:

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

1.12 **Clinical Negligence Costs**

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

1.13 **Non-clinical Risk Pooling**

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

1.14 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.14.1 **Financial Assets at Amortised Cost**

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

1.15 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of a 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 expired.

1.16 **Value Added Tax**

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

1.17 **Foreign Currencies**

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

1.18 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

1.19.1 **Critical Accounting Judgements in Applying Accounting Policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The ICB has operated Better Care Funds with Essex County Council, Southend City Council and Thurrock Council during 2025-26, 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 20 for further information.

1.19.2 **Sources of Estimation Uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Prescribing Creditor - The charges are a combination of Prescription Pricing Authority (PPA) 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 2025-26 that will be payable in 2026-27.

1.20 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted

● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2 Operating Income

	2025-26 Total £'000	2024-25 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	200	-
Non-patient care services to other bodies	4,446	3,807
Prescription fees and charges	13,731	13,821
Dental fees and charges	23,049	20,691
Other Contract income	3,003	1,806
Total Income from sale of goods and services	**44,429**	**40,125**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	91	23
Other non contract revenue	28	205
Total other operating income	**119**	**228**
Total operating income	**44,548**	**40,353**

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

	Education, training and research £'000	Non-patient care services to other £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other contract income £'000
Source of Revenue					
NHS	200	3,585	-	-	638
Non-NHS	-	861	13,731	23,049	2,365
Total	**200**	**4,446**	**13,731**	**23,049**	**3,003**
Timing of Revenue					
Over time	200	4,446	13,731	23,049	3,003

4 Employee Benefits and Staff Numbers

4.1 Employee Benefits

	Permanent employees £'000	Other £'000	2025-26 Total £'000
Employee benefits			
Salaries and wages	20,728	3,412	**24,140**
Social security costs	3,463	336	**3,799**
Employer Contributions to NHS pension scheme	4,385	316	**4,701**
Other pension costs	24	-	**24**
Apprenticeship levy	107	-	**107**
Termination benefits	7,019 *	-	**7,019**
Gross employee benefits expenditure	**35,726**	**4,064**	**39,790**
Net employee benefits	**35,726**	**4,064**	**39,790**

*The Termibnation benefits figure above includes accruals for staff that were under notice of redundancy at 31 Mar 26, who have since been found suitable alternative employment. These costs have therefore not been iuncluded in Note 4.3 Exit packages agreed in the financial year.

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

4.2 Average number of people employed

	2025-26			2024-25		
	Permanently employed	**Other**	**Total**	Permanently employed	Other	Total
Total number of people employed (WTE)	**377.55**	**11.43**	**388.98**	**386.93**	**7.88**	**394.81**

4.3 Exit packages agreed in the financial year

	2025-26		**2025-26**		**2025-26**	
	Compulsory redundancies		**Other agreed departures**			**Total**
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	1	8,000	4	21,762	5	29,762
£10,001 to £25,000	7	125,628	25	411,256	32	536,884
£25,001 to £50,000	6	239,573	25	809,714	31	1,049,288
£50,001 to £100,000	8	542,377	15	1,131,647	23	1,674,024
£100,001 to £150,000	2	281,658	13	1,505,959	15	1,787,617
£150,001 to £200,000	2	320,000	4	621,709	6	941,709
Over £200,001	-	-	-	-	-	-
Total	**26**	**1,517,236**	**86**	**4,502,047**	**112**	**6,019,284**

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

4.4 Analysis of Other Agreed Departures

	2025-26		2024-25	
	Other agreed		Other agreed	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	65	4,101,498	-	-
Contractual payments in lieu of notice	21	400,549	-	-
Total	**86**	**4,502,047**	**-**	**-**

Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. 2025-26 One retirement £21k, 2024-25 nil.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

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

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.
The NHS Pension Scheme employer contribution rate is 23.7% of pensionable pay, applicable from 1 April 2024. This rate is inclusive of the administration charge, making the total employer contribution rate 23.78%. Employers are responsible for remitting 14.38% directly through their normal payroll process, while the remaining 9.4% is paid centrally by NHS England. The scheme administration levy is 0.08% of pensionable pay, collected alongside the employer contribution rate.

5 Operating expenses

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	7,392	6,001
Services from foundation trusts	1,944,332	1,831,719
Services from other NHS trusts	226,516	213,125
Services from Other Whole of Government Accounts bodies	-	1,307
Purchase of healthcare from non-NHS bodies	532,698	490,210
Purchase of social care	-	146
General dental services and personal dental services	92,355	78,325
Prescribing costs	224,600	222,616
Pharmaceutical services	44,753	42,114
General ophthalmic services	12,669	12,224
NHS GP Services (APMS/GPMS)	261,651	244,103
Supplies and services – clinical	3,209	489
Supplies and services – general	18,409	14,739
Consultancy services	448	1,150
Establishment	4,007	2,344
Transport	251	247
Premises	8,590	9,963
Audit fees	199	189
Other non statutory audit expenditure		
· Other services *[1]	35	55
Other professional fees	3,034	4,172
Legal fees	805	765
Education, training and conferences	(28)	386
Total purchase of goods and services	**3,385,925**	**3,176,389**
Depreciation charges		
Depreciation	500	332
Total depreciation charges	**500**	**332**
Provision expense		
Provisions	4,135	2,200
Total Provision expense	**4,135**	**2,200**
Other operating expenditure		
Chair and non executive members	212	201
Grants to other bodies	309	252
Expected credit loss on receivables	(363)	595
Other expenditure	-	123
Total other operating expenditure	**158**	**1,171**
Total operating expenditure	**3,390,718**	**3,180,092**

*[1] Other services includes the fee for the MHIS (Mental Health Investment Standard) audit, performed by our External Auditors

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	76,368	1,010,163	70,959	899,461
Total non-NHS trade invoices paid within target	75,169	995,715	68,746	859,100
Percentage of Non-NHS trade invoices paid within targ	**98.43%**	**98.57%**	**96.88%**	**95.51%**
NHS payables				
Total NHS trade invoices paid in the year	2,295	2,465,921	2,334	2,094,543
Total NHS trade invoices paid within target	2,266	2,463,658	2,253	2,089,507
Percentage of NHS trade invoices paid within target	**98.74%**	**99.91%**	**96.53%**	**99.76%**

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

	2025-26 £'000	2024-25 £'000
Amounts included in finance costs from claims made under this legislation	-	0
Total	**-**	**0**

7 Finance Costs

	2025-26 £'000	2024-25 £'000
Interest		
Interest on lease liabilities	144	26
Interest on late payment of commercial debt	-	1
Total interest	**144**	**27**
Total finance costs	**144**	**27**

8 Other Gains and Losses

	2025-26 £'000	2024-25 £'000
(Gain) on disposal of right-of-use assets other than by sale	(12)	-
Total	**(12)**	**-**

9 Leases

9.1 Right-Of-Use Assets

2025-26	Buildings excluding dwellings £'000	Total £'000	*Of which: leased from DHSC group bodies £000*
Cost or valuation at 01 Apr 25	5,038	5,038	5,038
Additions	1,842	1,842	-
Lease remeasurement	381	381	381
Derecognition for early terminations	(3,047)	(3,047)	(3,047)
Cost/valuation at 31 Mar 26	**4,214**	**4,214**	**2,372**
Depreciation 01 Apr 25	923	923	923
Charged during the year	500	500	493
Derecognition for early terminations	(1,108)	(1,108)	(1,108)
Depreciation at 31 Mar 26	**315**	**315**	**308**
Net book value at 31 Mar 26	**3,899**	**3,899**	**2,064**
Leased from NHS Property Services		2,064	
Leased externally - Essex County Council		1,835	
Net nook value at 31 Mar 26		**3,899**	

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

All the RoU Assets were leased from NHS Property Services

9.2 Lease Liabilities

	2025-26 £'000	2024-25 £'000
Lease liabilities at 01 April 25	(4,375)	(2,410)
Additions purchased	(1,842)	(2,254)
Interest expense relating to lease liabilities	(144)	(26)
Repayment of lease liabilities (including interest)	533	315
Lease remeasurement	(381)	-
Disposals on expiry of lease term	12	-
Derecognition for early terminations	1,940	-
Lease liabilities at 31 March 26	**(4,257)**	**(4,375)**

9 Leases continued

9.3 Lease liabilities - Maturity Analysis of Undiscounted Future Lease Payments

	2025-26 £'000	**leased from DHSC group bodies £000**	2024-25 £'000	leased from DHSC group bodies £000
Within one year	554	491	589	589
Between one and five years	2,181	1,930	2,336	2,336
After five years	2,656	2,043	2,013	2,013
Balance at 31 Mar 26	**5,391**	**4,464**	**4,938**	**4,938**
Effect of discounting	(1,134)		(563)	
Total	**4,257**		**4,375**	
Included in:				
- Current lease liabilities	342		469	
- Non-current lease liabilities	3,915		3,906	
Total	**4,257**		**4,375**	

9.4 Amounts Recognised in Statement of Comprehensive Net Expenditure

	2025-26 £'000	2024-25 £'000
Depreciation expense on right-of-use assets	500	332
Interest expense on lease liabilities	144	27

9.5 Amounts Recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	533	315

9.6 Narrative

Phoenix Court, Basildon

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

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

- Rent management fees, rates, service charges and facilities mangement fees.

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

We enacted a break clause and left this premises in December 2025.

St. Edmund's Community Hall

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

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

Brentwood Community Hospital

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

We have also entered 10 year lease in February 2026, for space on the 1st floor of Brentwood Community Hospital, for corporate office space.

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

Seax House, Chelmsford

We have entered in a lease starting in February 2026, with the intention to occupy the building for 15 years. The leasing activities falling under IFRS 16 relate to the administration premises in Chelmsford.

The lease is with Essex County Council.

10 Trade and Other Receivables

	31-Mar-26	31-Mar-25
	£'000	£'000
NHS receivables: Revenue	2,873	3,630
NHS accrued income	-	377
NHS Contract Receivable not yet invoiced/non-invoice	638	-
Non-NHS and Other Whole of Government Accounts receivables: revenue	1,746	4,671
Non-NHS and Other Whole of Government Accounts prepayments	1,557	3,187
Non-NHS and Other Whole of Government Accounts accrued income	-	333
Non-NHS and Other Whole of Government Accounts contract receivable not y	-	2,136
Expected credit loss allowance-receivables	(223)	(595)
VAT	622	1,940
Total Trade & other receivables	**7,213**	**15,679**

10.1 Receivables Past Their Due Date but Not Impaired

	31-Mar-26 DHSC Group Bodies £'000	**31-Mar-26 Non DHSC Group Bodies £'000**	31-Mar-25 DHSC Group Bodies £'000	31-Mar-25 Non DHSC Group Bodies £'000
By up to three months	-	787	785	1,825
By three to six months	-	2	21	98
By more than six months	232	46	264	-
Total	**232**	**835**	**1,070**	**1,923**

10.2 Loss Allowance on Asset Classes

	Trade and other receivables - Non DHSC Group Bodies £'000	**Total £'000**
Balance at 01 April 2025	(595)	**(595)**
Lifetime expected credit losses on trade and other receivables-Stage 3 - reduction	363	**363**
Amounts written off	9	**9**
Total	**(223)**	**(223)**

11 Cash and Cash Equivalents

	2025-26	2024-25
	£'000	£'000
Balance at 01 Apr 25	(3,626)	(2,523)
Net change in year	11,152	(1,103)
Balance at 31 Mar 26	**7,526**	**(3,626)**
Made up of:		
Cash with the Government Banking Service	7,526	-
Cash and cash equivalents as in statement of financial position	**7,526**	**-**
Bank overdraft: Government Banking Service	-	(3,626)
Total bank overdrafts	**-**	**(3,626)**
Balance at 31 Mar 26	**7,526**	**(3,626)**

The ICBs cash position is reported in the financial statements as a positive balance of £5,458k at 31 Mar 26, (£3,626k) at 31 Mar 25, due to outstanding payments due to clear after year-end. As at 31 Mar 26, the ICB had a net positive balance deposited in its Government Banking Service bank account of **£**7,589k, £317k at 31 Mar 25.

12 Trade and Other Payables

	31-Mar-26	31-Mar-25
	£'000	£'000
NHS payables: revenue	2,737	5,457
NHS accruals	7,706	9,716
Non-NHS and Other Whole of Government Accounts payables: revenu	17,340	16,438
Non-NHS and Other Whole of Government Accounts accruals	122,868	96,674
Non-NHS and Other Whole of Government Accounts deferred income	22	107
Social security costs	386	328
Tax	477	384
Payments received on account	-	0
Other payables and accruals	2,569	2,717
Total trade & other payables	**154,105**	**131,821**

Other payables include £1,641k outstanding pension contributions at 31 Mar 26 (31 Mar 25: £1,495k).

13 Borrowings	**Current**	Current
	31-Mar-26	31-Mar-25
	£'000	£'000
Bank overdrafts:		
· Government banking service	-	3,626
Total borrowings	**-**	**3,626**

13.1 Repayment of principal falling due

	31-Mar-26	31-Mar-25
	£'000	£'000
Within one year	-	3,626
Total	**-**	**3,626**

14 Provisions

	Current 31-Mar-26 £'000	Non-current 31-Mar-26 £'000	Current 31-Mar-25 £'000	Non-current 31-Mar-25 £'000
Restructuring	731	-	293	-
Legal claims	3,326	792	1,254	-
Continuing care	715	3,594	1,292	3,594
Other	2,559	-	899	2,093
Total	**7,331**	**4,386**	**3,738**	**5,687**
Total current and non-current		**11,717**		**9,425**

	Restructuring £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 Apr 25	**293**	**1,254**	**4,886**	**2,992**	**9,425**
Arising during the year	438	3,597	-	100	**4,135**
Utilised during the year	-	(733)	(577)	(533)	**(1,843)**
Reversed unused	-	-	-	-	**-**
Balance at 31 Mar 26	**731**	**4,118**	**4,309**	**2,559**	**11,717**
Expected timing of cash flows:					
Within one year	731	3,326	715	2,559	**7,331**
Between one and five years	-	792	3,594	-	**4,386**
After five years	-	-	-	-	**-**
Balance at 31 Mar 26	**731**	**4,118**	**4,309**	**2,559**	**11,717**

Restructuring provisions

A restructuring provision was made as the ICB had a requirement to reduce costs by 30%. With the information available the ICB estimated the remaining potential one-off costs which could come to bear throughout 2026-27, as a result of decisions made during 2025-26. These costs are associated with staff displacement, retraining or redeployment on the basis of the new organisational form. The remaining provision related to staff on fixed term contracts, that will finish in the next year.

Legal provision

A provision had been made to cover the potential costs in relation to the Lampard Inquiry, which is a Statutory Inquiry investigating the deaths of mental health inpatients in Essex from 1st Jan 2000 to 31st Dec 2023.

Mid and South Essex ICB is a core participant in the Inquiry and is expected to receive requests for

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

A £165k legal provision has been created based on a 30% probability of a successful procurement challenge, see note 15 for details.

Continuing health care provisions

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

Other provisions

A provision has been created for dilapidation of rented buildings, and for returning Brentwood Community Hospital to its original condition following the end of temporary use of the space for clinical purposes during covid.

A provision to cover the need to retest a cohort of patients, who may have received an erroneous Haemoglobin A1c (HbA1c) result, (a blood test used to help diagnose and monitor diabetes), following a field safety notice, where they were issuing a positive bias for patient results.

15 Contingencies

During 2024 a joint procurement was undertaken with 23 other ICBs for a Primary Care clinical waste collection and disposal contract, for a period of 5 years with the option to extend by 4 years. Each ICB procured an individual Lot. In December 2024, 9 of the ICBs, including Mid and South Essex ICB, published standstill letters with an intention to award a contract. During the subsequent standstill period, in Dec 2024 legal proceedings challenging the contract award decisions were commenced by one of the unsuccessful bidders, naming all 22 of the ICBs which remained involved in the Procurement (2 ICBs having decided not to proceed) as Defendants. Further to the discussions, an indication was received that our liability (should we lose) will be circa £550k. We have now been able to asses the probability of success as 30% and based on that along with the indicated possible value, we have made a provision of £165k for this in the account in 2025-26, see note 14.

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

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

16.1.1 Currency Risk

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

16.1.2 Interest Rate Risk

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

16.1.3 Credit Risk

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

16.1.4 Liquidity Risk

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

16.1.5 Financial Instruments

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

16 Financial Instruments continued

16.2 Financial Assets

	Financial Assets measured at amortised cost 31-Mar-26 £'000	Total 31-Mar-26 £'000
Trade and other receivables with NHS England bodies	104	**104**
Trade and other receivables with other DHSC group bodies	3,408	**3,408**
Trade and other receivables with external bodies	1,746	**1,746**
Cash and cash equivalents	7,526	**7,526**
Total at 31 Mar 26	**12,784**	**12,784**

16.3 Financial Liabilities

	Financial Liabilities measured at amortised cost 31-Mar-26 £'000	Total 31-Mar-26 £'000
Trade and other payables with NHS England bodies	1,018	**1,018**
Trade and other payables with other DHSC group bodies	9,424	**9,424**
Trade and other payables with external bodies	142,778	**142,778**
Private Finance Initiative and finance lease obligations	4,258	**4,258**
Total at 31 Mar 26	**157,478**	**157,478**

17 Operating Segments

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

18 Gifts

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

19 Fees and Charges

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

20 Joint Arrangements - Interests in Joint Operations

Better Care Funds

Essex County Council

The ICB has operated a Better Care Fund of £72,970k during 2025-26, together with Essex County Council, under a section 75 agreement.

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

Thurrock Council

The ICB has operated a Better Care Fund of £14,455k during 2025-26, together with Thurrock Council, under a section 75 agreement.

This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. The lead commissioner for the Better Care Fund (BCF) in 2025-26 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 £17,214k during 2025-26, together with Southend City Council, under a section 75 agreement.

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

Transforming Care Partnership

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

21 Related Party Transactions

21.1 - Transactions with board members and those with significant influence over the Integrated Care Board
Transactions with the chair, chief executive or members of the board of directors are shown in the remuneration report. There are no other individuals who are considered to meet the definition of related parties under IAS24 as interpreted by the GAM (Group Accounting Manual).

21.2 - 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
Essex Cares Limited	Peter Fairley, Partner Member, Essex County Council	191	-	24	-
Essex County Council	Peter Fairley, Partner Member, Essex County Council Sarah Muckle, Partner Member, Essex County Council	88,107	23,452	584	(241)
Essex Partnership University NHS FT	Paul Scott, Partner Member, Essex Partnership University NHS FT	368,677	(126)	3,572	(52)
Healthcare Finance Management Association (HFMA)	Dawn Scrafield	8	-	8	-
Mid & South Essex NHS FT	Matthew Hopkins, ICB Board Partner Member (MSE FT) Dawn Scrafield	1,333,994	(6)	20	(1,877)
North East London NHS FT	Joseph Fielder, Non-Executive Member	28,457	-	284	-
Southend City Council	Mark Harvey, Partner Member, Southend City Council	20,981	(9,315)	687	(261)
Thurrock Council	Ian Wake, Partner Member, Thurrock Council Robert Persey, Partner Member, Thurrock Council	18,372	(4,046)	-	(24)

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

		Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
Coggeshall Surgery	Anna Davey, Primary Care Services Partner	1,240	-	1	-

21.4 - Material transactions in relation to Department of Health and Social Care Bodies
The Department of Health is regarded as a related party. During the year the NHS Integrated Care Board had a significant number of material transactions with entities for which the Department is regarded as the parent Department:

Barking, Havering & Redbridge University Hospitals NHS Trust
Barts and the London NHS Trust
East of England Ambulance Service NHS Trust
East Suffolk and North Essex NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Guy's & St Thomas' NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
NHS Business Services Authority
NHS England
NHS Property Services

In addition, the NHS Integrated Care Board 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.

21 Related Party Transactions continued

21.5 - Department of Health and Social Care

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

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

	Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
Accurx Ltd	1,198	-	284	-

22 Events After the End of the Reporting Period

With effect from 1 April 2026, Mid and South Essex ICB formed the Essex ICB together with the geographical areas of north east Essex and west Essex. The Essex ICB has been built from the consolidated outturn of Mid and South Essex ICB, and the Essex apportionment of Suffolk and North East Essex ICB & Hertfordshire and West Essex ICB. All of the assets and liabilities of NHS Mid and South Essex ICB transferred to NHS Essex ICB.

23 Losses and Special Payments

The total number of NHS Integrated Care Board losses and special payments cases, and their total

Losses

	Total number of cases 2025-26 number	**Total value of cases 2025-26 £'000**	Total number of cases 2024-25 number	Total value of cases 2024-25 £'000
Administrative write-offs	1	9	-	-
Fruitless payments	-	-	1	120
Total	**1**	**9**	**1**	**120**

24 Financial Performance Targets

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

NHS Integrated Care Board performance against those duties was as follows:

	2025-26 Target £'000	**2025-26 Performanc £'000**	**Duty achieved?**
Expenditure not to exceed income	3,431,042	3,430,925	Yes
Capital resource use does not exceed the amount specified in Directions	285	285	Yes
Revenue resource use does not exceed the amount specified in Directions	3,386,209	3,386,092	Yes
Revenue administration resource use does not exceed the amount specified in Directions	29,074	28,274	Yes

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

25 Mental Health Expenditure

	2025-26	2024-25 Restated*
Minimum expenditure in mental health services to meet the Mental Health Investment Standard (MHIS), as notified by NHS England (£000)	255,714	229,720
Eligible mental Health expenditure (£000)	256,054	229,737
Mental health expenditure above minimum investment required (£000)	340	17
Mental health expenditure as a proportion of total expenditure (%)	7.5%	7.2%*

* The prior year percentage has been restated from 7.3% to be calculated on total expenditure in line with the revised GAM requirements for 2025-26, previously this was calculated using the ICB programme allocation.

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

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Mid and South Essex Integrated Care Board ("the abolished ICB") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the abolished ICB as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2025/26; 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 NHS Essex ICB ("the successor ICB") and the abolished 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.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 April 2026 the abolished ICB was dissolved and its services transferred to the successor ICB. Under the continuation of service principle the financial statements of the abolished ICB have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

Going concern

The Accountable Officer of the successor ICB ("the Accountable Officer") has prepared the financial statements of the abolished ICB on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the abolished ICB's services within the successor ICB or dissolve the successor 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 of the abolished ICB ("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 successor 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 successor 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 successor 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 high-level policies and procedures to prevent and detect fraud , including the internal audit function, and the channel for "whistleblowing", 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 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 abolished ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for manipulation of the income that was reported.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual entries to Cash and Cash Equivalents, and Expenditure.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and from inspection of 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, there are 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, there are 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. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer of the successor ICB is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 61, the Accountable Officer of the successor ICB is responsible for the preparation of financial statements of the abolished ICB 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 successor 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 abolished ICB or dissolve the abolished ICB without the transfer of its services to another public sector entity.

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

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the abolished 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 abolished 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 59, the Accountable Officer is responsible for ensuring that the abolished 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 abolished 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 abolished ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the abolished ICB has achieved value for money during the year.

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

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the successor ICB in respect of the abolished ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the abolished ICB, or an officer of the abolished ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

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

This report is made solely to the Members of the Board of NHS 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 successor ICB in respect of the abolished 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 successor ICB in respect of the abolished ICB, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the abolished ICB's accounts consolidation template for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Mid and South Essex Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

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

18 June 2026

Health Inequalities Information Statement - Annual Report 2025/26

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Contents

Executive Summary

Mid and South Essex (MSE) serves a diverse population with significant levels of deprivation, which continue to shape health outcomes across the system. Persistent gaps in life expectancy and healthy life expectancy highlight long standing structural inequalities such as deprivation, housing, income and access to services.

- 1.24 million residents, with 12% living in the most deprived communities.
- Life expectancy gap: 14.4 years for men and 12.7 years for women between most and least deprived.
- Inequalities remain most pronounced for deprived communities, certain ethnic groups, younger adults with long term conditions, and people with severe mental illness (SMI) or learning disabilities (LD).

Key improvements

2025/26 saw measurable progress across several Core20PLUS5 priorities, with early signs of narrowing gaps in prevention, early intervention and management of long-term conditions.

- Smoking at Time of Delivery reduced to 4%, surpassing the national target of 6%, with greatest gains in deprived areas.
- SMI annual physical health checks increased to 61.5%, with more equitable uptake across deprivation levels.
- Early years oral health inequalities narrowed, with fewer tooth extractions in deprived communities.
- Children & Young People (CYP) mental health access improved, particularly among children and young people from global majority ethnic backgrounds.
- Cardiovascular Disease (CVD) prevention strengthened, including lipid optimisation at 47%, improved hypertension management and expanded community case finding.

Persistent inequality gaps

Despite progress, several areas show slow improvement or widening health inequalities, particularly where structural disadvantages remain deeply embedded.

- Preterm birth (6.8%) remains higher among Asian and Black women and mothers in the most deprived communities.
- Childhood asthma and diabetes emergency admissions remain patterned by deprivation and ethnicity.
- Vaccination uptake (COVID, flu, pneumonia) is consistently lower for deprived and global majority communities, with a widening COVID gap.
- Adults with SMI and people with learning disabilities continue to experience earlier mortality and poorer health outcomes than the general population.

Priority conditions

Efforts in 2025/26 focused on the conditions and population groups driving the greatest inequalities in outcomes, experience and access.

- Maternity: culturally responsive models, improved early booking pathways, and continued Smoke Free Pregnancy implementation.

- Children & Young People: expanded asthma support, FeNO diagnostic access, supervised toothbrushing and increased MHST coverage.
- Mental health: improved SMI checks, rising Talking Therapies recovery for younger adults, action on Mental Health Act detentions and restrictive interventions.
- Learning disabilities: strengthened Annual Health Checks, LD friendly accreditation and expanded personalised action planning.
- CVD: intensified hypertension and cholesterol optimisation, targeted work with ethnic minority groups and under 60s, and community outreach events.

Forward view for Essex ICB

The move to the wider Essex ICB footprint in 2026/27 provides an opportunity to build on this progress and align approaches to deliver more equitable outcomes across a larger geography as outlines in the Essex ICB Population Health Improvement Plan.

Introduction

Health inequalities are preventable, unfair and unjust differences in health across the population and between groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work, and age can impact health and wellbeing. These are sometimes referred to as the wider determinants of health. For example, people living in areas of high deprivation, with low educational attainment and in poor quality work would be at even greater risk of experiencing health inequalities. Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare.

NHS organisations have a legal duty to collect, analyse and publish information on health inequalities every year. NHS England's Statement on Information on Health Inequalities sets out how organisations should exercise this duty and what information should be published[1]. This includes a list of indicators which organisations should report against. The indicators are aligned to key health inequalities priorities for the NHS, which includes the five priority areas for addressing healthcare inequalities and the Core20PLUS5 approach to reducing inequalities for adults and children and young people[2].

This is now the third year in which NHS bodies have been required to publish this information, and we are beginning to build a clearer picture of trend patterns across key indicators. The availability of three years of data enables us to identify where health inequalities are persistent and sustained, and where further targeted action is required. In line with national guidance, NHS Mid and South Essex continues to take a proportionate, phased and intelligence led approach to gathering and using information on health inequalities. This year's report brings together both new analyses and ongoing monitoring across all areas included in the statutory statement, supported by strengthened local data quality and improved analytical capability.

The report has a section focused on each health condition or group of conditions covered within the statement. Each section opens with a brief description of the condition and key health inequalities issues and provides a summary of the information and data relating to that indicator. We highlight where inequalities may exist in relation to deprivation, gender, age, and ethnicity where the data is available.

This report should be read in conjunction with our annual report that sets out how MSE ICB meets its legal duty regarding the need to reduce health inequalities, including:

- Taking a population health improvement approach to understanding health needs and designing interventions that reduce health inequalities.
- Implementation of the Equality Delivery System within MSE.

[1] NHS England » NHS England's statement on information on health inequalities
[2] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities, NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

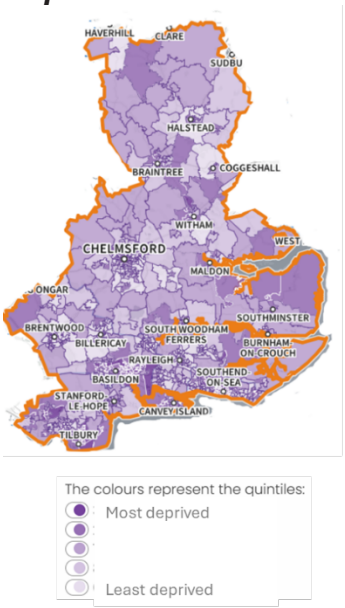
- Ensuring that health inequalities are properly considered when we make commissioning decisions for our population.

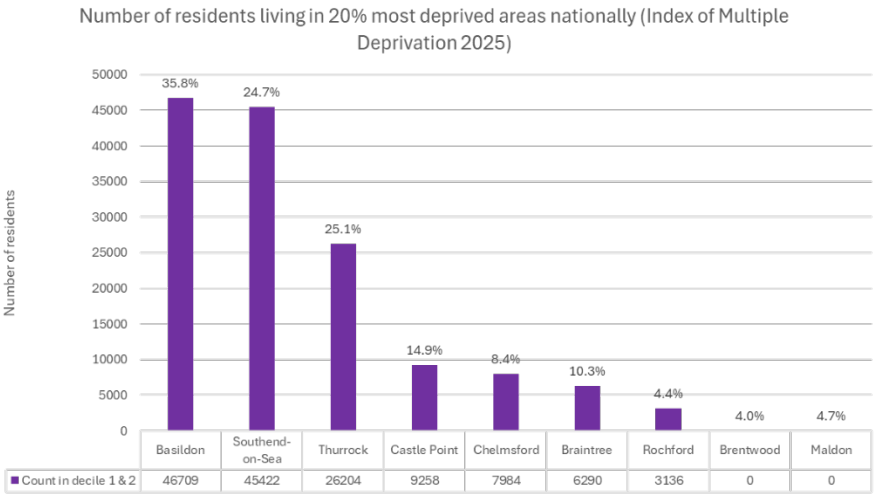
Health inequalities - Tackling Health Inequalities in Mid and South Essex

Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs and is at the heart of the Mid and South Essex (MSE) 10-year strategy.

There are 1.24 million people living in MSE. Across this area, there are localities of both relative affluence and high deprivation. According to the 2025 Index of Multiple Deprivation (IMD), around 148,000 people (12.0%)[3] in mid and south Essex live in areas ranked among the most deprived 20% nationally. This is an increase of 15,000 from the previous 2019 IMD Index. Residents in Basildon, Southend-on-Sea and Thurrock are more likely to face poorer health and premature mortality than those in more affluent areas such as Maldon and Brentwood.

Deprivation in MSE

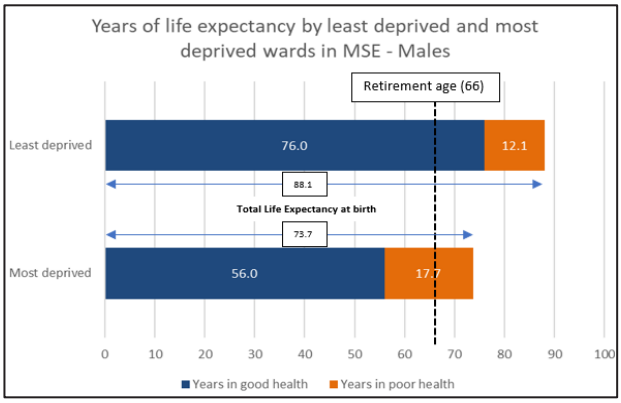


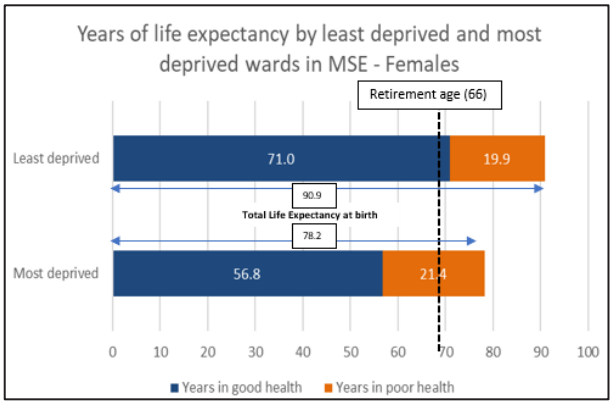


There is a 14.4 year difference in life expectancy for males living in our most and least deprived wards, and 12.7 for females. Those living in our most deprived wards will also live in ill health for longer.

[3] Based on IMD 2025 lower layer super output area (LSOA) English indices of deprivation 2025 - GOV.UK and Mid-2025 LSOA population estimates Population estimates by output areas, electoral, health and other geographies, England and Wales - Office for National Statistics

Indicator: Years of life expectancy by least deprived and most deprived wards in MSE





Source: Fingertips 2021-23

Within MSE there are over 140,000 registered patients who are from an ethnic minority background, which represents 10.8% of the population. Thurrock has a higher proportion (21.2%) of its population from an ethnic minority background. Those from an ethnic minority background can experience greater health inequalities and for example we see poorer uptake of vaccinations and breast cancer screening uptake in this group.

Within MSE the top three contributors to premature mortality attributable to socioeconomic inequalities are cancer, cardiovascular disease, and respiratory disease. In MSE about 65 in 100,000 people die prematurely from CVD, whilst this is an improvement on the previous year it remains above the East of England under 75 mortality rate. Furthermore, within MSE, 116 in 100,000 people die prematurely from cancer which is similar to the national average of 118 in 100,000.

The average age of death for people with a learning disability in MSE is 58, which is up to 20 years before the rest of the population. Respiratory conditions are by far the leading primary cause of death for people with a learning disability. Nationally, the median age of death for adults with a learning disability was 62.5 years in 2023, according to the LeDeR mortality review published in September 2025, indicating that outcomes in MSE remain below the national picture, although based on a different reporting period.

Adults with severe mental illness (SMI) have a life expectancy 15 to 20 years shorter than the general population. Southend-on-Sea and Thurrock have higher rates of premature mortality in adults with SMI compared to the national average.

Data intelligence and governance

MSE ICB worked in collaboration with the public health teams across the three Local Authorities, Population Health Management leadership and with Arden & GEM CSU (BI intelligence provider) to strengthen its use of data and insights to understand and respond to population needs through use of:

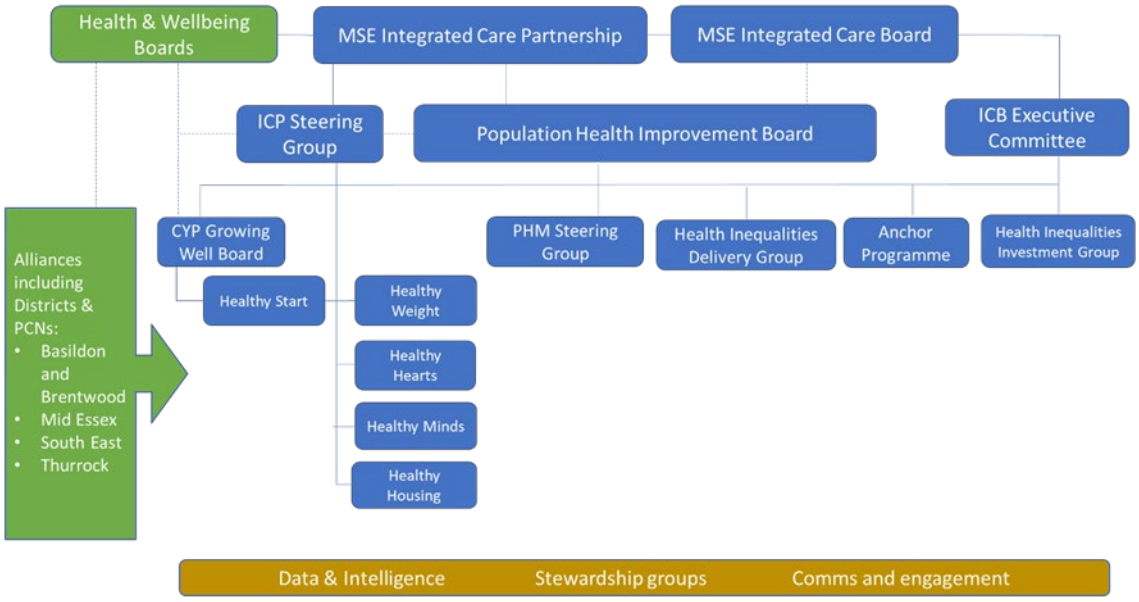
- Local Authority Joint Strategic Needs Assessments to inform decision making.[4]

[4] Essex's Joint Strategic Needs Assessment | Essex Open Data, Joint Strategic Needs Assessment (JSNA) – Southend-on-Sea City Council, Joint Strategic Needs Assessment | Public Health | Thurrock Council

- Integrated health and social care data and its expansion to include other socioeconomic factors such as housing data, to enable wholistic approaches to care delivery.
- Population segmentation tool that provides insights at Alliance, PCN and practice level to enable greater understanding of population needs.
- Core20PLUS5 Alliance and PCN packs to inform priority setting and opportunities for addressing local health inequalities.
- Health Inequalities dashboard to track high level impact and inform this annual report.
- MSE developed metrics, dashboards and reports now incorporate standard Health Inequalities functionality enabling review by deprivation, ethnicity, sex, and age.

The MSE Population Health Improvement Board provides system level governance that brings together programmes of work across:

- Health inequalities
- Population Health Management
- Prevention
- Personalised Care
- Anchor programme



The Population Health Improvement Board reports up to both the MSE Integrated Care Partnership, to bring together the work around wider determinants of health, and to the Integrated Care Board to drive improvements around specific healthcare priorities.

Addressing health inequalities in everything we do

In 2025/26 the MSE health inequalities programme continued to focus on embedding a culture of addressing health inequalities across all our business areas. In support of that ambition, we have:

- Applied the national Core20PLUS5 frameworks for Adults and Children and Young People to prioritise activities both across the system and through the local work delivered by alliance partnerships.
- Ensured Equality and Health Inequalities Impact Assessments are undertaken for service change proposals, to clearly demonstrate the impact on reducing health inequalities and actions identified to mitigate wherever possible.
- Developed Health inequalities champions across the system as part of the NHSE Health Inequalities Ambassador programme.
- Invested in PCN clinical leadership development to utilise a health creation approach to addressing health inequalities.

Working with our most deprived communities – CORE20

Narrowing the gap in health inequalities in our most deprived communities is a priority for all four MSE Alliance partnerships. Each Alliance has tailored their approach and focused on specific areas, groups or conditions based on the needs of their local populations and the engagement work undertaken with their communities. Some highlights include:

Basildon and Brentwood Alliance

- SMI health check coverage reached 73%, representing a 12% increase compared to last year.
- Record number of smoking quits achieved, 168 for period April to December 2025, including a focus on providing bespoke support for those people with SMI, working in partnership with Essex Wellbeing Service and Vita Minds.
- Referrals into weight management services for patients at risk from obesity related conditions is highest in Essex, representing 35% of countrywide activity.
- Application of population health management approaches, including risk stratification to proactively identify individuals who would benefit from Integrated Neighbourhood Team support has led to a sustained improvement in outcomes, with participating cohorts experiencing more than a 50% reduction in A&E admissions.

Mid Alliance

- Continued implementation of the Thriving Places index (TPI) with a focus on Healthy Housing by supporting people with respiratory conditions to directly access energy advice and grants.
- Clinical outreach scheme led by Chelmer PCN in partnership with, amongst others, Sanctus, Chess and Provide, to support individuals experiencing homelessness to develop confidence to engage with statutory services. During the last 12 months there were over 1,000 contacts and support with vaccinations and interventions to improve their physical and mental health including dressings, pain management and medications.

South East Alliance

- All nine PCNs delivered neighbourhood outreach events, reaching more than 700 residents to provide holistic health and wellbeing support with a focus on CVD prevention.

- Participated in Improving Cancer Journeys, supporting personalised care for prostate cancer patients to enable them access to practical, emotional and physical support to enable them to stay in treatment and out of crises.
- Increased the identification of carers, average of 70 new carers added monthly to the carers register, enabling improved access to a range of practical, health and financial support services.
- Health inequalities funding has supported a range of community-based developments to tackle health inequalities including culturally tailored CVD awareness for Jewish communities and digital inclusion for COPD patients.

Thurrock Alliance

- Continued HI partnership with Thurrock Council, including smoking cessation, air quality improvements and primary care outreach linked to the Thames Freeport development.
- The health inequalities funded Work and Health initiative, delivered through the Thurrock Opportunities employment website, has significantly expanded access to support for residents facing socioeconomic and health inequalities, with average monthly users increasing 74% to 3,540 and 'apply' clicks on job adverts rising 108% (31,415), showing far greater engagement with employment pathways.

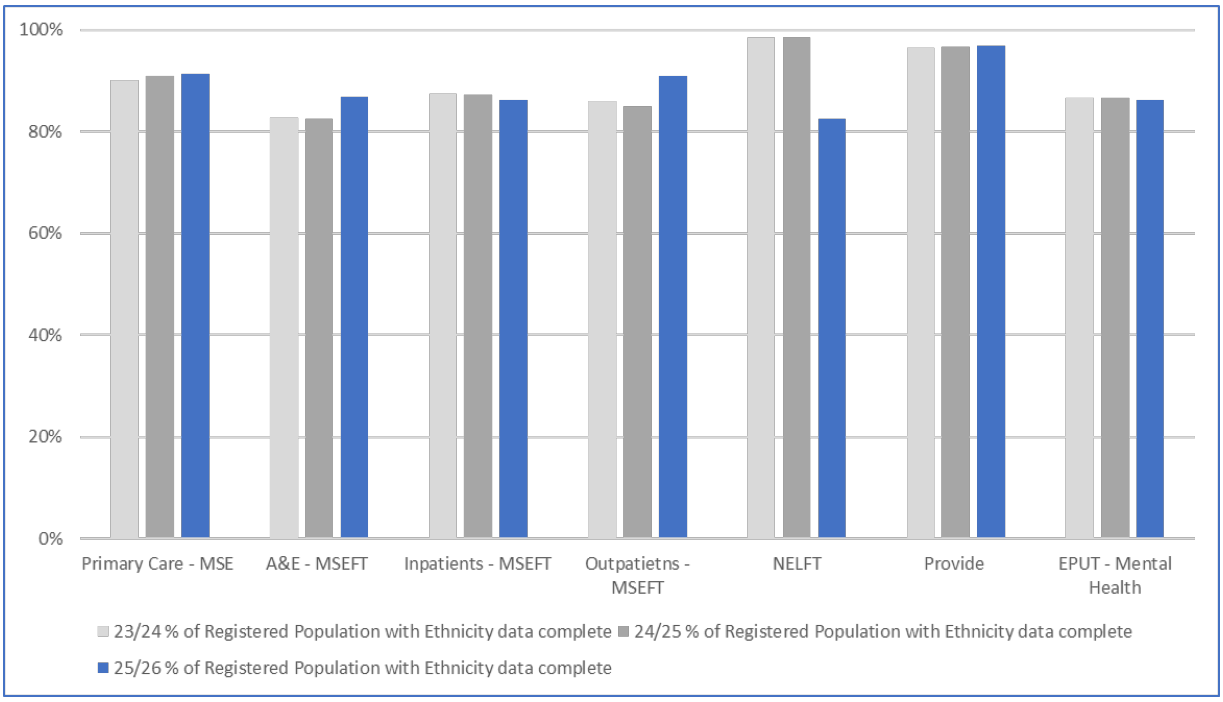
PLUS groups

The "PLUS" element of the Core20PLUS5 framework identifies population groups that experience disproportionately poor health outcomes, often due to structural exclusion, cultural barriers, stigma, or low engagement with traditional service routes. In mid and south Essex, the ICB has invested significantly in improving insight, engagement, and targeted intervention for these groups in 2025/26.

Ethnic Minority Groups

- Ethnic Community Leads have gathered maternity specific feedback from marginalised groups, including Jewish Orthodox families and Bengali women, which has directly informed improvements to communication, translation support and culturally responsive maternity care.
- The Research Engagement Network (REN) has strengthened engagement with underserved ethnic communities, including work with the Black Working Mothers Network, where Community Champions gather insight from Black African and Caribbean women to inform improvements in culturally responsive care and reduce barriers to participation in health services and research.
- Breast screening: a support video has been created to help women feel more informed about attending a mammogram appointment. Different versions of this video are also available covering community languages including Bulgarian, Polish, Bengali, and Tamil.
- Continued focus on improving the data completeness of recording of ethnicity, with 91.4% completeness in the Primary Care record in 2025/26.

Indicator: Data completeness for Ethnicity recording



Source: SystmOne (Primary Care) and local provider SUS submissions (MSEFT, NEFLT, EPUT and Provide) Dec 2025.

Veterans

- Improved the identification and recording of veterans in primary care and our three hospitals and using veterans' voices to inform how services are delivered utilising research conducted by Healthwatch.
- There are now over 100 GP practices that are veteran friendly accredited and both our major providers MSEFT and EPUT have also achieved veteran aware accreditation.
- MSEFT has expanded its Armed Forces support by onboarding 26 Service Champions and introducing the Veterans Aware Pathfinder, which has enabled the identification of 225 veterans to date and improved access to specialist support for the Armed Forces community.

Homeless

- In 2025, MSE ICB commissioned Pathway to assess the health needs of people experiencing homelessness, identifying good practice alongside system wide gaps, and partners are now developing a coordinated action plan to implement sustainable, integrated improvements.

Inclusion health groups

- MSE is the first ICB in EoE to commission Pride in Practice, offering free training and support with 34 accredited practices.

- A health inequalities grant supported a local Trans group to promote increased uptake of breast screening within the community.
- Our LGBTQIA, Women's, Neurodiversity and Ethnic Diversity staff networks provide forums for colleagues to share lived experience and insight that inform more inclusive organisational policies and practice.

Research and Engagement network

The ICB's Research and Engagement Network (REN) has continued to grow during 2025/26, bringing together 15 partner organisations and 19 Community Champions to support sustained engagement and research participation among underserved groups, including people with learning disabilities, ethnically diverse communities, neurodivergent individuals, and marginalised young people.

During 2025/26 the research and engagement network:

- Reached 22,848 residents through engagement activities.
- Gathered 5,337 contributions informing commissioning and service redesign.
- Supported major engagement events, including a successful Mega Research Event in Rayleigh with strong uptake of vaccinations, BP checks, and cholesterol testing.

Organisation	Working with	Organisation	Working with
Thinklusive	People with a learning disability & autistic people.	**Angel Pavilion Community Hub**	Veterans group, south Asian families, mental health, women of childbearing age, children and young people and those who are neurodivergent.
Motivated-Minds	Age extreme (under 25's or 65 and over), Women of childbearing age, LGBTQ+, HI, and neurodivergent.	**Seventh-Day Adventist Community Services**	Black, mixed especially from an African background
Thrive Together Foundation	Muslim women's group, families	**Multicultural Essex**	Muslim women's group, people under 25, mother and babies' group.
Southend YMCAA	Age extreme (under 25's or 65 and over), LGBTQ+, HI, and neuro divergent, community youth organisations young people under the age of 25.	**Sankalpo Chelmsford**	South Asian Group, families and children
Essex council for voluntary youth services	Age extreme (under 25's or 65 and over), Women of childbearing age, LGBTQ+, HI, and neuro divergent.	**Thurrock and Brentwood Mind**	Mental health research in Thurrock ad Brentwood areas
Signpost	Muslim community, young people under 25, refugees, migrants, ethnic minorities.	**Mid and North Essex Minds**	Mental health research in coastal and rural areas covering Maldon, Burnham on Crouch, Dengie area
Blade Education	Groups of adults with LD	**SAVS**	Deprivation, HI and those with COPD
South East and Central Essex Mind	Mental health research in coastal and rural areas covering Southend Shoeburyness and Canvey Island	**SUMMARY**	**Total of 15 partner organisations and 19 community champions.**

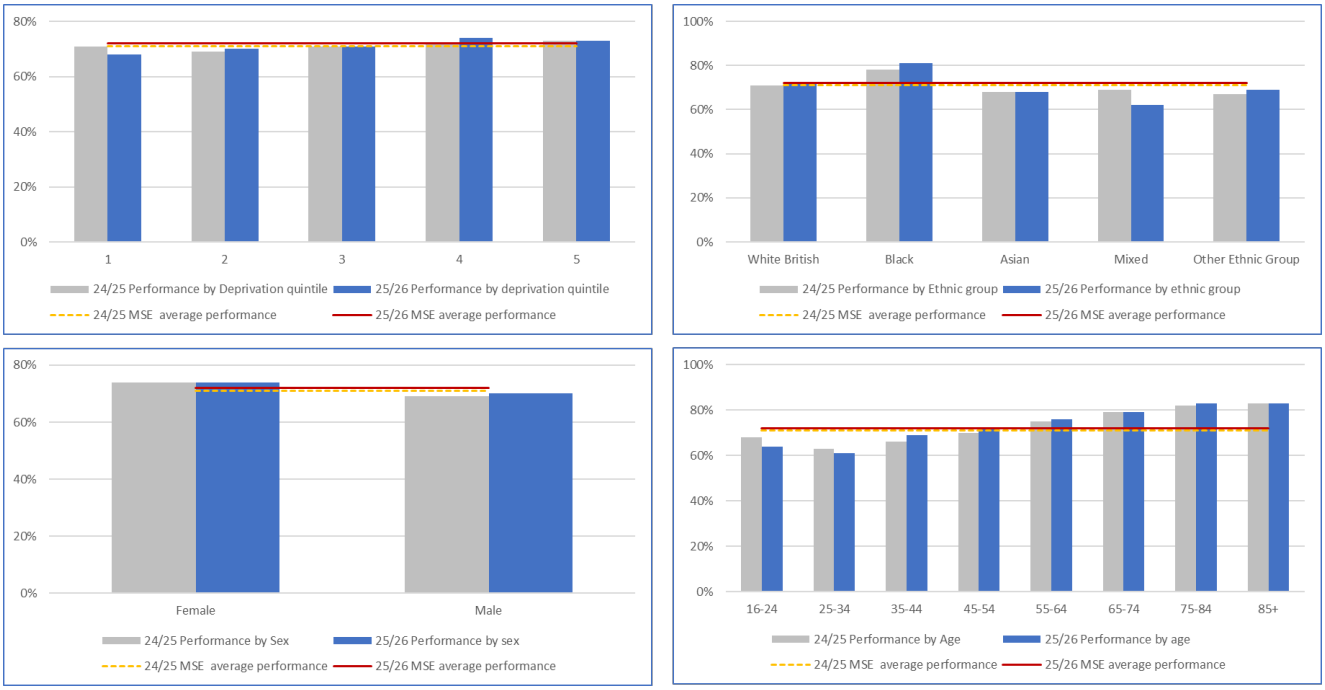
Inclusive Elective Recovery

Inclusive elective recovery remains a priority in 2025/26, to ensure that efforts to reduce waiting lists for planned care do not inadvertently widen the health gap for our most deprived populations. The ICB's approach has emphasised equity of access supported by structured reviews of waiting list across demographic groups.

Primary care

Understanding patient experience of GP services is essential, as variations in access and satisfaction often reflect wider health inequalities experienced by disadvantage communities. Overall, the ICB has seen an improvement in patient satisfaction with access and experience of primary medical service, pharmacy and dental services compared to 2024/25. The highest levels of satisfaction are amongst older age groups, who tend to be the heaviest users of services. There is variation in experience across the deprivation quintiles, with there being a reduction in satisfaction with GP services in our most deprived communities from the previous year. GP satisfaction by ethnic group varies with the highest amongst Black and Jewish communities, with lower reported satisfaction from those identified from a mixed background.

Indicator: GP patient experience – patient rating of very good or fairly good



Source: GP patient survey 2025.

In 2025/26 the ICB continued to embed its 'Connected Pathways' programme that supports GP surgeries in streamlining operations, enhancing patient experiences and empowering healthcare professionals to support patients to get the care they need quicker. This includes adoption of the Total Triage approach, a new way of managing care requests to ensure all patients are assessed on clinical need and directed to the right healthcare professional.

Making it easier to access local GP services - Mid and South Essex Integrated Care System

Dental access has been strengthened through targeted pilots and increased investment in areas of higher need, including the opening of a new dental practice in Grays. A Children and Young People's Pilot is also helping to improve access for children who do not regularly attend routine dental care, with a focus upon our most deprived communities.

Community Collaborative

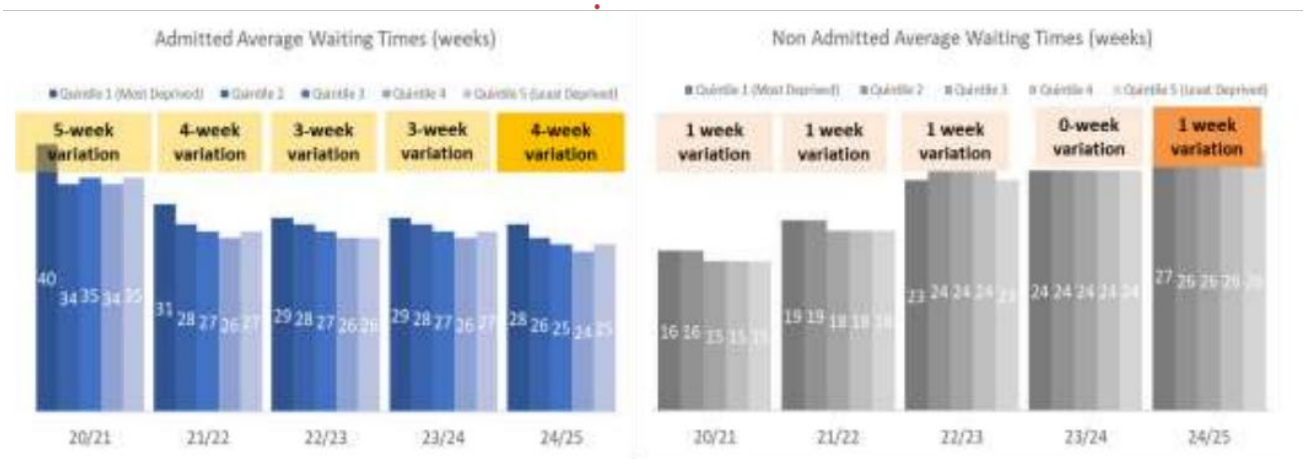
The Community Collaborative have focused on reducing health inequalities through:

- Cardiovascular Disease Prevention Programme of work, introducing a blood pressure protocol and guidance to standardise follow up for abnormal or overdue blood pressure readings and reduce unwarranted variation in care. Early findings show the protocol is identifying previously missed opportunities for intervention, with a full evaluation underway to inform wider rollout across community services. Review of Children's Asthma Service as part of the EDS2 2024/25 report incorporating patient engagement to identify actions for improvement.

Acute services delivered by Mid and South Essex Foundation Trust (MSEFT)

MSEFT completed an annual impact report and evaluation of access on the waiting list and patient experience that was presented to their public Board in June 2025. This highlighted the gap in waiting times between ethnic groups and deprivation variation gap has remained stable despite wait time increasing.

Indicator: MSEFT admitted and non-admitted average waiting times by IMD quintile by year

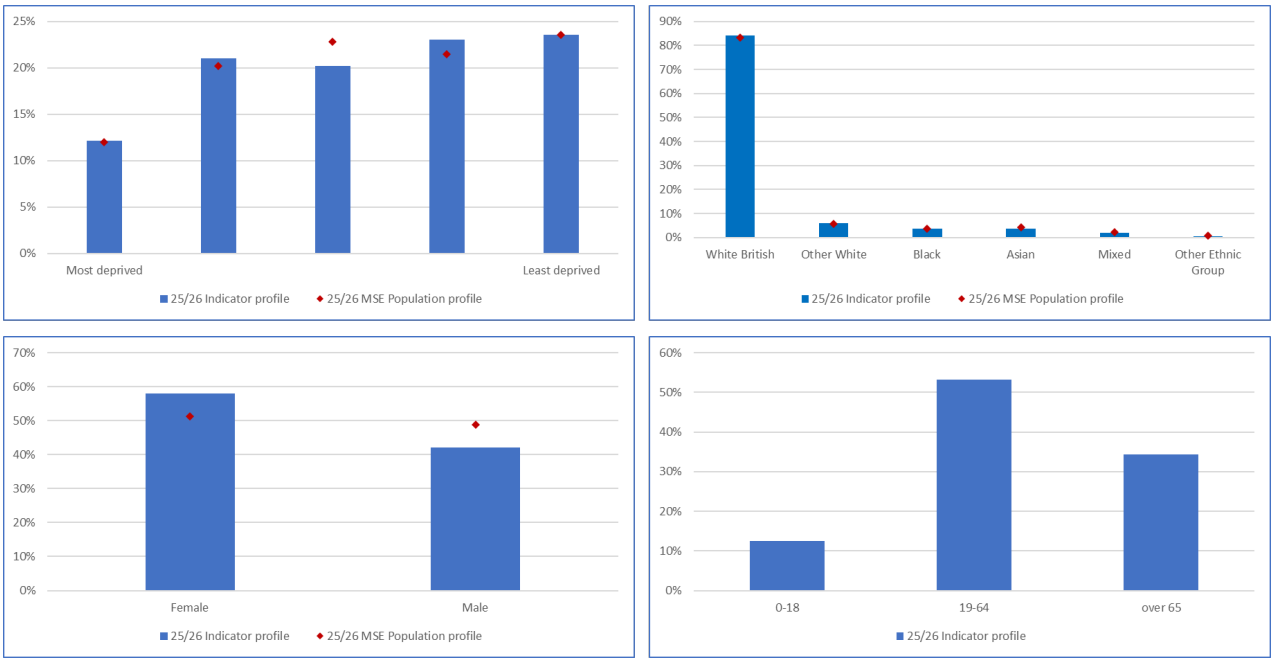


Source: MSEFT Board report June 2025.

National NHSE data provides analysis of acute provider waiting list by age, sex, ethnicity, and deprivation levels[5]. The latest data for MSEFT shows that the proportion of patients waiting over 18 weeks is broadly in line with the demographic profile of the MSE population, with the notable exception of a higher proportion of females compared to males. This gender disparity mirrors national trends and is likely driven by women's higher healthcare use and longer life expectancy.

[5] Statistics » Waiting List Minimum Data Set (WLMDS) Information

Indicator: MSEFT patients waiting over 18 weeks



Source: Waiting List Minimum Data Set, 25th January 2026.

Mid and South Essex Foundation NHS Trust continues to report bi-monthly to their Board on health inequalities within elective waiting lists as part of the integrated performance report. There are a number of health inequalities projects underway within MSEFT:

- Friends and Family Test insights (from 130,000 people) have been used to identify specialty level variation in experience, including a focused review of female patient feedback, to better understand themes influencing satisfaction and inform targeted improvements.
- The User Centred Design (UCD) Better Letters programme is now live across 14 specialties at multiple sites, supporting clearer communication and improved patient experience.
- Review of Ophthalmology services as part of the EDS2 2025/26 report incorporating patient engagement to identify actions for improvement.

As part of its Anchor commitment, the ICB continues to work and support MSEFT with initiatives that reduce health inequalities by improving access and socioeconomic opportunity. In particular:

- The Essex Pedal Power scheme has expanded further, with the distribution of over 230 bikes helping eligible residents access employment, education and community services.
- Participation in the NHS England Widening Access Demonstrator is helping over 100 local residents develop skills, secure placements and progress into employment across the NHS and wider public sector.

Maternity

In MSE, reducing inequalities in maternity outcomes remains a priority, as too many women still face avoidable risks linked to deprivation and ethnicity. MSEFT continue with the implementation of the Maternity Equity and Equality action plan to reduce the risk of preterm births with focus on those from a Black ethnic background.

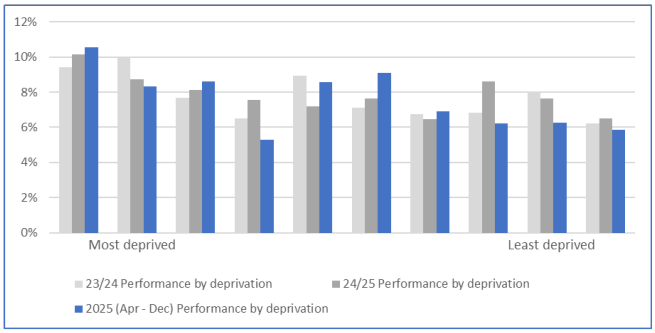
Preterm births

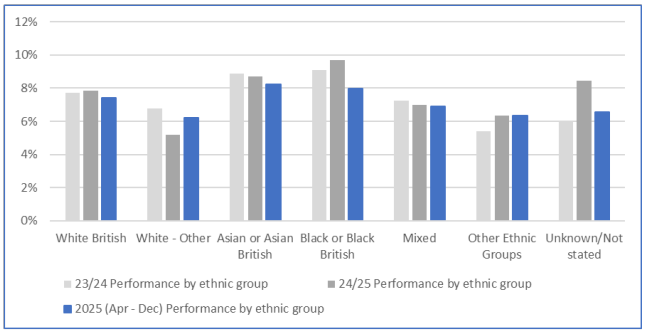
In 2025 the rate of preterm birth at MSEFT was 6.8% (Jan-Dec 2025) compared with the national ambition of 6%. This reflects improvement compared with 2024, where the rate was 8.6%.

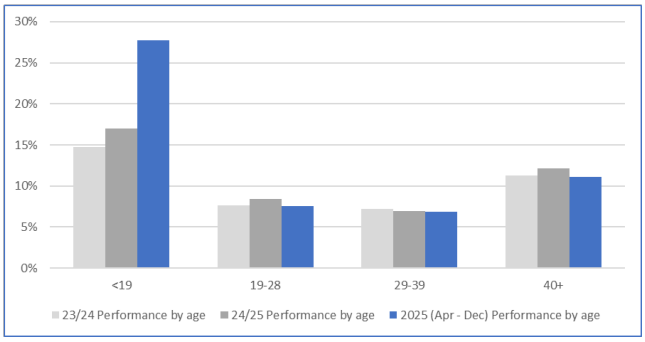
However, there is an overrepresentation of preterm births under 37 weeks from non-White British women but particularly from women of an Asian or Black ethnic background. The overrepresentation of women from the most deprived areas (first quintile) has increased in 2025/26 from the previous year. However, the proportion from the second quintile has decreased. Rates of preterm births in the under 19 years of age increased in 2025/26.

Higher preterm birth rates among Asian and Black women are likely linked to the combined effects of socioeconomic disadvantage, structural and environmental factors, and variation in access to antenatal care. The increased proportion of preterm births among women from the most deprived areas reflects the strong association between deprivation and preterm birth risk, driven by social, environmental and maternal health factors. Higher rates in mothers under 19 are consistent with known risk factors, including later engagement with antenatal care and greater social vulnerability.

Indicator: Preterm birth ≥ 22 weeks and ≤ 37 weeks







Source: MSEFT Maternity Dataset.

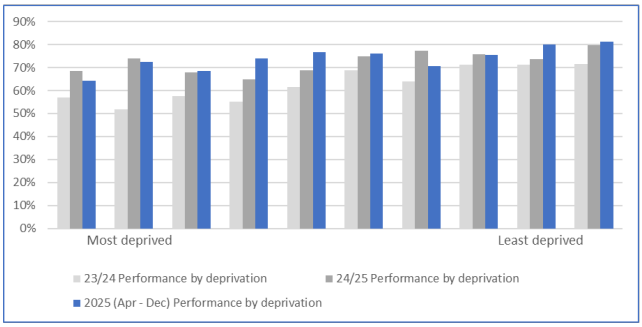
Pregnancy booking by 10 weeks

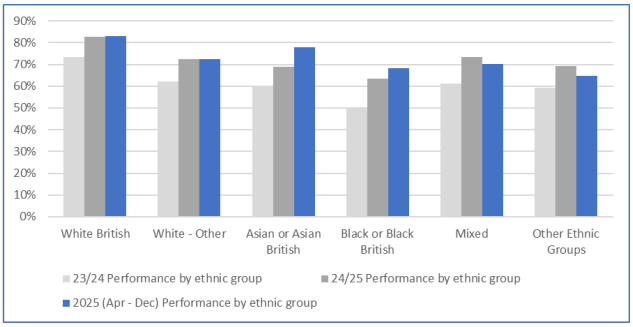
Early booking before 10 weeks is essential for timely risk assessment, screening and personalised care, helping to reduce inequalities by ensuring earlier support for women with complex needs or who may be at greater risk.

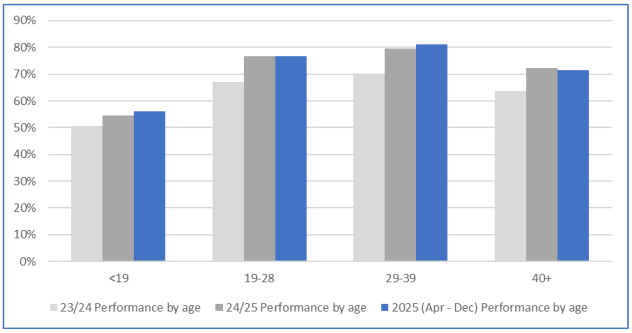
Pregnancy booking by 10 weeks continues to highlight inequalities, with women in the most deprived areas booking later and those under 19 still more likely to book late. Overall, women from non-White British backgrounds tend to book earlier, although there has been a notable improvement in early booking among women from Asian and Black backgrounds.

These patterns are likely influenced by underlying social and structural factors such as socioeconomic disadvantage, variable access to antenatal services, and greater vulnerability among younger women, all of which are known to contribute to later engagement with maternity care.

Indicator: Booking before 10 weeks gestation







Source: MSEFT Maternity Dataset.

Given the overrepresentation of preterm births among women from Black, Asian and deprived communities, and the continued inequalities in early booking, the following actions were prioritised to improve maternity outcomes:

- MSEFT's Maternity and Neonatal Voice Partnerships ensures that women and families shape service improvements. With Ethnic Community Leads helping us hear from those who may be marginalised, recent engagement has included the Jewish Orthodox community's experiences of maternity care and feedback from Bengali women on communication and translation.

- Perinatal Pelvic Health Teams have been undertaking targeted work to highlight the increased incidence and risk of perineal trauma for Asian women; education to help staff identify risk factors has helped reduce the incidence in 2025.
- Implementation of the Smoke Free Pregnancy pathway in MSEFT have seen a reduction in rates of smoking at time of delivery to around 4% which is in below with the national ambition (see Risk factors section).

Children and Young People

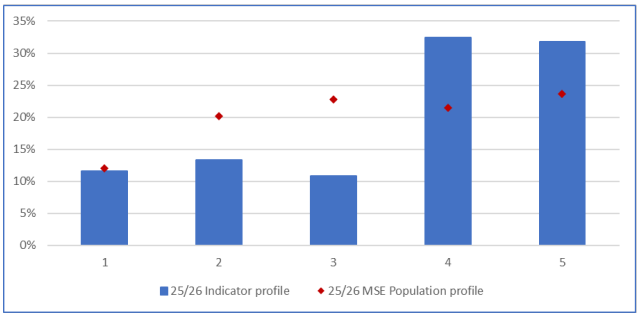
Childhood and adolescence are key life stages where people face inequalities in health outcomes (such as infant mortality rate and obesity rates) alongside inequalities in accessing services. In MSE, one in eight children live in our most deprived areas and are at risk of experiencing poorer health outcomes. The ICB has adopted the national Core20PLUS5 framework for Babies, Children and Young People.

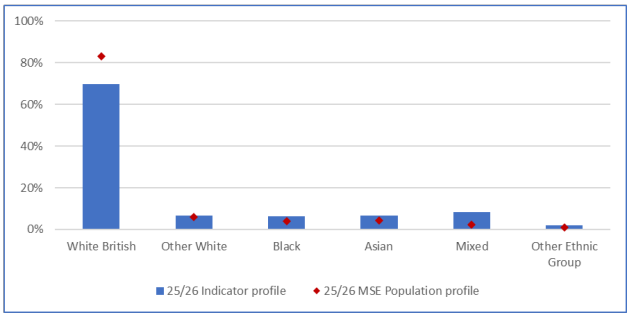
Asthma

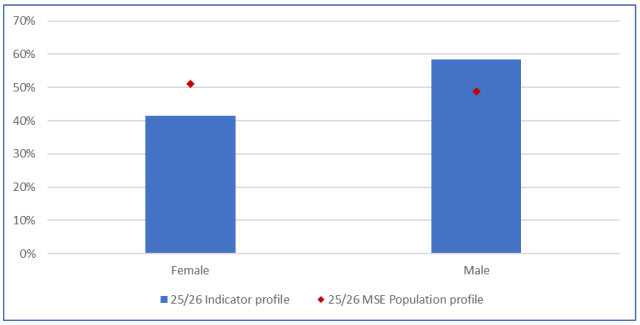
Childhood asthma remains a national CORE20PLUS5 priority and continued focus in mid and south Essex helps ensure we maintain equitable, high-quality care for all children.

The prevalence of childhood asthma in MSE is found to be considerably higher in the least deprived areas, boys and among children from the global majority. However, lower prevalence in some groups may reflect under diagnosis or reduced engagement with primary care services rather than lower underlying clinical need.

Indicator: Prevalence of childhood asthma (under 18)





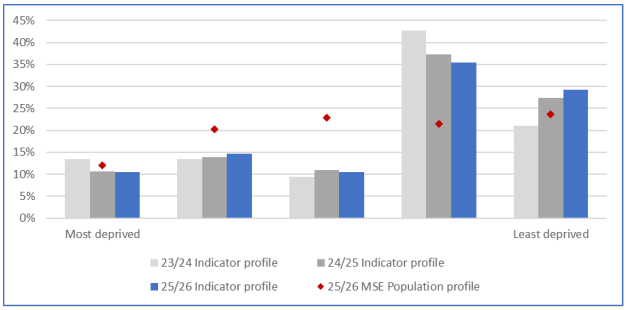


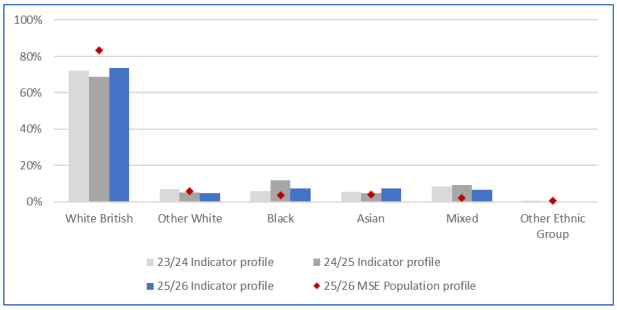
Source: MSE local dataset – Athena.

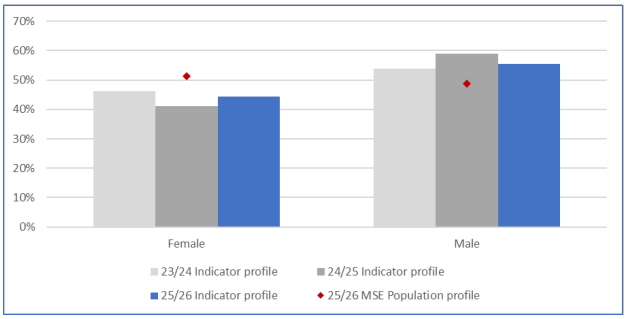
Childhood asthma is most prevalent in the least deprived communities and among global majority ethnic groups, and emergency admissions mirror this distribution with higher rates

in these same populations. These patterns are likely driven by differences in environmental exposures, health seeking behaviour and access to primary care, with some communities facing higher exposure to triggers while others may experience under diagnosis or delayed diagnosis.

Indicator: Emergency admissions of childhood asthma (under 18)







Source: MSE local dataset – Athena.

MSE ICB has taken a range of actions to improve care for children with asthma and reduce health inequalities, including:

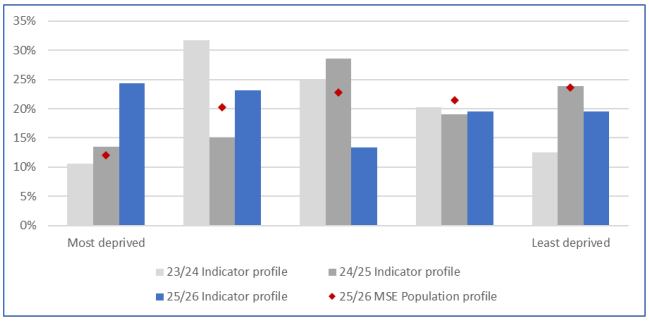
- Expanding the specialist asthma service across south east Essex to improve equity of access and ensure consistent support for children and families.
- Piloting FeNO devices in 16 practices located in areas of greatest deprivation and clinical need, enabling faster diagnosis and earlier treatment.
- Developing local expertise through four trained Asthma Health Champions, who are supporting pathway transformation, creating a practical Toolkit for practices, and working with selected practices to review data, embed updated NICE guidance, and improve outcomes.

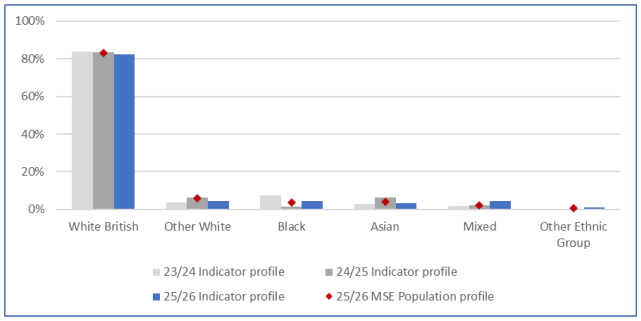
Diabetes

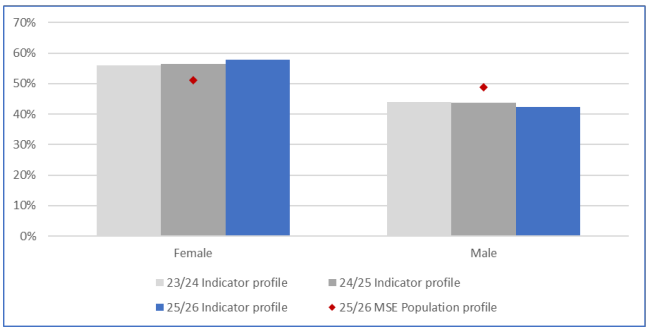
CYP diabetes is identified nationally as a CORE20PLUS5 priority, MSE has prioritised expanding hybrid closed loop technology to support equitable, high-quality care.

Emergency admission rates are higher for children and young people with diabetes living in the most deprived areas and for girls, and the steady increase over the past three years highlights the importance of strengthening earlier support. These inequalities are likely driven by higher levels of social and clinical vulnerability in more deprived communities, alongside variations in access to timely primary care and early diabetes management support.

Indicator: Emergency admissions for Diabetes (under 19 years)







Note: Emergency admissions among non-White British groups are fewer than five per group, so these figures should be interpreted with caution.

Source: MSE local dataset – Athena.

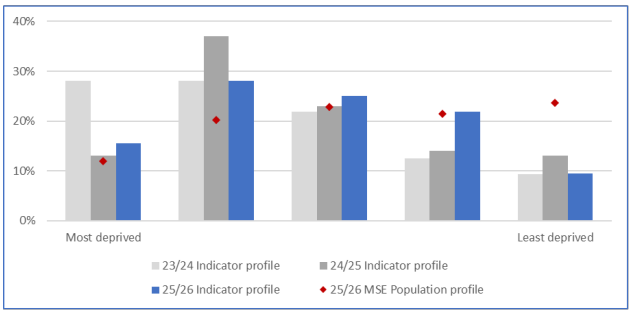
The ICB has prioritised expanding hybrid closed loop technology, a system that automatically helps regulate blood sugar, raising uptake in children with type 1 diabetes from 35% in April 2025 to over 70% in January 2026, with the aim of reducing hospital admissions.

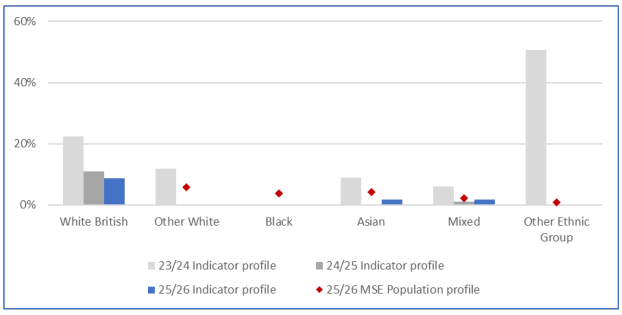
Oral Health

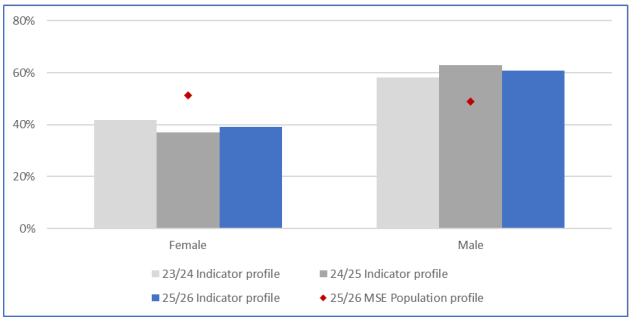
Nationally, children in more deprived communities experience poorer oral health, with tooth decay remaining a significant but largely preventable cause of pain and ill health. In 2025/26, extraction rates for decay in children aged 10 and under in MSE remained stable, with a narrowing of the deprivation gap due to improvements in the most deprived areas, although inequalities persist. As the 2025/26 dataset covers only nine months and includes small numbers within ethnicity groups, it is not possible to draw conclusions about changes in ethnic inequalities. Boys continue to be overrepresented among those requiring tooth extractions.

These patterns are likely driven by underlying socioeconomic factors that influence diet, oral hygiene practices and access to preventative dental care, contributing to earlier and more severe tooth decay in some groups.

Indicator: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under







Source: MSE local dataset – Athena from SUS (Note: 24/25 12 months, 24/25 9 months data).

Given the continued burden of tooth decay in more deprived communities and the persistent overrepresentation of boys among extractions, the following actions were prioritised to improve oral health outcomes.

- MSE Bright Smiles campaign has delivered strong engagement, including over 55,000 views of the toothbrushing video and targeted digital messaging in areas of highest deprivation in Thurrock and Southend.
- Supervised toothbrushing schemes have expanded across early years and primary schools, focused on areas with high levels of oral disease, delivered by three providers in partnership with Local Authorities.
- Thurrock's Early Years Oral Health programme, launched in January 2024, has:
    - trained early years staff, volunteers and students, distributed over 11,000 toothbrush packs, including SEND specific packs, provided direct dental access support to over 400 families and implemented supervised toothbrushing in 17 early years settings
    - contributing to increased dental attendance, over 2,300 children were seen by dental practices in Thurrock and saw a 23% reduction in 5 year old children examined with Enamel decay
- An ICB safeguarding resource on recognising and escalating concerns about dental neglect has been rolled out across primary care and recognised regionally as good practice.
- Improved NHS dental access, with a pilot delivering oral health promotion in all 325 mainstream Essex schools, linking each school with a local dental practice and supporting the upskilling of the wider dental workforce.

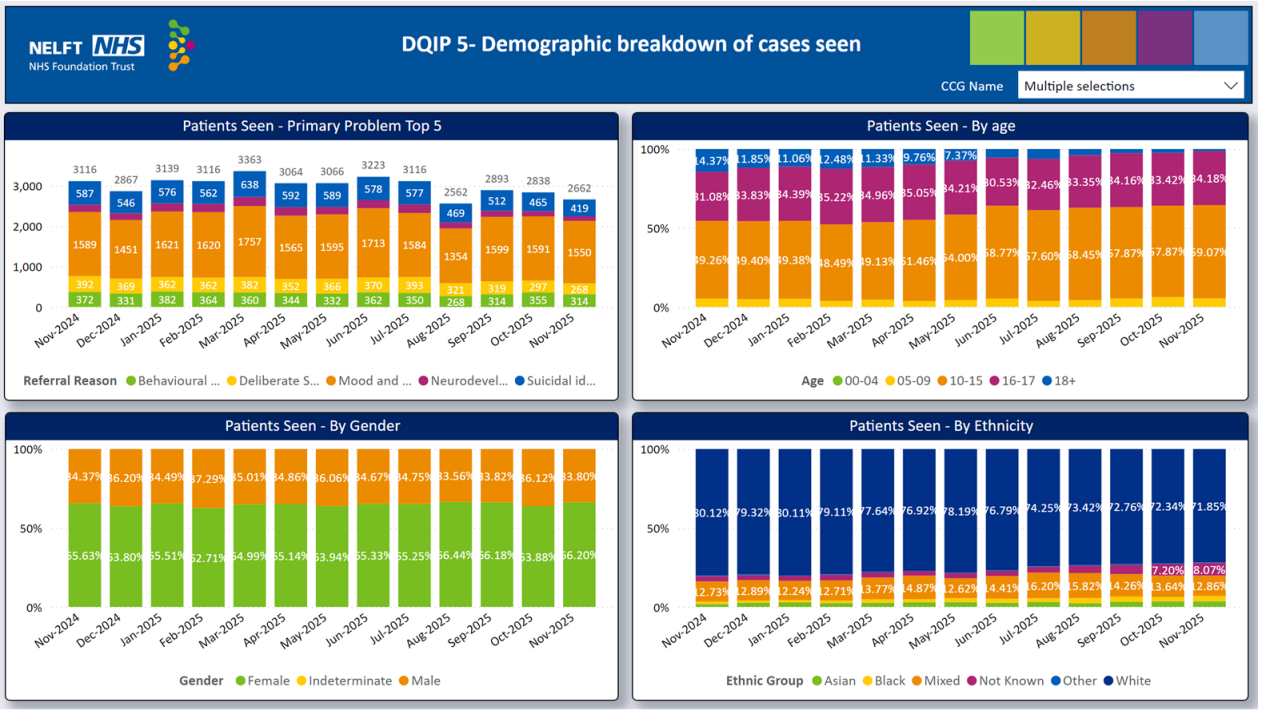
Mental Health

Up to one in five children and young people in England experience a mental health difficulty, and those from socioeconomic deprived areas can be disproportionately affected. Demand for children and young people's mental health services (CAMHS) has continued to rise since the Covid pandemic. Nationally, girls make up 60% of those accessing CAMHS, and this pattern is even more pronounced in MSE, where a consistently higher proportion of service users are female.

In 2024/25, a significant proportion of patients seen did not have a recorded ethnic background; this was addressed in 2025/26, enabling a clearer understanding of who is accessing services. The updated data shows an increasing proportion of patients from global majority ethnic backgrounds accessing the service. The trend also continues towards more children being seen in the younger age groups (10-15 years), with proportionately fewer aged 16 and over. Alongside the higher representation of girls, this shift in age profile has remained stable over time and aligns with national patterns of emerging need in early adolescence.

These patterns are likely driven by a combination of socioeconomic pressures, varying levels of emotional distress post pandemic, and differences in help seeking behaviour and service engagement across age, gender, and ethnic groups.

Indicator: Patients seen within children and young people's mental health services (CAMHS)



Source: NELFT data dashboard.

In response to rising demand among girls, younger adolescents and children from global majority backgrounds, a range of actions were taken to strengthen support and improve equitable access across CAMHS.

- Expansion of Mental Health Support Teams (MHSTs): As part of the national rollout, MHST coverage is planned to reach six in ten pupils by March 2026, and NELFT is progressing the onboarding of additional teams to extend support across more schools in Mid and South Essex.
- Improved equity of provision and support for families: This includes the commissioning of the SNAP family support service, which provides ongoing emotional, physical and practical support for children and young people with SEND and their families, helping to reduce variation and ensure more consistent access to early help across MSE.
- Strengthened insight from SEND inspections: Two recent area SEND inspections highlighted a broad and strong offer of local mental health provision and identified priority groups requiring greater focus to ensure equitable access to support.

Adult Mental Health

People with a mental illness such as schizophrenia or bipolar disorder die on average 15-30 years sooner than the general population. These stark and persistent inequalities highlight the urgency of improving access, quality and outcomes across the mental health pathway, from routine physical health checks to therapeutic support and crisis care.

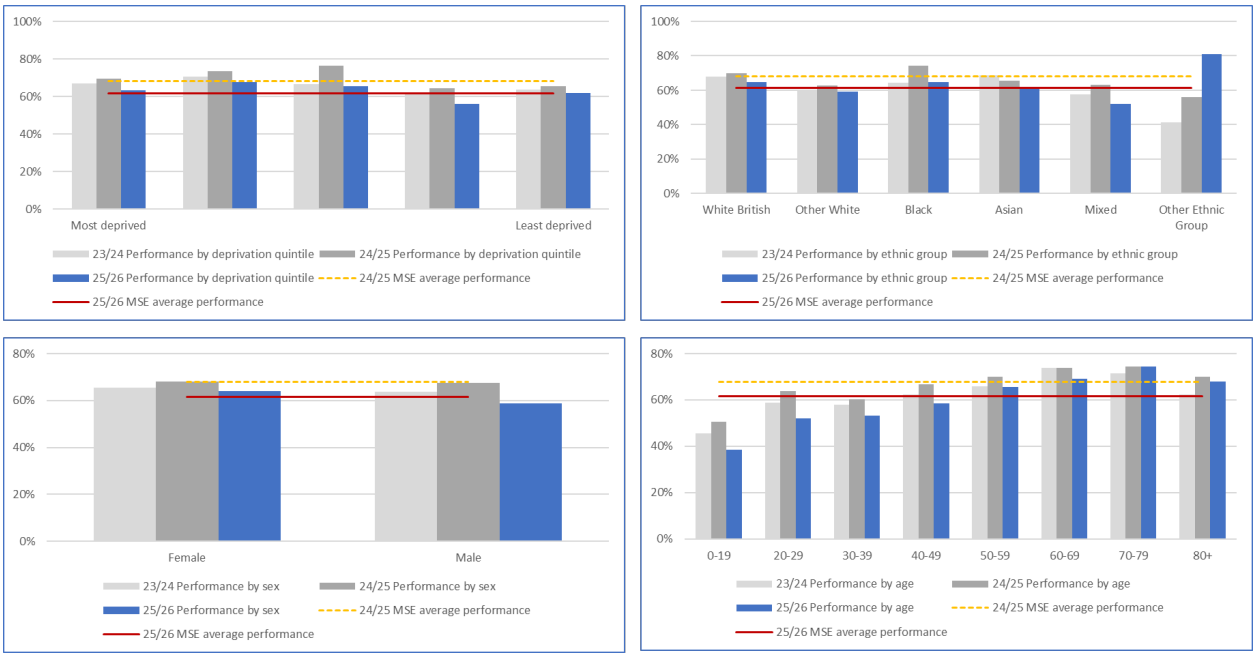
SMI Health checks

The ICB continues to prioritise reducing premature mortality for people with severe mental illness (SMI) by increasing uptake of annual physical health checks. The proportion of completed SMI health checks in the last 12 months continues to rise year on year, reaching 61.5% in December 2025 against a national minimum target of 60%, an improvement from 58.7% in December 2024. As many GP practices undertake these checks in the final quarter of the year, performance is expected to continue to improve.

Uptake among people living in our most deprived communities remains broadly in line with the least deprived, indicating equitable access across deprivation levels. However, uptake is disproportionately lower among people from mixed ethnic backgrounds and among younger adults aged under 40, highlighting groups where additional focus is needed.

These trends may reflect lower engagement with primary care among younger adults and some ethnic groups, including differences in trust, access and competing demands that make routine checks harder to complete.

Indicator: Percentage of patients with Severe Mental Illness had a health check in last 12 months



Source: MSE local dataset – Athena, rolling 12 months ending in March 2024, March 2025 and December 2025.

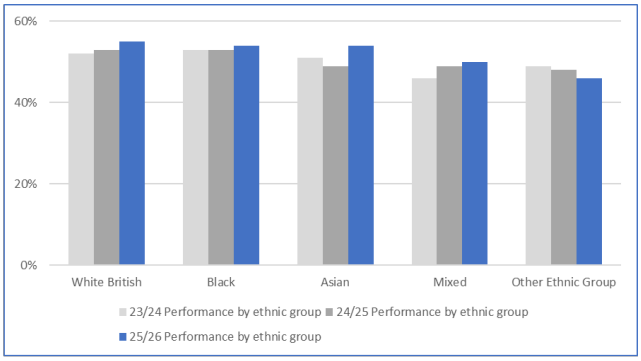
In response to the variations in uptake and to support more equitable access overall, the following actions were taken to strengthen delivery and engagement with SMI physical health checks.

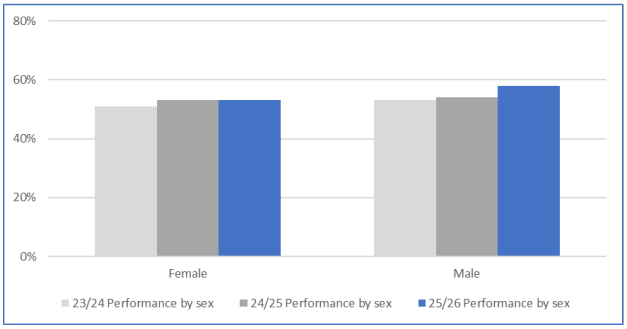
- Monitoring of the Standard Operating model and universal adoption of the step by step guide implemented across the three providers and General Practice. This has ensured consistency in health check delivery, leading to improved performance.
- Focus on principle ‘Don’t just screen, intervene’ and ensuring follow up interventions supporting healthy behaviours and lifestyle changes are accessed.
- Worked with VSCEs and other partners on outreach activities to target marginalised communities.

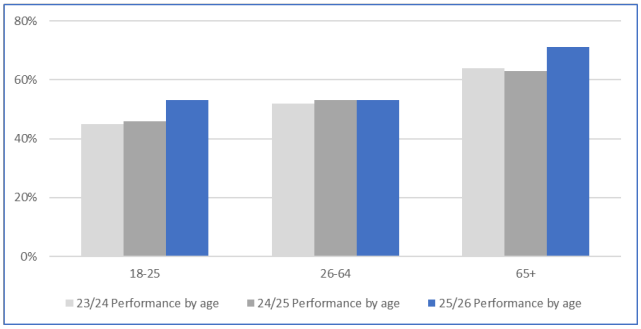
Talking Therapies

Nationally, evidence has found that those from Black and minoritised ethnic backgrounds have poorer outcomes from NHS talking therapies. In 2025/26, within MSE those from a Black and Asian background have seen improved recovery outcomes that are in line or exceed those individuals that are White British. There has also been a notable improvement in recovery rates in those aged 18 to 25 years.

Indicator: Talking Therapies patient recovery rates







Source: NHS Talking Therapies Protected Characteristics Dashboard, April to October 2025.

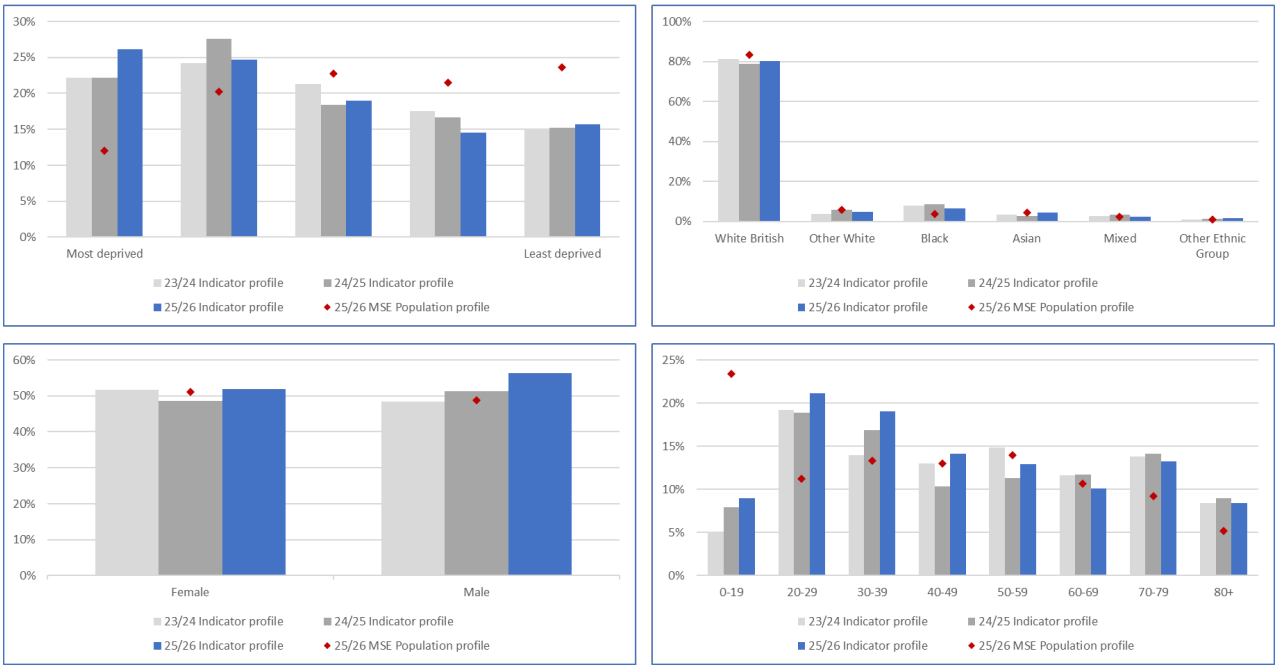
In 2025/26 the ICB has remained focused on the development of a new service specification that underpins the procurement process that is underway. The outcome will be an equitable service across MSE where inequalities are addressed by reducing variation. Service user engagement has directly informed the specification to ensure the future service addresses health inequalities.

Mental Health Act detentions

Rates of Mental Health Act detentions and rates of restrictive interventions are shown nationally to be higher for those patients from deprived areas or from global majority background. In MSE there is overrepresentation from the most deprived areas (quintiles one) and the younger age group (those under 40 years) for Mental Health Act detentions. There also remains an overrepresentation from those with a Black ethnicity.

These patterns are likely driven by underlying social and structural factors, including higher levels of socioeconomic disadvantage, differential experiences of crisis care, and longstanding inequalities in how mental health services are accessed and responded to across ethnic groups.

Indicator: Rates of Mental Health Act detentions



Source: EPUT local dataset January 2025. This data represents unique patients not volume of detentions.

To support more consistent, compassionate crisis care and reduce avoidable escalation, the following actions were implemented.

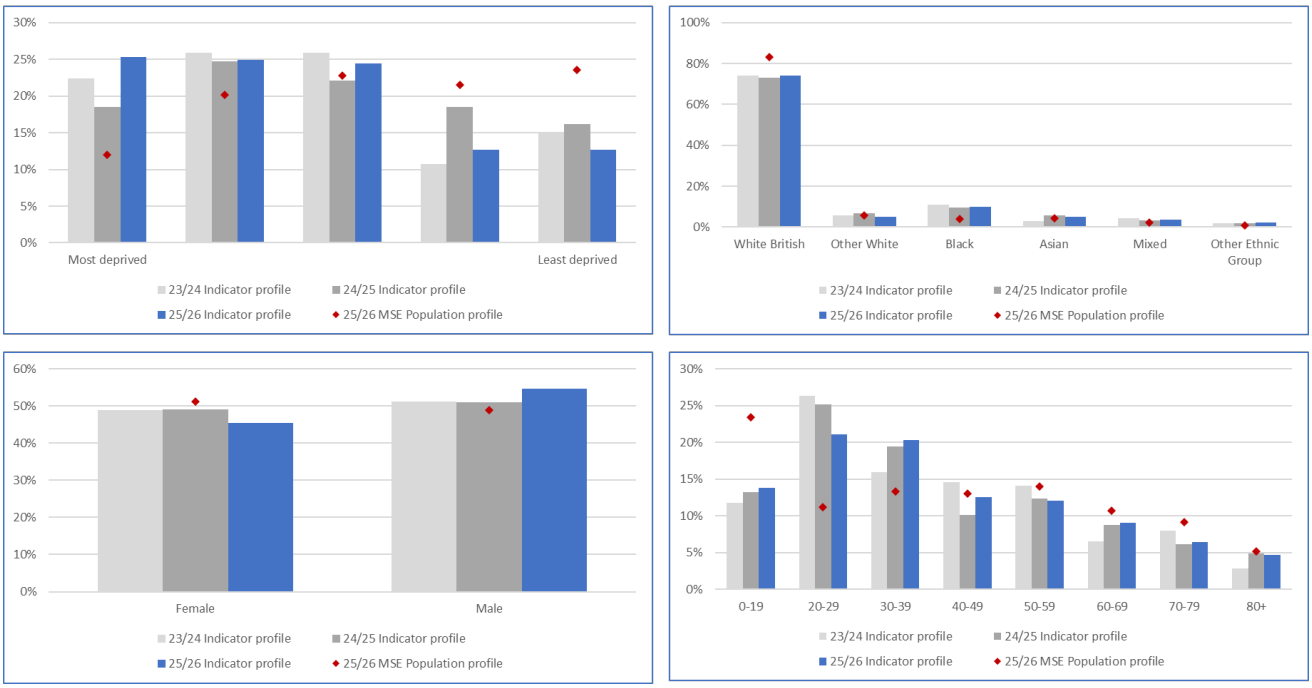
- Roll out of Psychology delivered 3-day Trauma informed training, Neurodiverse and personality disorder launched in October 2025 to strengthen staff understanding of factors linked to crisis escalation and detention.
- Expansion of trauma informed practice through co-production with people with lived experience, including the *Trauma Buddy* passport pilot across four mental health wards, supporting staff to respond more appropriately to triggers and reduce escalation risk.

Restrictive interventions

In MSE rates of restrictive interventions show continued overrepresentation among people from the most deprived areas, those from global majority backgrounds and adults under 40 years. Mental Health Act detentions continue to increase year on year between 2023/24 and 2025/26.

These patterns are likely driven by the combined effects of socioeconomic disadvantage, differing pathways into crisis care, and longstanding structural inequalities that influence how restrictive practices are used across age and ethnic groups.

Indicator: Rates of restrictive interventions



Source: EPUT local dataset, February 2025.

To improve the quality, consistency and person-centred use of restrictive interventions, the following actions were progressed.

- A new Lived Experience Ambassador has been appointed to support oversight of the restrictive practice workstream and contribute directly to change ideas.
- Dialectical Behaviour Therapy (DBT) skills embedded in specialist services, with adult acute wards progressing plans for staff training to improve support for people in distress.
- The Global Restrictions Policy has been reviewed and updated to ensure consistent, proportionate, person-centred use of restrictive measures.

Learning Disabilities

People with a learning disability and autistic people face significant health inequalities leading to lower life expectancy and more avoidable deaths than the general population. Improving outcomes requires a strong focus on proactive physical health screening and reducing avoidable admissions to mental health inpatient care.

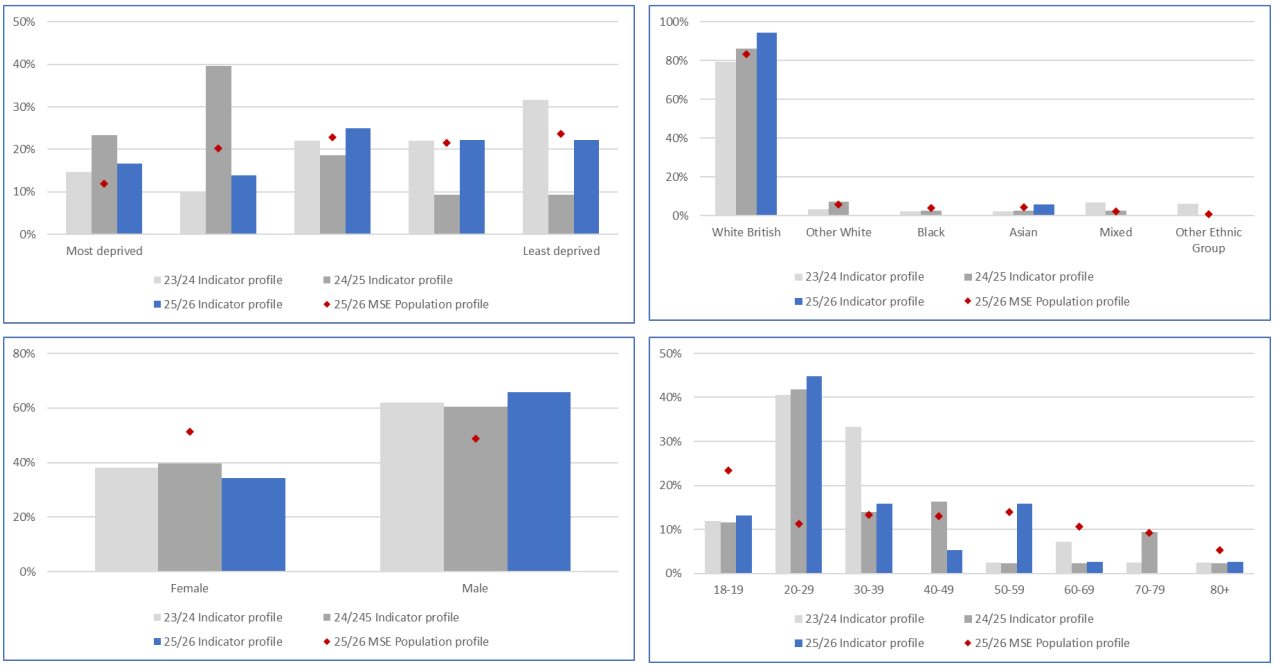
Adult mental health for people with a learning disability and autistic people

The NHS long term plan set out an aim to reduce the number of people with learning disabilities and autism in inpatient mental health care. The NHS long term plan set out an aim to reduce the number of people with learning disabilities and autism in inpatient mental health care. In MSE, progress has been made, with a reduction in the number of inpatients with learning disabilities between 2024/25 and 2025/26. There has also been a positive

decrease in the proportion of people admitted from the most deprived areas. However, the data shows an increasing overrepresentation of people from White British backgrounds, which highlights the need for continued focus on equitable access and support.

These trends are likely influenced by variations in access to community support and persistent structural inequalities that shape who is most likely to reach inpatient mental health care.

Indicator: Adult mental health inpatient rates for people with learning disability and autistic people



Source: EPUT, 2025/26 is reported for April-25 to January-26. The data represents admissions of LDA patients in these periods.

A significant number of adults have stepped down from the Dynamic Support Register (DSR); a list of people with learning disability and autistic people at risk of hospital admission, reflecting improved oversight of individual risks and more effective personalised care planning. Building on the progress reported last year, the ICB continues to strengthen use of the DSR and ensure regular multi-disciplinary reviews are in place. For those who are admitted, robust C(E)TRs remain a core assurance mechanism to support timely discharge to less restrictive settings.

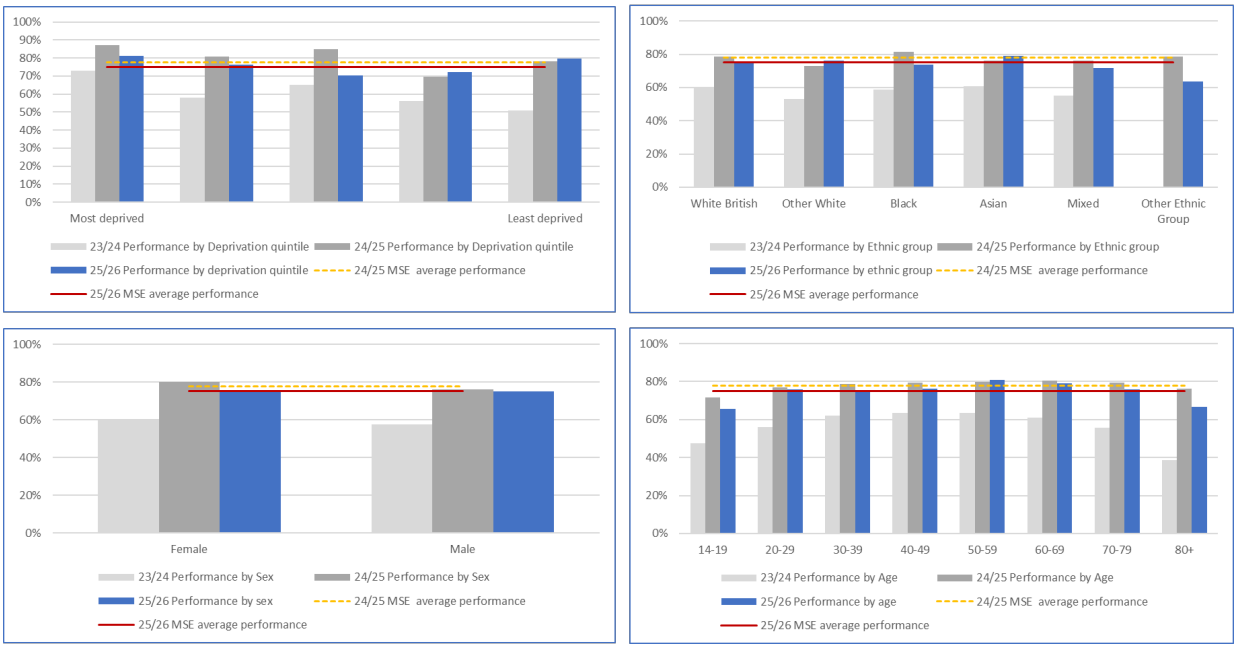
Annual health checks for people with Learning Disabilities

Annual health checks for people with learning disabilities are crucial for addressing health inequalities by identifying and managing previously unrecognised health needs. In MSE, completion rates have continued to meet the national target of 75%, standing at 75.1% as of December 2025, although this represents a slight decrease from the 77.8% that was achieved in March 2025.

Completion rates are higher among people living in the most deprived areas and those from an Asian background. While a lower proportion are seen among 'Other' ethnic groups and in the youngest age cohort.

These patterns are likely influenced by competing life demands among younger adults, alongside cultural, language and trust related barriers experienced by some ethnic groups, all of which can reduce engagement with primary care and make routine preventative health checks harder to access or prioritise.

Indicator: Learning Disability Annual Health Checks (rolling 12 months)



Source: MSE local dataset – Athena, December 2025.

To strengthen equitable access and reduce health inequalities in annual health checks for people with learning disabilities, the following actions were taken across MSE.

- Notable quality improvements through combined delivery of annual health checks and personalised Action Plans, with more consistent and sustainable practice now embedded across providers.
- Progression of the LD Friendly Accreditation scheme by the Essex Learning Disability Partnership (ELDP), with Audley Mills (Rayleigh) becoming the first accredited GP practice and strong demand from others to join.
- Innovative access models, including specialist weekend clinics run by South East Essex PCNs and a Home First approach to reach individuals unable or reluctant to attend practices, ensuring reasonable adjustments and widening access.

Respiratory

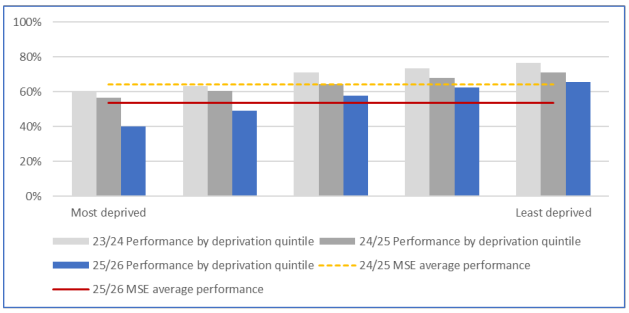
There has been continued focus within MSE to maintain uptake of COVID, flu and pneumonia vaccines to reduce respiratory emergency admissions. Ensuring equitable access to vaccination programmes is key to sustaining improvements in respiratory health.

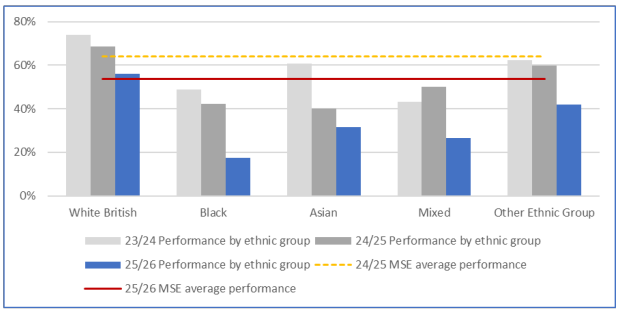
COVID vaccinations

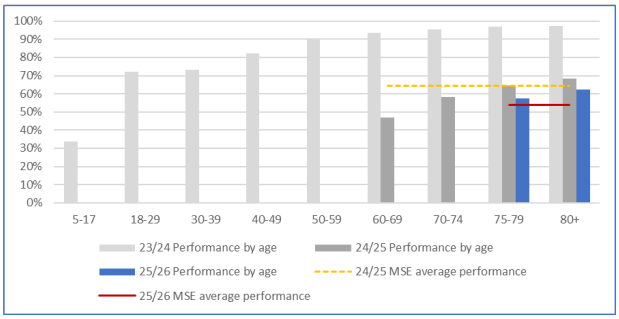
In line with the national picture, MSE has seen a decline in the overall uptake of COVID vaccinations. In 2025/26, uptake is lower among people living in the most deprived areas and among those from global majority backgrounds and the gap between groups is widening.

These patterns may reflect reduced confidence in COVID vaccination and reduced access to convenient vaccination opportunities and wider socioeconomic pressures, which consistently impact uptake more heavily in deprived and global majority communities.

Indicator: Uptake of COVID vaccinations







Source: Foundry December 2025.

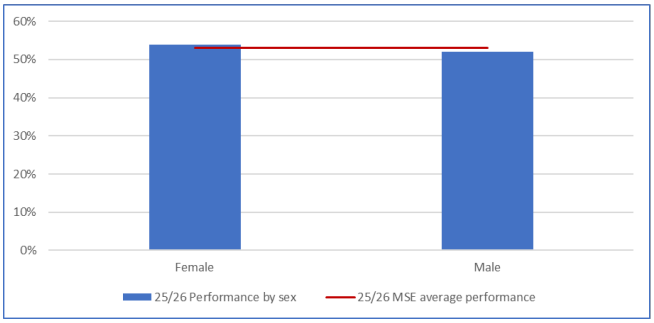
To address the widening gap in uptake of COVID vaccinations, the ICB has undertaken a range of targeted actions, including promotional activity in deprived communities and winter communications campaigns focused on areas with historically lower uptake. Access has also been improved through a significant increase in the number of community pharmacies delivery COVID-19 vaccinations, enable more providers than in the any previous campaign and enhancing reach across communities. Learnings from the 2025/26 campaign will shape targeted approaches next year to increase uptake among key demographics, including people living in deprived communities and Black communities.

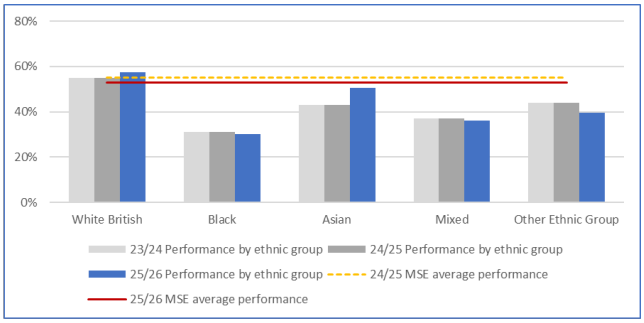
Flu vaccinations

Flu vaccinations uptake in 2025/26 is broadly in line with previous years, as of December 2025. However, uptake continues to be significantly lower among non-White British groups across the programme. The full dataset for the 2025/26 flu season will be published by September 2026, enabling a more detailed assessment of uptake by deprivation, age and other inequality dimensions.

Lower flu vaccination uptake among some ethnic groups may be influenced by differences in awareness, culturally relevant communication, and engagement with routine seasonal vaccination programmes.

Indicator: Uptake of Flu vaccinations





Source: Foundry December 2025.

To support more consistent and equitable uptake of flu vaccinations, the following actions were progressed across the system.

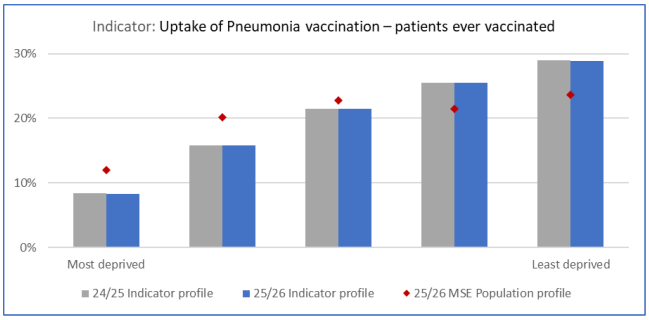
- Targeted promotional activity in communities with higher deprivation and historically lower flu uptake, supported by MSE's 2025/26 winter campaign toolkit, which provides inclusive messaging for all eligible adult groups.
- Delivery aligned with the NHS 'Super Bodies' children's flu campaign, widely promoted across mid and south Essex to increase uptake in areas with low childhood vaccination rates, including Thurrock and Southend.
- Engagement with primary care and community pharmacies to promote early booking and reduce barriers to access ahead of the 2025/26 flu season, especially in high need neighbourhoods.

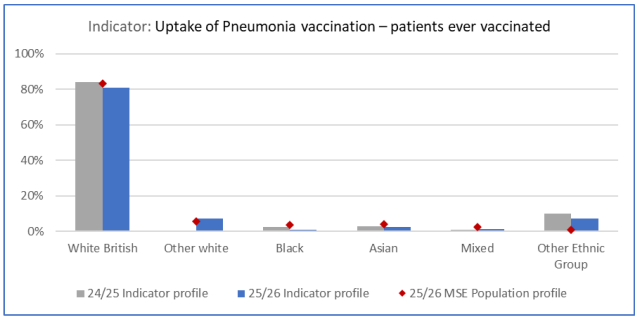
Pneumonia vaccinations

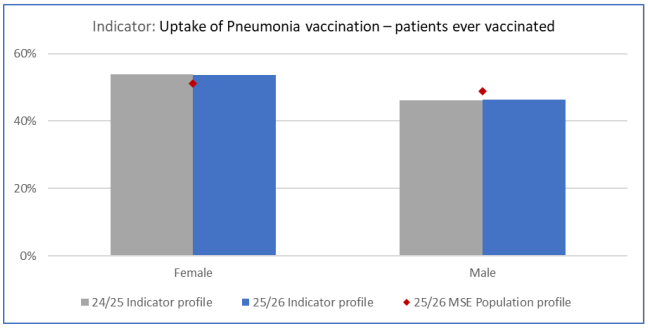
Most adults require only one dose of the pneumonia vaccine for long term protection. Year on year performance is consistent across overall numbers and sociodemographic factors. However, there continues to be underrepresentation in uptake among people living in our most deprived communities and from males.

This continued underrepresentation may be influenced by lower awareness of eligibility, reduced engagement with preventative health services and differing perceptions of risk among people in deprived areas and among men.

Indicator: Uptake of Pneumonia vaccinations







Source: MSE local dataset – Athena, December 2025.

The roll out of SystmOne alerts for eligible patients has proved operationally successful, helping practices more easily identify those due the pneumonia vaccine. As part of the wider ICB winter campaign, messaging about pneumonia vaccination was aligned with broader winter health communications, ensuring the programme remained visible alongside flu and COVID-19. Together, these measures increased awareness of the vaccination offer, even though uptake remains unchanged.

Cancer

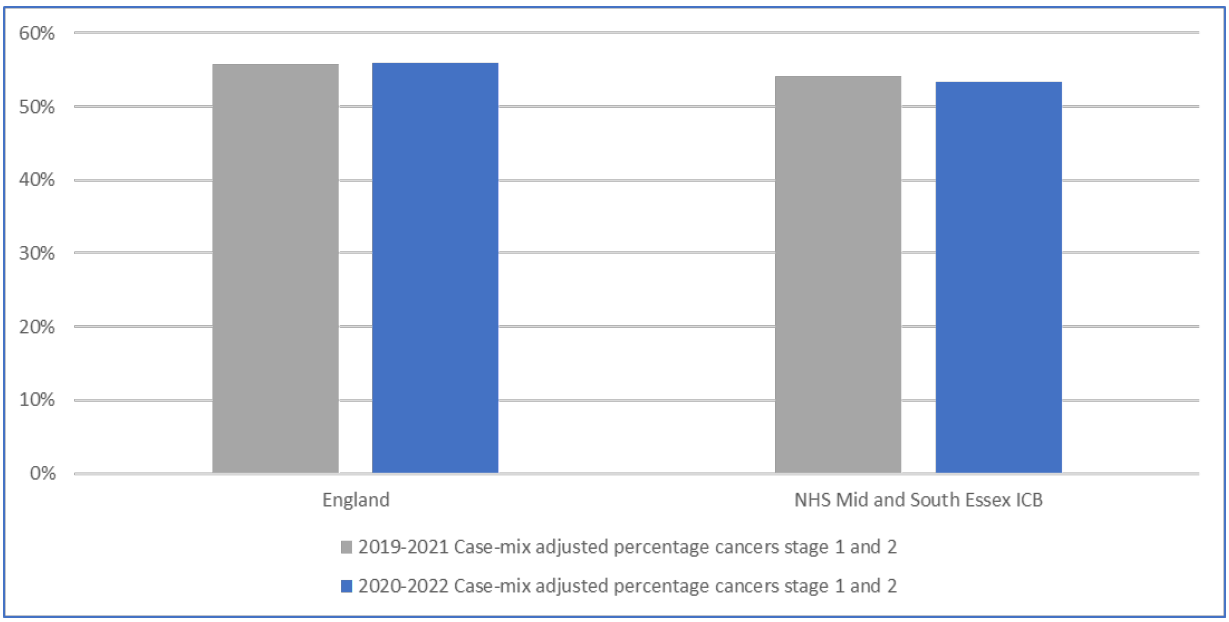
Early cancer diagnosis is a specific priority for MSE ICB as part of its adoption of the Core20PLUS5 framework. A collaborative approach has been taken across the ICB, Cancer Alliance, NHSE East of England region, MSEFT, PCNs and GP practices in reducing health inequalities in cancer. This coordinated effort aims to improve earlier detection, reduce delays across cancer pathways and ensure that all communities benefit from timely access to screening, diagnosis and treatment.

Early Cancer Diagnosis

A national ambition has been set that 75% of all stageable cancers will be diagnosed as stage 1 and 2 by 2028. The National Disease Registration Service provides the cancer staging data, with the latest data available being for 2020-2022. During this period, MSE ICB saw a slight reduction in the proportion of cancers diagnosed at stage 1 and 2, and performance remains below the England average.

These patterns may reflect challenges in achieving earlier presentation and diagnosis, including variations in symptom awareness, help seeking behaviour and access to timely diagnostic investigations.

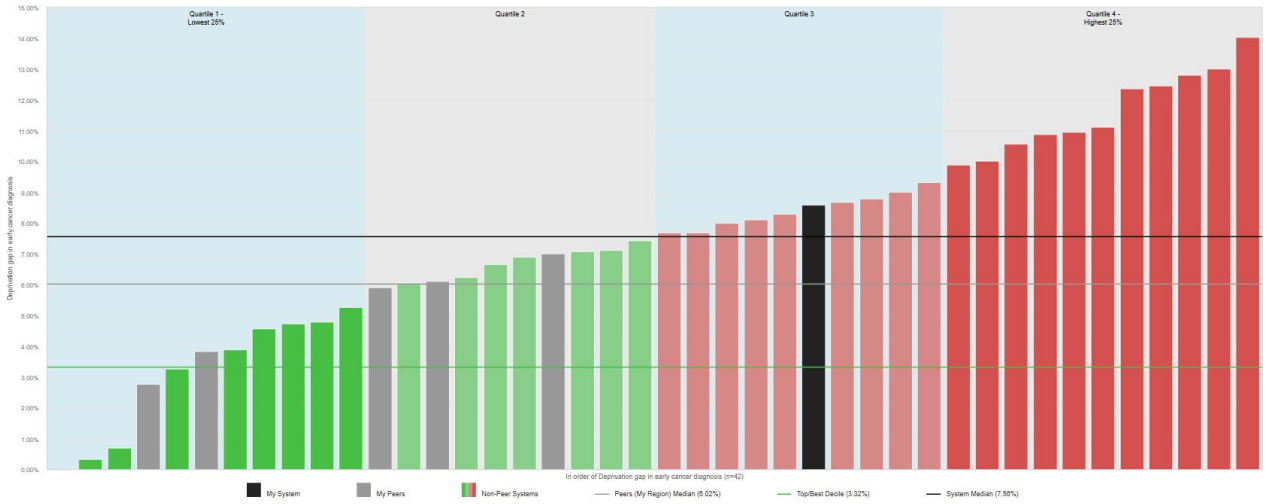
Indicator: Case mix adjusted percentage cancer diagnosed at stages 1 & 2



Source: Cancer Registry staging data from NDRS.

As part of the NHS Oversight Framework, the Slope Index of Inequality (SII) is used to measure the gap in early cancer diagnosis between the most and least deprived areas, helping to identify where inequalities may be emerging within an ICB. The chart below is taken from Model Hospital, a national NHS benchmarking tool that allows organisations to compare performance. It shows that in Q2 2025/26 the ICB's SII for early cancer diagnosis was 8.59%, reflecting a greater inequality than the England average of 7.56%.

Indicator: Deprivation gap in early cancer diagnosis



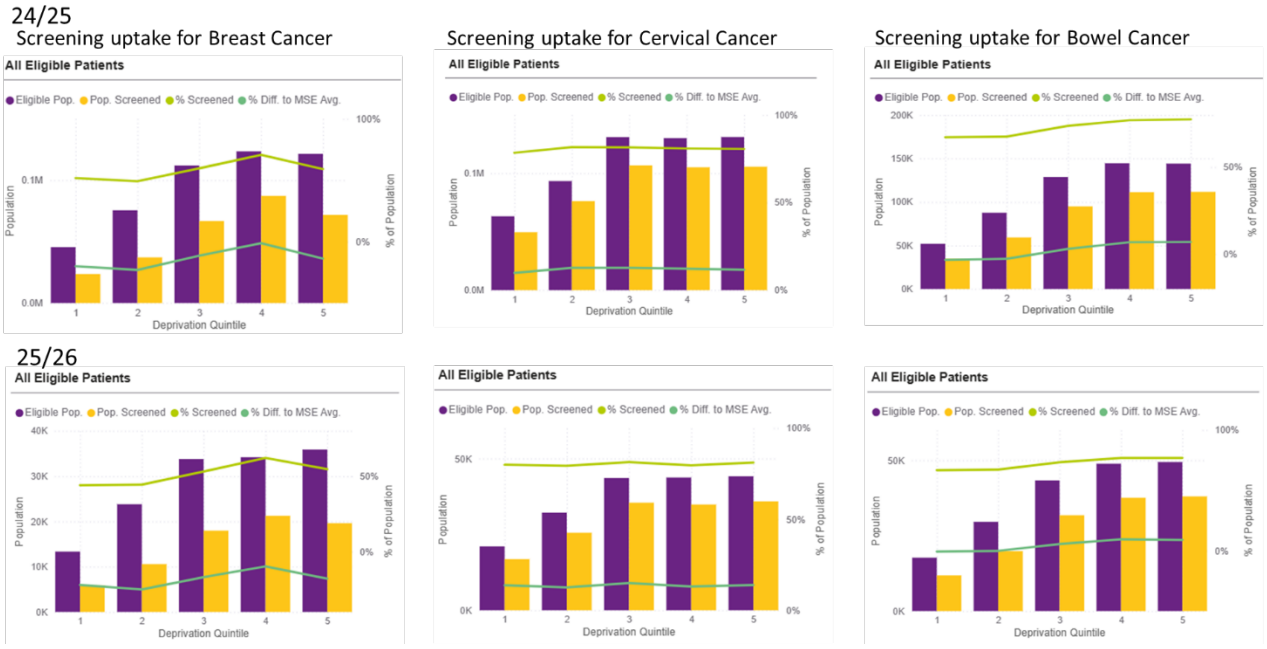
Source: Model Hospital.

Cancer Screening

Nationally, 90% of cancers found via screening were diagnosed at an early stage. However, there is lower uptake of cancer screening programmes in adults living in more deprived areas. In MSE there is marginal variation in cervical screening rates by level of deprivation. However, for breast and bowel screening the uptake is lower in areas of deprivation (quintile one and two).

These patterns may reflect lower awareness, confidence and engagement with screening, as well as practical barriers such as understanding and completing home test kits, all of which can reduce participation in more deprived communities.

Indicator: Screening update for Breast Cancer, Cervical Cancer and Bowel Cancer



Source: MSE local dataset - Athena extracted from SystmOne.

To help improve equitable uptake of cancer screening and reduce the inequalities seen in more deprived communities, the following actions were taken across MSE.

- Monthly screening data provided to PCNs, including HPV and lung cancer screening metrics, with breakdowns for key inequality groups such as people with learning disabilities, global majority communities, and people living with severe mental illness.
- Accessible screening communications, including new breast screening videos (with a version tailored for people with learning disabilities) and work underway on a cervical screening video, all available in multiple languages to support wider reach.
- Resources for community providers, ensuring annual health check teams promote cancer screening and awareness of red flag symptoms as part of routine contact with patients.
- Training through Taking the Lead (TTL) on the importance of early diagnosis and reducing emergency cancer presentations.
- Improving Cancer Journey (ICJ) programme, delivered in partnership with UCLP/Macmillan, testing this approach and working closely with the three most deprived PCNs in Southend to support earlier engagement and personalised care.
- Lung cancer screening has been expanded locally, with a mobile Lung Health Check unit brought to Canvey Island to make screening easier to access. More than 4,000 eligible residents were invited, and over 1,000 people completed a lung health check through the mobile service.

Cardiovascular

Cardiovascular disease (CVD) causes 1 in 4 deaths in England and is one of the leading causes of morbidity in MSE. CVD and stroke are largely preventable and therefore have remained a priority for the ICB over the last year. The CVD Prevention Programme has prioritised earlier detection and management of hypertension and high cholesterol, with targeted work to improve access for groups at higher cardiovascular risk.

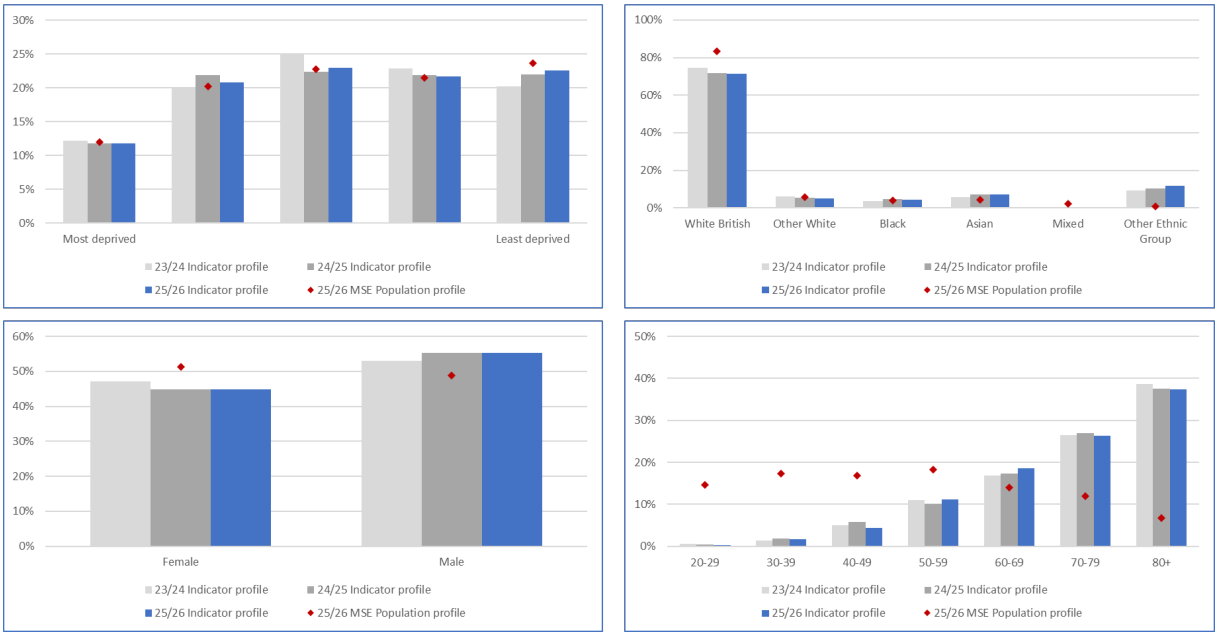
Stroke and Heart Attack Admissions

Nationally, the number of people admitted to hospital following a stroke continues to rise, with those from lower socioeconomic groups experiencing strokes earlier and facing poorer outcomes. In MSE, stroke admissions in 2025/26 are broadly in line with the population profile by deprivation. However, there is an overrepresentation among people from ‘Other’ ethnic groups and among males.

Model Hospital data shows that, as of September 2025, the gap in stroke admissions for the most deprived quintile in MSE was 7.4%, compared with the national median of 27%, indicating a closing of the deprivation gap locally.

These patterns may reflect underlying differences in cardiovascular risk profiles and health seeking behaviours, as well as barriers to early prevention and management, which can disproportionately affect some ethnic groups and men.

Indicator: Stroke rate of non-elective admissions (per 100,000 age sex standardised)



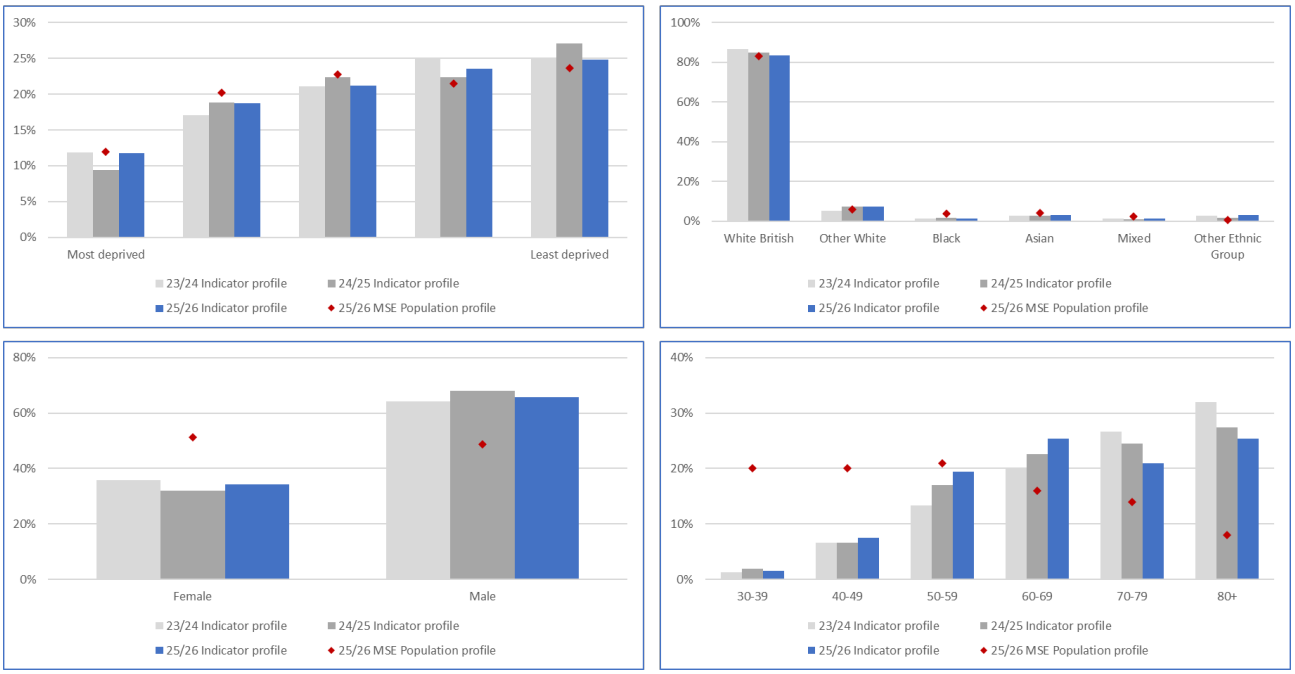
Source: MSE local dataset - Athena from SUS (Note: 24/25 12 months, 25/26 9 months data).

Heart attacks (myocardial infarction) is a leading cause of hospital admissions and mortality in the UK. Nationally, the emergency admission rate for heart attacks is higher from lower socioeconomic groups and women often face disparities in care and outcomes. In MSE, there is a notable overrepresentation of males although this reduced slightly in 2025/26. This may indicate potential underdiagnosis in women, due to differences in how symptoms present compared with men.

In MSE, there appears to be no inequalities gap in myocardial infarction admissions linked to socioeconomic deprivation or ethnicity, with admissions broadly reflecting the overall population profile. Model Hospital data supports this, showing that the gap in heart attack admissions for the most deprived quintile is comparable with the national average.

Given the continued overrepresentation of men, these patterns may reflect differences in how symptoms are experienced, recognised and acted upon by men and women, alongside variations in help seeking behaviour, which can contribute to under diagnosis in women.

Indicator: Myocardial infarction (heart attack) rate of non-elective admissions (per 100,000 age sex standardised)



Source: MSE local dataset - Athena from SUS (Note: 24/25 12 months, 25/26 9 months data).

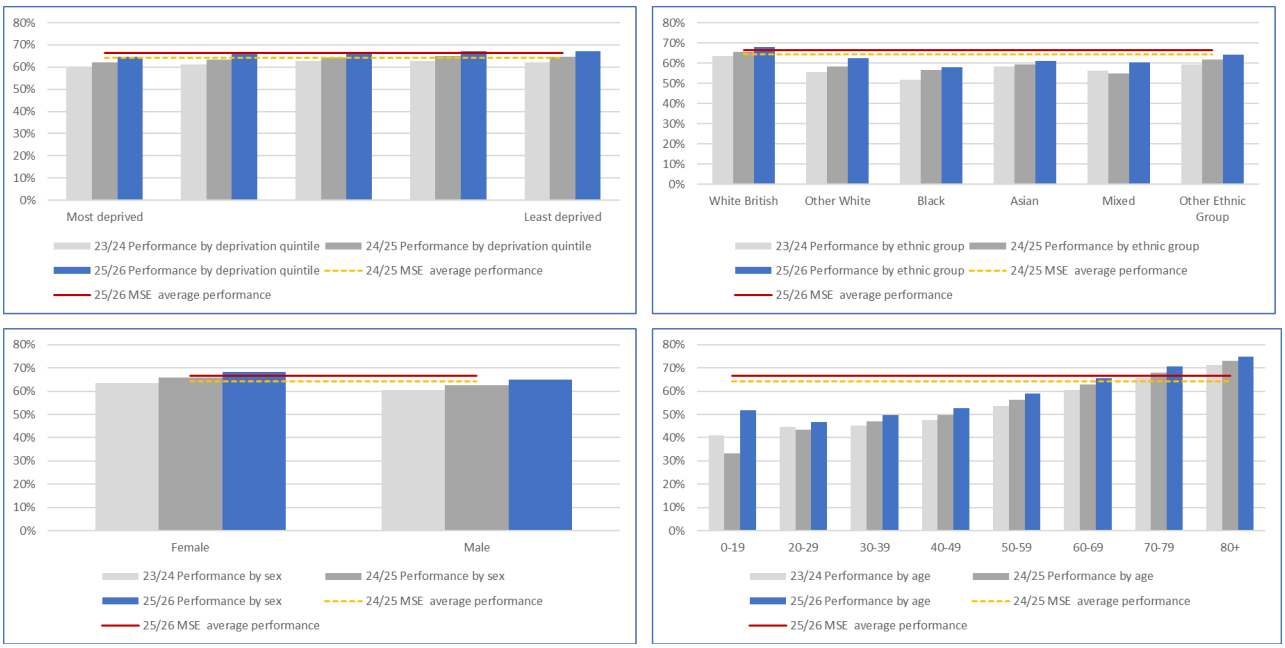
The ICB has focused on interventions for the prevention and treatment of cardiovascular disease across three main areas (1) Hypertension – diagnosis and treatment of high blood pressure (2) Cholesterol – reduction through prescribing of statins (3) Atrial fibrillation or abnormal heart rate – regulate through prescribing of anticoagulants.

Hypertension

Hypertension (high blood pressure) is a key priority within the NHS Long Term Plan and was a national objective for 2025/26, with a focus on increasing the proportion of patients treated in line with NICE guidance. In MSE, there has been a continued increase in the proportion of patients treated to threshold, including among those living in the most deprived areas. There has also been improvement across all ethnic groups; with a closing of the inequality gap for those from an Other White or mixed ethnic background. However, an inequality gap remains, particularly for people from Black ethnic backgrounds. Performance has also improved among younger age cohorts (under 60 years), although a treatment gap persists for this group.

These patterns may reflect the fact that younger adults and some ethnic groups often face greater barriers to regular monitoring and optimisation of hypertension management. These barriers can include lower ongoing contact with primary care, competing work and life pressures, and cultural or language factors that can affect confidence and engagement with treatment.

Indicator: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (in last 12 months) is below the age appropriate treatment threshold



Source: MSE local dataset - Athena, 25/26 data latest position as at end of December 2025. NOTE: 24/25 could not be updated, so data represents 9 months.

Given the continued treatment gaps among younger adults, residents in more deprived areas and some ethnic minority groups, the following actions were taken to strengthen identification, monitoring and management of hypertension across MSE.

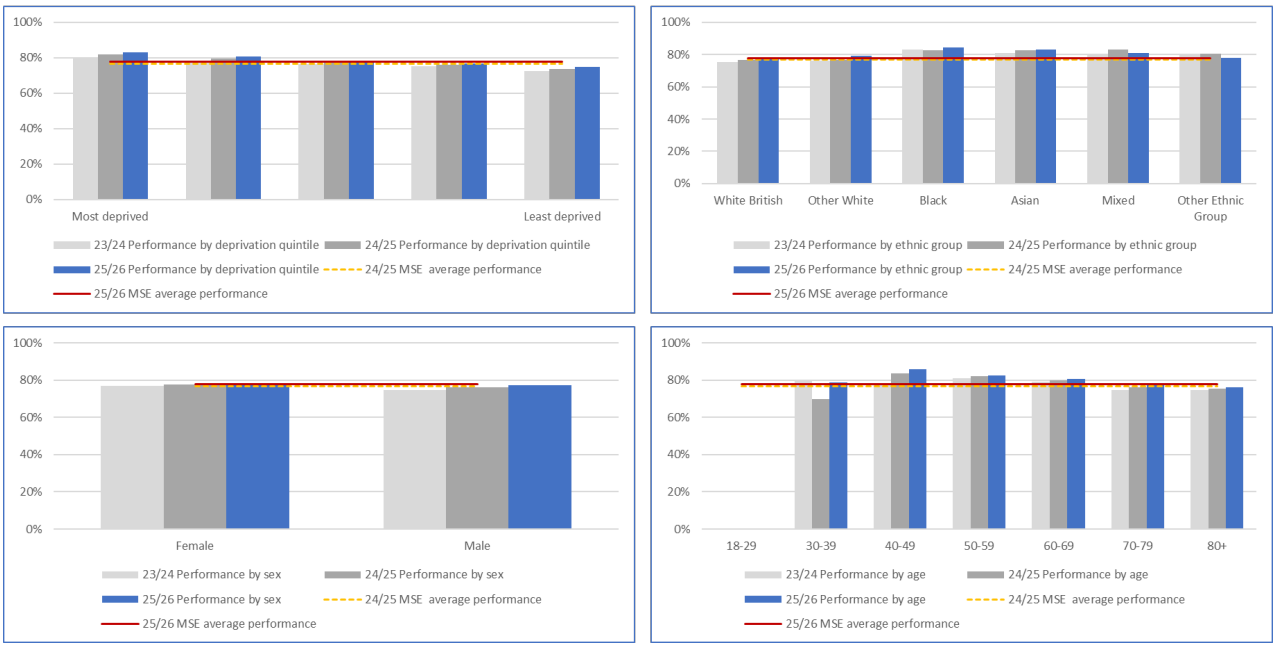
- Increased engagement from GP practices, supported by targeted feedback on local hypertension performance across MSE.
- Delivered community outreach events through the CVD Community Outreach Grant Scheme, targeting people least engaged with primary care. Across 17 events in 10 PCNs, 969 residents were reached, and 182 individuals were identified with uncontrolled hypertension requiring medical intervention. All outreach has included hypertension case finding and management.
- Launched the MSE CVD Detect & Perfect programme (September 2025) to support primary care in identifying and managing hypertension using digital population-health management tools. Since launch, over 4,000 patients have taken an up-to-date blood pressure reading, helping practices identify those needing clinical review.
- Ran a 12-month hypertension communications campaign, delivered with local authority public health teams as part of the regional CVD New Care Model, raising awareness of the importance of blood pressure. The campaign generated over one million impressions across NHS Mid and South Essex social media, YouTube and Meta advertising, increasing visibility of key messages.
- Collaborated with Essex County Council and Essex Library Services on the blood pressure library loan scheme. From September 2025, BP monitors have been available free of charge in all Essex libraries, with 15 libraries also offering free standing machines for onsite readings to support wider access.

Cholesterol

Raised cholesterol is one of the top three modifiable contributors to cardiovascular death. Statins, as lipid lowering therapies, are the most effective medicines for reducing cholesterol levels for most people. Improving treatment for people with recorded cardiovascular disease (CVD) or a QRISK score of 20% or more is a national NHS priority, with a focus on ensuring eligible patients receive appropriate lipid lowering therapy. In MSE, performance has improved year on year, with greater uptake of lipid lowering therapies in the most deprived areas and among people from global majority backgrounds.

These patterns may reflect the impact of strengthened system wide efforts to identify and treat high risk patients, while still highlighting the need for continued focus on groups where uptake remains comparatively lower.

Indicator: Percentage of patients aged 18 and over with GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

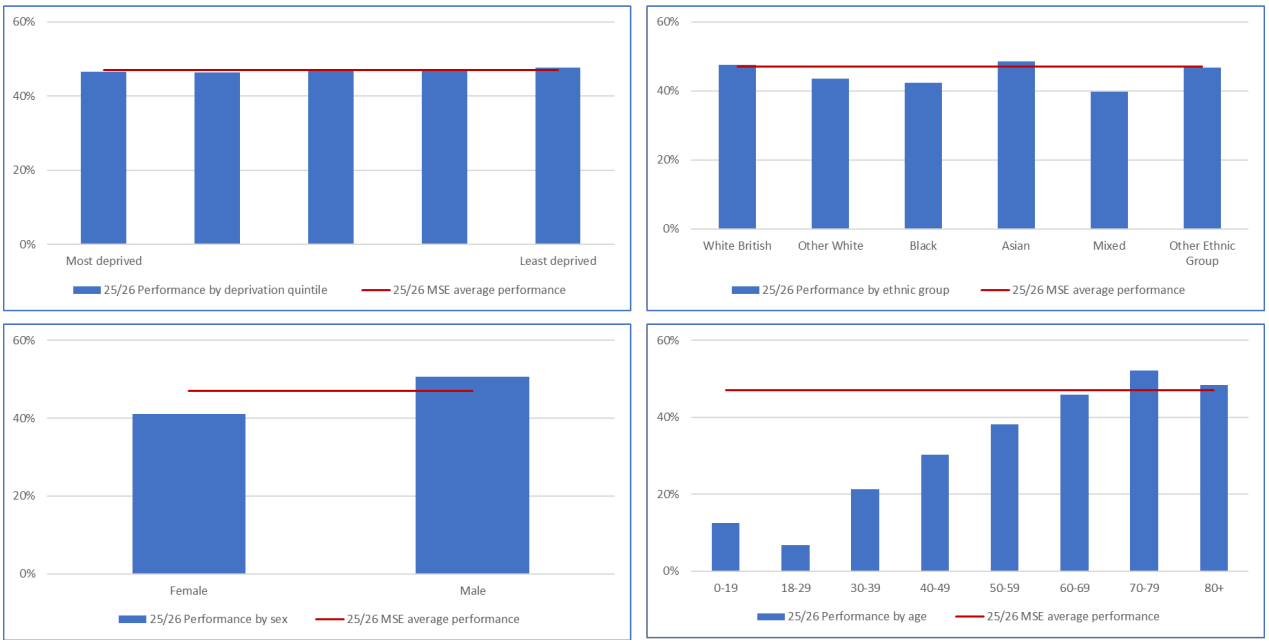


Source: MSE local dataset - Athena, 25/26 data latest position as at end of December 2025. NOTE: 24/25 could not be updated, so data represents 9 months.

In 2025/26, the national oversight framework was expanded to include ensuring that patients on lipid lowering therapies are optimised in line with NICE guidance. Against the national target of 50% by March 2026, MSE is on track to achieve this, with performance at 47% as of the end of December. There is equality in lipid optimisation across deprivation groups; however, a lower proportion of people from Other White, Black and Mixed ethnic backgrounds, and those under 60 years of age, are managed to NICE targets. Women are also less likely to reach NICE lipid targets, reflecting national evidence that they are less often prescribed higher intensity statins and may report higher levels of statin intolerance.

These patterns may reflect lower ongoing contact with primary care, fewer opportunities for dose review, and varying levels of understanding and confidence in lipid lowering therapies, all of which can make optimisation more challenging for some groups.

Indicator: Percentage of patients aged 18 and over with GP recorded CVD who have their cholesterol levels managed to NICE guidance



Source: MSE local dataset - Athena, 25/26 data latest position as at end of December 2025.

To strengthen consistency and support more equitable optimisation of cholesterol treatment, the following actions were implemented across MSE.

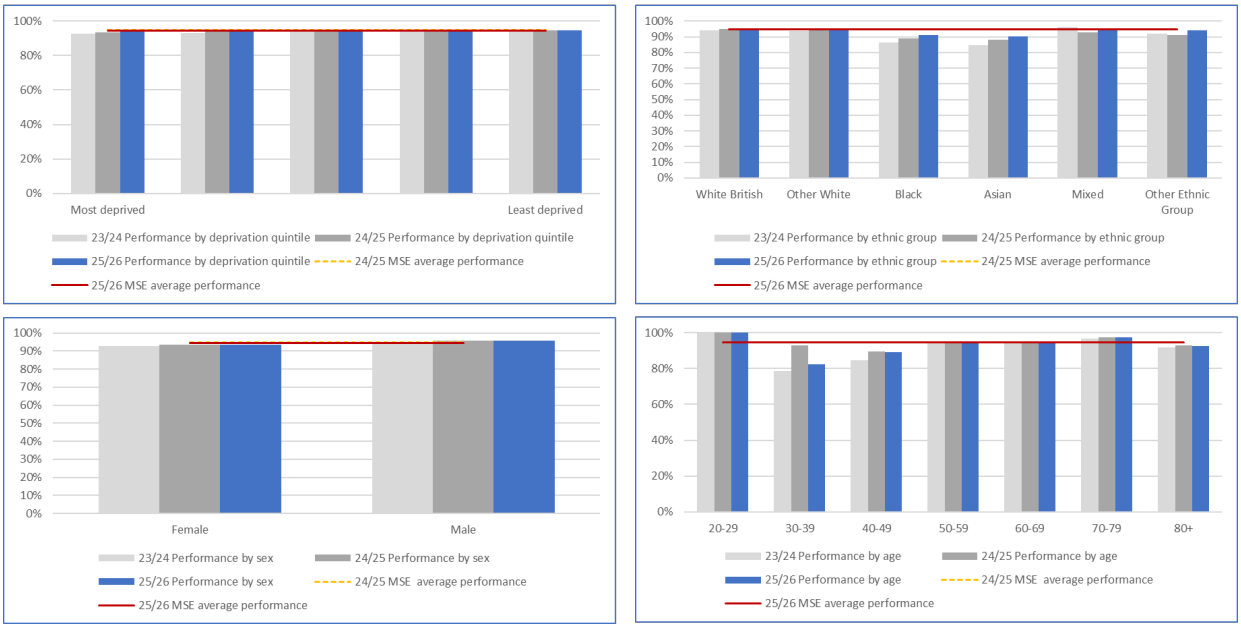
- Strengthened engagement with GP practices by providing tailored feedback on local cholesterol management performance across MSE.
- Delivered community outreach through the CVD Community Outreach Grant Scheme, where 25 people were identified at outreach events as needing a blood test to investigate possible high cholesterol.
- Worked with general practice and local residents to understand barriers to starting and optimising cholesterol treatments. Feedback from clinicians highlighted the need for further education, while a patient survey of 299 residents found people wanted clearer information to support decisions about managing their cholesterol.
- Developed and launched a three-part cholesterol education programme for the primary care workforce. The sessions cover primary prevention, secondary prevention and familial hypercholesterolaemia, promoting best practice in engaging patients and initiating and optimising lipid lowering therapy.

Atrial Fibrillation

Atrial fibrillation (AF) is the most common heart rhythm disorder and doubles a person's risk of stroke. Prescribing anticoagulants for people with AF is an effective and low risk way to reduce this risk. In MSE, the proportion of patients with AF receiving anticoagulation has been maintained in 2025/26 and remains above the national average. Uptake continues to be lower among people from Black and Asian ethnic backgrounds, although this gap has begun to narrow. However, the lower uptake among those aged 40-49 years has not improved.

These patterns may reflect differences in engagement with long-term anticoagulation, levels of confidence and understanding about treatment, and the need for ongoing monitoring, which can present greater barriers for some ethnic groups and younger adults.

Indicator: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy



Source: MSE local dataset - Athena, 25/26 data latest position as at end of December 2025. NOTE: 24/25 could not be updated, so data represents 9 months.

The CVD Community Outreach activities delivered across 10 PCNs include carrying out pulse checks to identify new cases of atrial fibrillation (AF) and exploring opportunities to optimise treatment for existing patients. Of the 52 pulse checks completed, 20 people were subsequently diagnosed with AF.

Diabetes

Diabetes does not affect everyone equally, with inequalities in access to service and outcomes, along with the risk of developing type 2 diabetes being driven particularly by ethnicity and socioeconomic deprivation. Improving completion of the 8 Care Processes

remains central to addressing these inequalities, ensuring that people receive comprehensive annual monitoring to reduce risks and prevent complications.

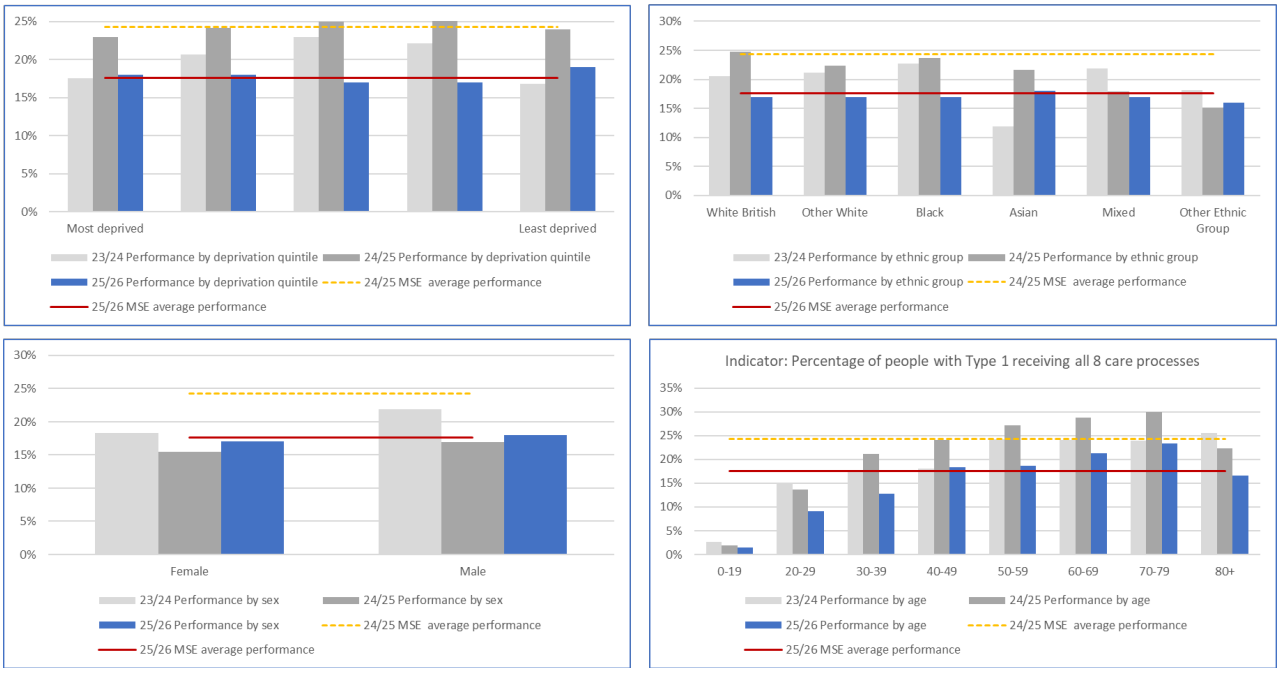
Type 1 Diabetes

For those with type 1 diabetes there are eight key care processes that are recommended by NICE that support the prevention of complications associated with diabetes. In MSE it appears there has been a deterioration in the overall percentage of people with type 1 diabetes receiving the eight care process. However, it should be noted that the data is recorded up to end of December so doesn't represent a full year. Many GP practices undertake these checks in the final quarter of the year, and therefore the data could be under reporting activity and performance. The rolling 12 months position shows improved performance at 29.6%.

Based on the available data, there has been a proportionate improvement in type 1 diabetic patient living in less deprived areas receiving the eight care processes, alongside a narrowing of the ethnicity gap, with a greater proportion of patients from a mixed or other ethnic group having the appropriate checks. However, despite these improvements, a significant lower proportion of patients aged under 40 years continue to receive all eight care processes.

These patterns may reflect fewer routine opportunities for diabetes monitoring and varying levels of engagement in ongoing care among younger adults, making completion of all eight care processes more challenging for this group.

Indicator: Percentage of people with Type 1 diabetes receiving all 8 care processes



Source: MSE local dataset – Athena extracted from SystmOne.

To strengthen the consistency and equity of type 1 diabetes care, particularly where younger adults face greater challenges completing the full set of care processes, the following actions were taken across MSE.

- Redesigning care pathways in high deprivation areas, with a strong focus on clinician education and reinforcing the importance of annual diabetes checks.
- Expanding use of digital diabetes technologies (e.g., CGM, Hybrid Closed Loop) to improve management for people with more complex diabetes.
- Strengthening workforce capability through targeted education on insulin management, DKA awareness, type 1 recognition in children, and improving access to foot checks and specialist training.
- Improving integration and engagement with primary care, including peer to peer learning, understanding non-attendance patterns, and sharing care process performance data.
- Promoting proactive identification of risk, using cohort finding and stratification tools to prioritise patients with the greatest needs.

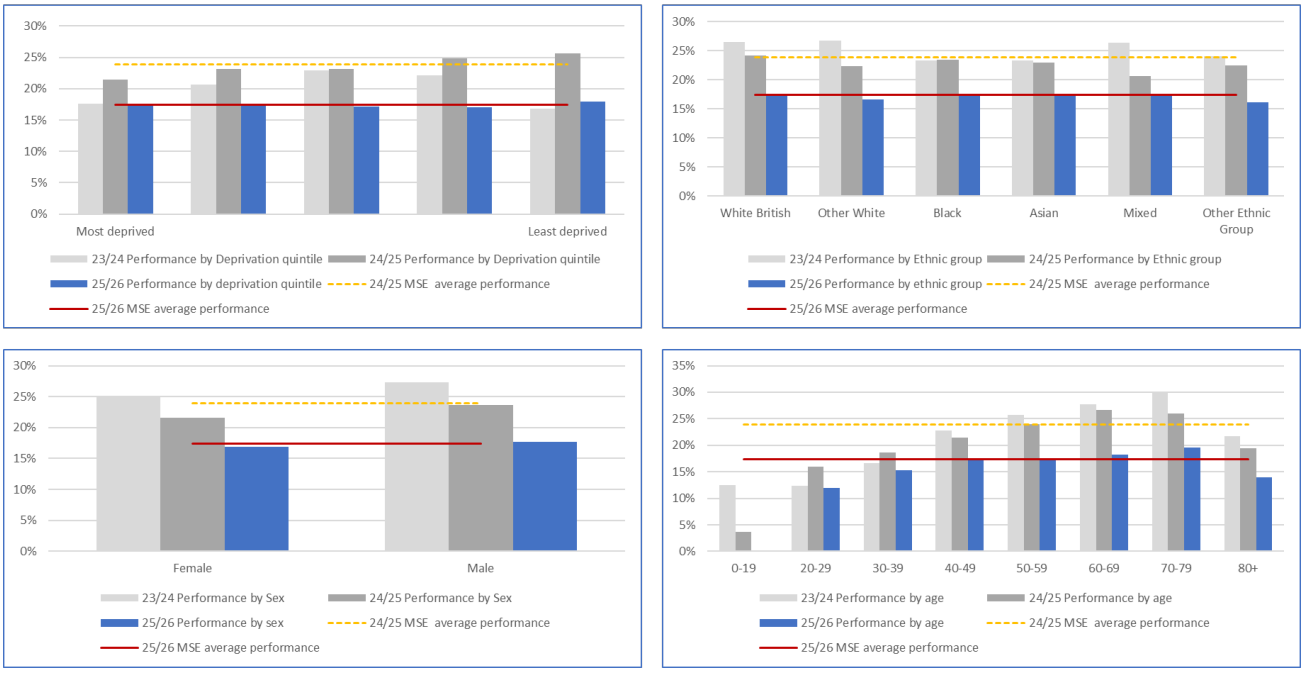
Type 2 Diabetes

The eight care processes are also recommended by NICE for those with type 2 diabetes. It should be noted that the same data limitations apply for type 2 and described above for type 1 diabetes with respect of checks undertaken in final quarter of 2025/26 that are not represented in the graphs. However, the rolling 12 months indicates improved performance with 39.9% of patients receiving all eight care processes.

It appears that the deprivation gap has narrowed, with similar uptake of the eight care processes across all socioeconomic deciles. Patients from ‘Other White’ or ‘Other’ ethnic groups show slightly lower completion rates compared with other groups. There remains continued under performance among patients aged under 40 years.

These patterns may reflect competing work and life pressures for younger adults, together with language, communication and engagement barriers that can affect confidence in diabetes monitoring and make it harder for some ethnic groups to complete all eight care processes

Indicator: Percentage of people with Type 2 diabetes receiving all 8 care processes



Source: MSE local dataset - Athena extracted from SystmOne.

To strengthen the consistency and equity of type 2 diabetes care across MSE, the following actions were taken to support completion of the eight care processes.

- Redesigning pathways in areas of highest deprivation, with targeted clinician education on complex diabetes management and reinforcement of annual checks.
- Strengthening workforce capability, including training on insulin and GLP-1 RA management, improved access to foot checks, and broader diabetes professional development.
- Increasing proactive identification of need, using cohort finding, risk stratification tools, and clinical system searches to prioritise patients at highest risk.
- Enhancing integration across primary and specialist care, including consultant support in the community, peer to peer learning, and engagement to address missed processes and non-attendance.

Risk factors; Smoking and Obesity

Smoking and Obesity are the main risk factors that drive premature mortality from cardiovascular disease, lung cancer and chronic lower respiratory diseases. Smoking is the single largest driver of health inequalities in England. Targeted action to reduce smoking prevalence and support healthy weight is therefore essential to improving population health and narrowing the gap in life expectancy.

Smoking

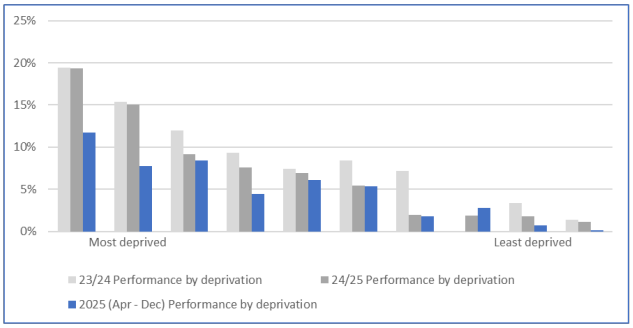
The MSE maternity stop smoking pathway launched in February 2024 across Basildon, Broomfield and Southend, enabling systematic identification and next day contact for all birthing people who currently smoke or have quit since conception. This approach has

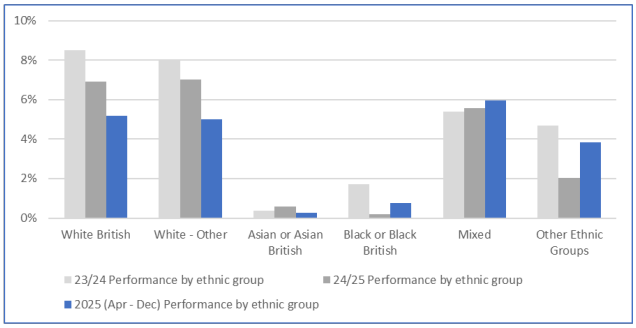
driven a sustained reduction in Smoking at Time of Delivery, falling from 9% in 2023 to below 6% in December 2024 and 4% in December 2025, surpassing the national target of 6%.

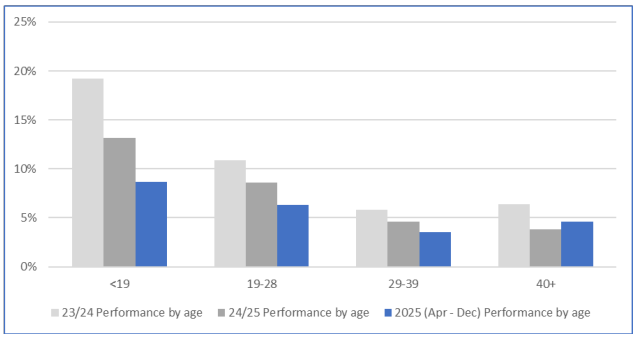
The service is also having a clear impact on inequalities, with the greatest reductions seen among those living in the most deprived areas. While rates have continued to decline for women from White ethnic backgrounds, increases have been observed so far in 2025 among those from Mixed and Other ethnic groups. Rates are also falling among mothers aged under 19, with reductions across most age groups over the past three years, except for an increase among those aged over 40 in 2025.

These patterns may reflect differences in how consistently support is accessed, understood and acted upon across communities, with variations in engagement, stressors and social influences contributing to slower progress among some ethnic and age groups.

Indicator: Smoking at time of delivery







Source: MSEFT maternity data.

To strengthen the impact of the maternity stop smoking pathway and continue reducing health inequalities, the following actions were taken across MSE.

- Delivering the National Smokefree Pregnancy Incentive Scheme (NSPIS) across MSE, with strong engagement and uptake of the Carbon Monoxide (CO) verified voucher programme.
- Supported smoking cessation for around 298 women referred in 2025, helping to sustain smokefree behaviours.
- Secured recurrent ICB funding for three full time Tobacco Dependency Advisor roles to provide ongoing specialist support beyond March 2026.
- Strengthened collaboration with Local Authorities, including integration of stop smoking support for pregnant women experiencing substance misuse.

For those patients admitted into wards in Basildon, Broomfield and Southend Hospitals who are identified as smokers, they were offered a referral into the Local Authority public health commissioned community smoking cessations services.

MSEFT have expanded its pre-operative assessments to include smoking cessation and weight management with staff actively engaging with patients and making appropriate referrals.

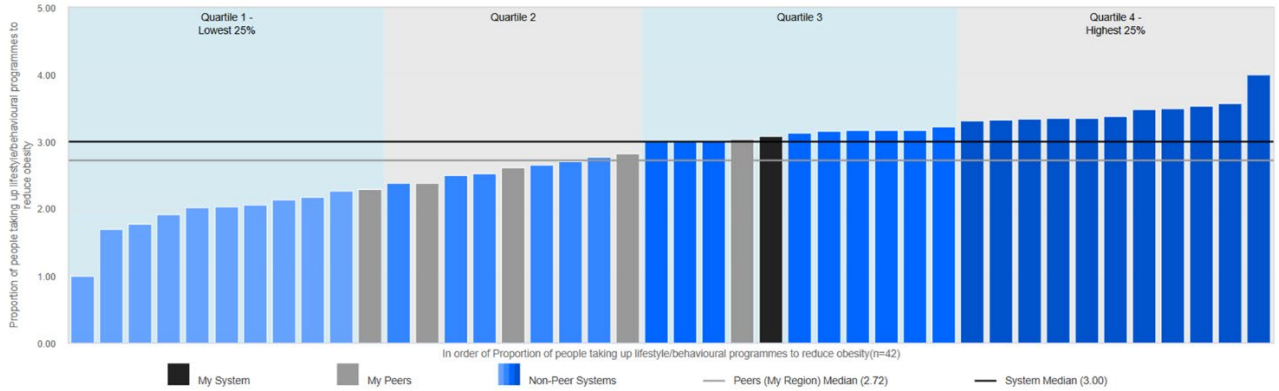
EPUT have trained staff working in mental health settings to provide support for smokers via the National Centre for Smoking Cessation and Training including developing knowledge on nicotine replacement therapy and medication interactions. The dataset for 2025/26 is not yet available, however this will be submitted to NHSE in May 2026, enabling an assessment of whether any inequalities exist in access to the service and outcomes.

Weight Management

In 2025/26 the NHS Oversight Framework, was expanded to include the proportion of people taking up lifestyle/behavioural programmes to reduce obesity. The ICB refers a greater proportion of the eligible population to the nationally commissioned NHS Digital Weight Management Programme and the Diabetes Prevention Programme. This is in addition to the Local Authority commissioned community lifestyle programmes available within MSE.

Further increasing access will require continued work to raise awareness of available programmes, strengthen referral pathways and support people to overcome practical barriers that can limit engagement with lifestyle and behavioural interventions.

Indicator: Eligible Referrals to lifestyle/behavioural weight management programmes (rate per 100,000 people living with obesity)



Source: Model Hospital.

To strengthen support for healthy weight and ensure equitable access based on need across MSE, the following actions were taken.

- Tier 3 specialist weight management service (Second Nature) launched in April 2025, supporting improved access and strong completion rates, particularly for those with greatest clinical need.
- Tirzepatide prescribed to priority cohorts within Tier 3, ensuring those at highest risk of obesity related harm receive evidence-based treatment.
- Promotion and signposting to all Healthy Weight and Diabetes services, helping improve awareness and access across communities with higher prevalence of obesity.
- Enhanced self-referral routes, with QR codes across MSEFT sites to simplify access for underserved groups to weight management, smoking cessation and alcohol reduction services.

Forward Look

The transition to the new Essex Integrated Care Board in 2026/27 presents a significant opportunity to consolidate strengths, reduce unwarranted variation and embed a more consistent approach to addressing health inequalities across a wider geography. As the footprint expands, the intelligence contained within this report will help shape priorities at system, alliance and neighbourhood level, ensuring that interventions reach those with the greatest need. The Essex ICB Population Health Improvement Plan (PHIP) will drive the ICB direction setting for Essex supporting health inequalities priorities.

A key focus for 2026/27 will be improving data completeness, linkage and interpretability across the new ICB. Strengthening ethnicity coding, expanding integrated datasets and maturing PHM tools will be essential for identifying hidden variation and enabling earlier, targeted intervention. The expanded footprint also provides opportunities to scale prevention programmes such as smoking cessation, cardiovascular identification and management and weight management services, ensuring equitable reach across diverse communities.

Improving equity in primary care access will remain central to narrowing inequalities. Enhancements to Connected Pathways, digital triage and community pharmacy provision will support more consistent access. Alongside this, governance arrangements will be strengthened to ensure that all commissioning decisions consider inequalities and that impact is transparently monitored across deprivation, ethnicity, age, and other characteristics.

Finally, place-based and neighbourhood level action will be central to tackling the areas where inequalities remain most entrenched: preterm birth, respiratory vaccination uptake, screening coverage, cardiovascular risk management, and premature mortality among people with learning disabilities and SMI. The formation of a single Essex ICB offers an opportunity to harmonise standards, reduce unwarranted variation and target resources where they will have the greatest impact for local communities.

Conclusion

With three years of data now available, this report offers our clearest understanding of where progress is being made and where significant inequalities continue to affect local communities. Improvements are evident in several priority areas, reflecting sustained and targeted work across the system. The analysis also shows that the most substantial gaps remain for people living in the most deprived areas, certain ethnic groups, younger adults with long-term conditions and those with severe mental illness or learning disabilities.

As we move into the wider Essex ICB footprint in 2026/27, these insights will play a vital role in shaping priorities at system, place and especially neighbourhood level, ensuring that resources and support are directed to communities with the greatest need. A continued focus on neighbourhood level action, supported by stronger data and consistent approaches to reducing unwarranted variation, will be key to achieving meaningful and sustained reductions in health inequalities.