NHS
Hertfordshire and
West Essex
Integrated Care Board

# ANNUAL REPORT AND ACCOUNTS

# 2022/23

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**HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD (ICB)**

NHS Hertfordshire and West Essex Integrated Care Board (ICB) is the local NHS organisation that plans and oversees how NHS money is spent and makes sure health services work well and are of high quality. The ICB's role is to join up health and care services, improve health and wellbeing and reduce health inequalities.

For 2022/23 the ICB had a budget of around £2.2 billion, for the 1.5 million people who live in this area. The budget is set by NHS England.

ICBs work collaboratively with key partners across the system including NHS providers, local authorities, voluntary community, faith and social enterprise sector and communities themselves to understand population needs, determine key priorities and design, plan and resource services to meet those needs, taking a more collective approach to planning and improving services and delivering services in an integrated way for the benefit of our communities.

This section provides an outline of the performance of NHS Hertfordshire and West Essex Integrated Care Board (ICB) from 1 July 2022 to 31 March 2023. It gives an overview of how we have commissioned services and discharged our statutory functions on behalf of the population we serve.

# Overview from the Chief Executive

It has been a busy but productive time since the three former Clinical Commissioning Groups in Hertfordshire and west Essex came together as one Integrated Care Board (ICB) in July 2022.

Our staff have worked incredibly hard to adapt to new ways of working, sometimes adjusting to new responsibilities and working in new teams, all the while continuing to focus on our mission to help support better, healthier and longer lives for all through our key priorities.

The ICB has continued to move ahead with its work to transform services across Hertfordshire and west Essex, including plans to care for more people at home under the expert supervision of their hospital team and community nurses through the 'virtual hospital' programme, increased diagnostic capacity, and the creation of more appointments in primary care over the winter period. Just in time for winter, the new integrated urgent care hub at St Albans City Hospital successfully opened on 31 October 2022. GP practices and the NHS 111 service can book patients into appointments in the service from 9am to 6pm, seven days a week, for same-day care for minor illnesses and injury.

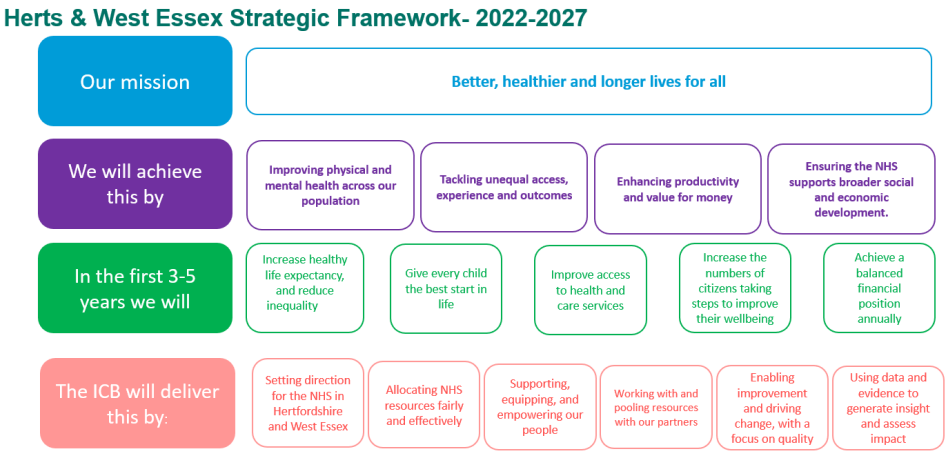
Another important focus for us has been, and in 2023/24 will continue to be, developing, finalising and implementing the five-year NHS Joint Forward Plan and working with system partners to develop the 10-year Integrated Care Strategy, both of which are critical to our ambition to improve the health and wellbeing of Hertfordshire and west Essex residents by making a ground-breaking shift to a population health focus for our work and the way we utilise our resources.

**Our strategic approach**

In November the Integrated Care Board agreed its strategic framework for 2022-2027, which will guide the work of the organisation during that time. The framework sets out an ambitious set of strategic objectives for that time:

- Increase healthy life expectancy and reduce inequality

- Give every child the best start in life
- Improve access to health and care services
- Increase the number of citizens taking steps to improve their wellbeing
- Achieve a balanced position annually




Over the course of the year the ICB has also worked with system partners to develop system wide strategies for two of the critical factors to successfully achieving our objectives - our workforce across the system and the opportunities presented by digital solutions and approaches.

**People Strategy**

In 2022 the ICB also agreed the ICS People Strategy for 2023-2025. This strategy supports integrated workforce planning, innovation and new ways of working, a sustainable workforce supply, improved staff wellbeing, experience, and education, talent, and leadership development. This Strategy outlines some of the ways in which the ICB meets it's legal duties to promote education and training.

You can read more about the strategy here: **papers-for-the-integrated-care-board-meeting-in-public-on-18-november-2022 (icb.nhs.uk)**

**Digital Strategy**

The Hertfordshire and West Essex ICS Digital Strategy for 2022-2032 provides a framework of principles and goals in which ICS-wide digital priority programmes will support the ICS transformation initiatives and how investment decision making is made.

You can read more about the strategy here: **digital-strategy-2022-23-pdf-version (hertsandwestessexics.org.uk)**

**Getting back on track – recovering from the impact of the pandemic**

The impact of the COVID-19 pandemic on our population and health services has been significant. Some more routine work and planned (non-urgent) operations were paused to

enable the NHS to prioritise the treatment of people who were seriously ill with COVID-19. Working in new ways to reduce the risk of COVID-19 infection to patients and staff had the effect of reducing our capacity to treat people, and we know that some patients put off seeking help with their health worries. Together with the impact of the infection on staff sickness rates, these factors have increased waiting lists for planned procedures and created backlogs in some services.

Our ICB teams are working with colleagues from across the NHS to reduce delays and implement new and more efficient ways of working, such as re-thinking the way that routine follow-ups are scheduled and extending opening hours at some of our diagnostic test centres. We are also encouraging everyone to come forward at an early stage if they have worrying symptoms, to try to ensure that patients don't miss out on vital diagnoses, treatments and care.

The unfortunate reality is that the impact of COVID-19 will be felt for some time in Hertfordshire and west Essex, and across the whole of the NHS. Our ICB has significantly reduced the number of people who have been waiting the longest for non-urgent treatment. The small group of patients who until recently have been waiting for treatment for two years or more have all been treated, or offered treatment at an alternative hospital if they would prefer.

We are now focused on reducing the number of patients waiting over 78 weeks for planned treatments, reviewing plans with our hospital trusts as we learn which actions are most effective. The ICB's aim is to ensure that by the end of March 2023, no-one has waited for more than 78 weeks for treatment. While the number of patients waiting over 52 weeks continues to increase, we are ensuring that patients with the most urgent clinical needs are treated first. Patients waiting for treatment are not forgotten – their circumstances are reviewed regularly to make sure they are not negatively impacted, and they are offered support.

**Vaccination programme**

The COVID-19 seasonal booster vaccination programme concluded in February 2023 – after delivering more than 3.7 million vaccinations over two years to residents across Hertfordshire and west Essex. The successful Hertfordshire and west Essex COVID-19 vaccination programme was a huge team effort, involving GP practices, pharmacies, our community and acute hospital trusts, district, borough and county councils, the voluntary and community sector, and everyone who helped us spread the word about the lifesaving vaccinations. I would like to extend my thanks to everyone who supported our efforts to get as many people vaccinated as possible, working around the clock to ensure everything ran as smoothly as it could.

In moving forward, vaccinations will be offered on a seasonal basis to those who are the most vulnerable to COVID-19.

**Community diagnostic centres – new announcement of funding**

Developing sufficient diagnostic capacity across Hertfordshire and West Essex is critical to recovering and transforming our services.

The ICB's new diagnostics strategy is being developed with input from the public, stakeholders, GPs and diagnostic staff – you can read more about this work in the engagement section of this report. The strategy will include a two-to-five-year programme of establishing or increasing the capacity of community diagnostic (test) centres in our area. These one-stop-shop centres offer checks, scans and tests in one place, rapidly assessing patients identified to be at risk of an illness or condition, including suspected cancer. Patients can undergo tests including X-rays, CT and MRI scans. Following a successful bid, we were recently awarded NHS England funding to develop a new community diagnostic centre 'hub' covering Epping, with a 'spoke' site in Bishop's Stortford.

**Cancer services**

The NHS across the country is seeing record levels of cancer referrals, significantly exceeding pre-pandemic levels. Cancer awareness campaigns, including our own patient-led 'Cancel Out Cancer' programme, are encouraging people to come forward and be checked – raising awareness of a range of potential cancer symptoms.

With the support of the ICB and NHS England, NHS organisations across our area are working together to recover cancer services towards pre-pandemic levels.

**Winter pressures**

During winter 2022/23, our winter action plan, produced in collaboration across our system, received additional funding from the 'Demand and Capacity Fund', the 'Adult Social Care Discharge Fund' and the 'Additional Care/Step Down Fund'. In total we secured almost £30 million, of which £26 million has been spent on a number of schemes to improve our capacity to care for the increased number of patients who need our help during the winter months. Funds have been used to provide more specialist mental health beds and community support, to improve workforce retention across social care and primary care, to increase the support for rehabilitation in the community, and to pay for voluntary sector initiatives to help people to get discharged home from hospital with the right support for their needs.

Our winter plan priorities have included reducing ambulance handover times, reducing the number of patients who spend more than 12 hours in the emergency department (A&E), increasing the number of patients seen or treated within four hours of arriving at an emergency department, and getting people home from hospital when they are medically fit to leave. Our 'virtual hospital' programmes have come into their own, enabling people's conditions to be expertly supervised with the use of digital technology, while they receive

care in their own homes where appropriate. In primary care the recruitment of new staff, including social prescribing link workers and care coordinators, was prioritised and additional funding was granted to GP practices in order to enable them to offer additional appointments.

Throughout winter we have worked together as a system, focusing on providing mutual support across our organisations during times of peak demand.

Despite our careful planning and preparation, winter 2022/23 was particularly challenging, as COVID-19 and flu rates increased, affecting members of the public and our own staff, and our primary and secondary care colleagues worked tirelessly to keep services running effectively to the best of their ability.

We recognise that there is still more to do to improve our response to seasonal pressures and have carried out a 'needs analysis' to make sure we have the right urgent and emergency services for our population, and that we make the best use of the staff and facilities we have.

Information gained through this 'needs analysis' work includes:

- evidence of frequent A&E admissions for children and adults that could have been avoided through the use of alternative services
- a number of attendances are as a result of drug or alcohol misuse
- children repeatedly present at A&E with respiratory conditions
- there are a number of potentially avoidable emergency admissions of people with severe frailty, dementia and at the end of their lives.

These findings, and the recommendations made as a result, are shaping the improvements that we need to see, including revised treatment pathways and new services.

**Strike action**

During the winter colleagues from various NHS organisations, as well as other industries, have chosen to take industrial action. While the ICB does not provide direct patient care, a small number of our nurses did join in the industrial action in 2022.

Our ICB staff have worked closely with their colleagues from NHS trusts to support the safe delivery of essential patient care during periods of industrial action. During this time our message to patients has been consistent – the NHS is here for you if you are in urgent need. Patients have been reminded to attend booked appointments unless specifically instructed not to do so – in order to ensure that vital appointments and treatments are not missed.

**Our 'virtual hospital' programme**

Virtual hospitals have really established themselves in the last year. Across the ICB, in the three local places of west Essex, south and west Hertfordshire and east and north

Hertfordshire, there has been great focus on supporting patients who can be discharged from hospital to continue their recovery at home with appropriate monitoring from clinicians. This would not be possible without the great collaboration of the health and care partnerships, which are made up of NHS organisations in each area, community and voluntary sector colleagues and the local authorities.

The virtual hospital programmes enable teams, where it is safe to do so, to utilise new technologies to ensure patients can receive the care they need more quickly and at home. Patients on virtual wards receive an excellent service, with clinicians and professionals from primary, secondary, community and social care coming together. While the name 'virtual wards' suggests remote appointments and monitoring, home visits from district nurses and other health professionals play a vital part in caring for our virtual ward patients.

The service in south and west Hertfordshire was shortlisted in the Place-Based Partnership Category of the HSJ Awards in August 2022 for the way a local hospital, primary and community health services are working together to support patients being discharged quickly from hospital and continue their recovery at home.

We look forward to developing and expanding our virtual hospital services in future.

**Mental health**

Demand for mental health services has increased since the start of the COVID-19 pandemic, with the demand for adult community services alone rising by 18% in the last two years. Patients in Hertfordshire and west Essex are coming forward with conditions which are more acute and complex than before. This is translating into the need for longer treatment programmes and longer lengths of stay for those who need hospital treatment.

Our mental health provider organisations are working together to deal with this increased demand, including looking at investment in additional capacity for those in crisis, and additional transformation investment to bring services closer to home, with mental health teams providing care and support through links with our 'Primary Care Networks' of GP practices. This has had an impact on waiting times for mental health services in some cases.

Despite the challenges faced, our providers have been seeing patients within the psychiatric liaison service in good time and we continue to work with them and offer support where we can.

Dementia is of huge concern, particularly to our growing population of older people and their families and carers. I am pleased to report that we have consistently met our targets for diagnosing dementia, with services remaining fully operational throughout the pandemic. We are now focusing on identifying and supporting people in care homes, and plan to increase the number of people using talking therapies to manage their mental ill-health.

**Joint Forward Plan**

Every ICB is required to produce a five-year plan in collaboration with our NHS Trusts, called the NHS 'Joint Forward Plan'. The plan must be published by the end of June 2023.

The plan is an extensive document, setting out how the ICB and our partner NHS trusts intend to arrange and provide NHS services to meet our local populations' physical and mental health needs. It will link in with the overarching priorities of the **Integrated Care Partnerships' 10 year strategy,** which was agreed in December, as well as the Hertfordshire County Council and Essex County Council health and wellbeing strategies. The plan will cover areas including performance around waiting times and the quality of services, from primary care to emergency care, cancer services and so on. We have worked with residents and staff and Healthwatch in Hertfordshire and Essex to ensure that their views, priorities and suggestions are fed into the plan, which must be updated every year. Joint forward plans should be supported by all of the organisations in our integrated care system, including local authorities and voluntary, community and social enterprise partners.

**Primary care**

Improving patient access to, and experience of, primary care has been a high priority for the ICB these last nine months. Practices are seeing more patients through different methods than before the pandemic. We have worked closely with practices to help them find solutions to issues that are affecting them and put action plans in place where improvement is needed. This is an ongoing process, and we continue to review and adapt based on patients' needs and practice resources.

Among the progress made within primary care are the implementation of 'cloud-based' telephone lines which have the capability to offer calls backs, queue management and to increase the number of lines available if needed. More than 70 practices are in the process of implementing this system, funded by the ICB. We will also support the remaining practices that didn't take part in this programme with an enhanced telephone system in the coming months. The new telephone systems are already making a great deal of difference for both patients and staff.

Patient engagement and involvement has been a strong focus for primary care in the last nine months. We have been working closely with practices and the Patients Association, a national organisation, to develop and strengthen practices' Patient Participation Groups (PPG). To date the membership of some PPGs taking part has grown, diversified and its members have taken part in training to make sure the groups are as productive as they can be.

To follow the NHS Long Term Plan requirements that every patient is offered 'digital-first' primary care by 2023/24, the ICB has procured an online consultation tool for every practice. With digital first, patients have the option to contact their primary care health professional digitally, which saves patients' time and gives an alternative to visiting the

surgery or phoning. This tool also allows patients to request test results, ask for an appointment, seek advice, fit notes and GP letters.

Similarly, practices have a digital option to communicate important messages with patients too. The ICB has purchased a patient communication digital tool which allows practices to send text messages, questionnaires and online forms to patients in a tailored way. This system also enables practices to set up confidential and secure video consultations where appropriate, further offering a wider range of appointment options for patients who need healthcare advice but can't visit the surgery in person.

**New hospital plans**

The new hospital development programmes for Princess Alexandra Hospital NHS Trust - which plans to build a new hospital on a new site, West Hertfordshire Teaching Hospitals Trust, and the Mount Vernon Cancer Centre are still being developed. We await the outcome of the national funding decisions which are required to take these vital programmes forward. As part of their preparatory work, West Hertfordshire Teaching Hospitals NHS Trust (WHTH) has been working with the national New Hospital Programme on its plans to redevelop its three existing sites.

**Looking forward**

As highlighted above, the ICB has made considerable progress during what has been a challenging operating context for its first year of operation. Next year will be equally challenging, as we seek to progress our ambitious transformation agenda, continue to recover services following the pandemic and implement NHS England's request that we reduce our running costs by 30% over the next two years.

The start of the new financial year sees the ICB taking on commissioning responsibilities for dentistry, optometry and community pharmacy, with pharmacy and ophthalmology staff being hosted by our ICB on behalf of the entire East of England region.

Our teams have already begun work to ensure staff working in these areas have a smooth transition to the ICB, and to make sure patients and practitioners are kept informed when changes begin. In July we will celebrate one year of being an ICB – in the same week the NHS turns 75 years old – which is an ideal time to reflect on what the NHS means to us all – and to look forward to the improvements in treatments, outcomes and services that we are planning for the future. The accounts are prepared on a Going Concern basis as per page 106 in the financial statements.

# Engaging with People and Communities

We can only successfully tackle the health and wellbeing challenges faced by our residents if we actively involve and engage people and communities in the heart of our health and care system, so that they can shape and influence the development and commissioning of local health and care services.

Through the Health and Care Act, our ICB has a legal duty to involve the public and stakeholders, and this commitment is embedded in the **ICB's constitution**.

Our **'Working in Partnership with People and Communities' Strategy**, agreed by our Board in their inaugural meeting on 1 July 2022, outlines our commitment to ensuring that NHS England's 10 core principles on involvement guide our work. The strategy was praised by NHS England, which noted that it built on existing good practice, and used the strengths of our partner organisations to support our work.

The ICB's over-arching approach to involvement was adopted by the Integrated Care Partnership (ICP) on behalf of our system, during the first formal meeting of the ICP in 2022. This means that ICS-wide health and care organisations now have a common agreed approach to involvement and engagement, helping all partners to meet their duties. Monthly meetings are held between the ICB, NHS Trusts and Healthwatch communications and engagement leads to ensure that engagement and involvement work is joined up, for the benefit of the public and best practice. The ICB promotes patients right to choose where they are treated, you can read more here on the ICB website: patient choice

**Patient stories**

Our ICB Board members hear directly from a patient as part of every Governing Body meeting in public. In September 2022, Mark Seal from Hertfordshire shared his experience of being cared for by the cardiology 'virtual hospital', run by West Herts Teaching Hospitals Trust and his local community trust. Mr Seal's heart condition was able to be closely monitored by hospital consultants and community nurses using digital health monitoring technology which sent key health information to the expert team caring for him. This meant that he could be looked after from the comfort of his own home.

These patient stories are aligned with a planned 'deep dive' into a particular area of health provision. Other topics already covered include primary care and community health services. The ICB board always encourages patients featured to give full and frank feedback on the services they receive, so that this can be considered when decisions are made, and services planned.

**Working with the Patients Association**

Registered patients are at the heart of our work with the public, thanks to a project with the Patients Association to support GP practices in developing their patient groups.

This project has been co-designed with patients and began with an online survey of patients and practice managers. The results helped us to create a series of workshops which included a step-by-step guide to establishing, recruiting, and developing a patient group. A steering group, which included patient representatives, has also been formed to help shape this work and continues to carry it forward.

A buddy scheme is now being created from this work which, alongside one to one support for practices, will help patients feel confident and supported in setting up their own groups.

This work has helped to build our patient network to include more than 400 members, who we regularly engage with.

**The local community of Hertfordshire and West Essex have been involved in the development of both the ICBs five-year joint forward plan and the ICP ten-year strategy.**

**Community diagnostics**

The development of the ICB's new community diagnostic strategy is being shaped by input from those with recent experiences of diagnostic tests, as well as staff with an interest in these services.

Engagement activities have included surveys, focus group interviews and informal online feedback sessions with GPs, those facing health inequalities, carers, and learning disability social care professionals.

A comprehensive feedback report has been produced which raises issues such as the need to consider patients on low incomes, disabled patients, and digitally excluded patients when planning services. Positive feedback has been received about arranging appointments and hospital experiences, and areas of improvement such as communicating the outcomes of tests and staffing issues have been highlighted. The outcomes of the engagement process will be fed back to participants as the strategy development continues.

**Quality Strategy**

Several patient representatives and partners across the system have helped develop an ICS-wide **Quality Strategy for 2023-2026**.

The strategy focuses on ensuring our population receives the best possible, joined-up and high-quality services in partnership with our local people whether they are at home, in the community or in hospital, whether they are young or old, and from every background.

Feedback and insights from system partners and patient representatives, including our new Patient Safety Partners, was gathered at a workshop held in February as well as through task and finish groups. It has been used to inform the final version of the strategy, including

our quality vision and principles. This engagement continues as the strategy was finalised, ready for implementation from April 2023.

**Campaigning: Cancel Out Cancer**

February 2023 marked the fourth anniversary of the launch of Cancel Out Cancer, a volunteer-led programme of free information sessions about symptoms, screening, and positive changes people can make to their lifestyle to reduce the risks of some cancers.

Face-to-face sessions were re-introduced in 2022, which opened up more opportunities for people to hear about the key messages in the campaign and means those who are not able to access information online are not excluded.

The volunteer presenters have worked with GP practices to set up face-face sessions for patient cohorts including in Hertford, Ware and Hatfield, and they have delivered bitesize sessions at events including at the University of Hertfordshire, and community health days in Broxbourne, Potters Bar and Borehamwood.

In 2023/24 the focus will be on attracting new volunteers to increase the number of sessions that can be offered. There will be a focus on reaching people facing the most challenging health inequalities, so that more people feel confident about having screening tests and talking to their GP about potential cancer symptoms.

**Reader Panel**

We have extended the membership of the former Herts Valleys CCG (Clinical Commissioning Group) Reader Panel since establishing the ICB. The panel includes members of the public with disabilities that affect their ability to receive information. Made up of volunteer patients, carers, community members and others, panel members review leaflets and other material and feed back on whether information is easy to understand, accessible and free from jargon.

Its involvement has led to changes in content to make information more relatable for the audience, changes in language to use words that are more familiar to patients, and amendments to layout and font size to make information clearer and changes to avoid ambiguity.

**Voluntary organisations/VCFSE and events**

We continue to work closely with voluntary sector groups.

As part of the ICB's establishment, the Hertfordshire and West Essex VCFSE (Voluntary Community Faith and Social Enterprise) Alliance was formed. The ICB participated in the creation of the Alliance, and we continue to support its work.

In the months since the ICB formed, we have continued to attend public events across Hertfordshire and west Essex, speaking to residents and encouraging their feedback and views on healthcare.

Attending events and working with the Alliance has given us the opportunity to speak to patients and residents about the different ways we currently share news and ask people to get involved, namely our weekly newsletter, ICB Update. It also gives us a chance to subscribe new readers and talk to them about the ways they can get involved and what really matters to them. These events can also give us the chance to follow up enquiries on behalf of patients.

In September 2022 we attended the POhWER event in Stevenage for people who experience disability and vulnerability, and in October, Epping District Council's 'Stay Well this Winter' event in Waltham Abbey, for older residents.

We also joined an event hosted by MP Bim Afolami to support and welcome refugees arriving in Hertfordshire, who needed immediate advice on where to turn for health and care. The ICB has also supported GP practices with communications to help refugees register with a GP.

The annual 'Carers in Herts' Conference provided another valuable opportunity to hear from some of the people who have the biggest involvement with health and social care services. We used the opportunity to answer questions and listen to suggestions.

**COVID-19 vaccination programme**

Throughout 2022/23, work continued to ensure as many people as possible took up the vaccinations they were entitled to, with particular efforts made to reach those who live in areas where uptake remained slow.

As the autumn booster programme began, we took part in a three-day event run by the Essex County Fire and Rescue team on the Ninefields housing estate, Waltham Abbey, to meet and engage with people living in this area where uptake had been low.

Students at the Hertfordshire University Freshers Fair were provided with information about vaccinations, along with an event for overseas students, and a community event was held by Rainbow Services in Harlow.

We adopted the Make Every Contact Count Model at the five large vaccination sites in the ICB area, focusing on general health and offering blood pressure monitoring, weight checks and signposting for other long-term conditions such as diabetes.

Service users helped us create our I am Getting Protected campaign, giving their own views and helping increase uptake of the vaccine.

**Making every contact count**

In Hatfield, the NHS, the University of Hertfordshire and Welwyn Hatfield Borough Council have worked together throughout the vaccine programme to improve the take-up of the COVID-19 jab among students and staff, in an area where vaccination rates were among the lowest in our ICS area. **Pop-up vaccination sessions and engagement events** at the university enabled joint teams to improve vaccine take-up, whilst also helping students to register with a GP practice and connecting them with the support and information available through the borough council's Healthy Hub.

**Healthwatch**

We have developed a close working relationship with Healthwatch since becoming the ICB, building on already well-established contacts Healthwatch Hertfordshire and Healthwatch Essex have been commissioned by the ICS's Primary Care Workstream to undertake a series of engagement projects.

The surveys they have carried out on our behalf are just one of the many ways in which we are working to put the voices of patients front and centre of our work to support practices to implement improvements that will benefit patients and practice staff.

The first two surveys and reports were to explore access to GP services with a specific focus on engaging with:

- parents, carers and children and young people across Hertfordshire and west Essex
- residents living in the Borough of Broxbourne, Harlow and Uttlesford.

Senior leaders at the ICB are starting to put into action the feedback received during the survey and the resulting recommendations from both Healthwatch organisations.

We also meet regularly with Healthwatch to discuss patient experience themes, based on queries and concerns people raise directly with them about accessing services and quality of care. These meetings help the ICB understand even more about the needs of patients and keep Healthwatch appraised of our work to bring improvements for patients.

**Thank you**

The ICB would like to thank those residents, staff, patients and carers who have taken the time to share their views, priorities and feedback with our organisation since July 2022. Your contributions are vitally important to everything we do – thank you.

# SYSTEM DEVELOPMENT

**What are integrated care systems?**

**Integrated care** is about giving people the support they need, joined up across the NHS, local councils and other partners. It removes traditional divisions between hospitals and GPs, between physical and mental health, and between health and social care services. In the past, these organisational structures have meant that too many people experience disjointed care.

Integrated care systems (ICSs) are partnerships between the organisations that meet health and care needs across an area, to plan and deliver services in a way that improves the health of the wider population and reduces inequalities between different groups.

**The Hewitt Review** into the oversight and governance of integrated care systems was published in April. Hertfordshire and West Essex submitted evidence to the review as a system and Paul Burstow, the Chair of the ICB, was joint lead for the oversight workstream. We welcome the review's recognition of the important contribution that ICBs can make to health, care and the future wellbeing of our residents, as well as the need for oversight and governance arrangements to be value adding and not barriers to genuine integration and transformation. As you would expect the ICB is currently considering the impact of the review's findings on our work

## HEALTH AND CARE PARTNERSHIPS (HCP)

Health and Care Partnerships (HCPs) bring together health, social care and voluntary sector organisations across smaller areas of our integrated care system (ICS) to work as one.

Whilst they aren't statutory like the ICS and ICB, HCPs are responsible for leading the detailed design and delivery of joined-up services across their communities. This means linking services together to ensure people can get the care they need in the right place and at the right time. They are also transforming services to improve people's health and wellbeing.

There are three of these partnerships in Hertfordshire and West Essex ICS:

- **East and North Hertfordshire HCP**
- **South and West Hertfordshire HCP**
- **West Essex HCP**

Each shares a well-established local area and includes a major hospital.

In addition to these three partnerships there is also a **Mental Health, Learning Disability and Autism Health and Care Partnership**.

**Integrated Care Partnership**

Representatives from the ICB and Hertfordshire County Council led on the development of the Hertfordshire and West Essex Integrated Care Strategy for the Integrated Care Partnership (ICP). The strategy was initially developed with local strategy leads through a series of workshops and then further developed through stakeholder engagement via a survey, focus groups and various groups and boards across the HWE system.

The strategy, which was a requirement of the Health and Care Act 2022, sets out the ways in which the ICP members (including the ICB) will work to ensure that our residents can all live, work and play in healthy and safe communities where everyone's contributions are valued, and they have the opportunities and support needed to thrive. Drawing on the assessed needs from the Hertfordshire and Essex joint strategic needs assessments, it outlines how the organisations that form part of the ICP will work together to improve the health and wellbeing of people living and working in Hertfordshire and West Essex, including increasing the years that people live in good health and reducing the gap between the healthiest and the least healthy in our community.

Our approach is grounded in an understanding that our residents' health is the product of a complex interplay of factors including education, employment and housing as well as our networks of friends and family, and the neighbourhoods and communities in which we live.

The strategy is a 10-year strategy covering 2023-2033. The strategy sets out our six strategic priorities for integrated work across the system. Each priority describes the outcomes we are seeking to achieve through this strategy.

An overview of the strategy, including its vision, principles, priorities and enablers is outlined below:


The Strategy was agreed by the HWE ICP Board and published on the ICP website in December 2022. The strategy has also been endorsed by the ICB Board and both Essex and Hertfordshire Health and Wellbeing Boards. Following approval of the strategy the next steps are to develop a delivery plan to support delivery of the strategy including key metrics to monitor success.

# Hertfordshire and West Essex ICB's direct functions

## Commissioning

We use information and evidence about local services and people's experiences of them to look at whether those services are meeting people's needs. If improvements or changes are needed, we work with the organisations which provide services and local people to put forward new ideas or ways of delivering care.

**Our role is to:**

- ensure health services are high quality
- involve local people in planning and improving services
- make the most effective use of the money given to us to improve services for patients

**NHS Operational Planning and Contracting Guidance** sets out what is required of NHS organisations and covers system planning, full operational plan requirements, workforce transformation requirements, the financial settlement and the process and timescales around the submission of plans.

## Pharmacy and Medicines Optimisation Team

The three place based pharmacy and medicines optimisation teams (PMOT) have been through a re-structure to form one ICB wide team. The team have continued their excellent work supporting prescribers and health and care providers across the system.

Areas driving prescribing budget pressures include supply difficulties leading to nationally negotiated price concessions and implementation of NICE technical appraisals (TAs) and guidance. It should be noted that the ICB spends less than the national average on primary care prescribing.

## Continuing Healthcare

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in the NHS National Framework for Continuing Healthcare and Funded Nursing Care

(2022)1. Such care is provided to adults to meet needs that have arisen as a result of disability, accident or illness.

The performance in the provision of CHC is measured by NHS England through Key Performance Indicators referred to as Quality Premiums. The Quality Premium is measured against the expectation that no CHC assessments will be completed whilst an individual is in hospital and that 80% of all assessments will be completed within 28 days.

# ASSURANCE AND OVERSIGHT

**NHS Oversight Framework – How are local health services performing?**

ICBs will be assessed on their performance each year by NHS England. This is done though the NHS Oversight Framework, with the overall result derived from our performance against a broad range of indicators.

The assessment is a detailed review of more than 50 indicators which show how well the ICB is working in five key areas.

During 2022/23 the ICB Nursing and Quality Team has worked to establish and develop robust governance and accountability arrangements to support oversight and assurance relating to quality as well as to support quality improvement. Key areas of work have included:

- ongoing development of the ICB Quality Committee, System Quality Group and sub-groups including strengthening membership across our health and care system
- working to develop and strengthen relationships with our system partners and focusing on development of quality oversight at Place
- developing the ICS Quality Strategy in collaboration with system partners and patients
- identifying system level risks and working across the system to ensure mitigating actions are taken
- sharing learning, best practice, and innovations across the ICS to influence and improve the delivery of high-quality care and experience
- developing an agreed way to measure quality, including the ongoing development of the Quality Dashboard

[1] **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1087562/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care-July-2022-revised.pdf**

# The Work of Hertfordshire, Bedfordshire and Luton (HBL) ICT Services

Hosted by Hertfordshire and West Essex ICB, HBL ICT provide IT services to the four member organisations of the HBL Partnership, delivering its agreed five-year business and digital strategy, which includes embracing collaborative technologies, automation through robotics and enhancing our communication channels to make the service more responsive and accessible to our service users.

This year we have refreshed our Business and Digital Strategy which sets out our vision and operational plan for the next five years and complements the digital strategies of our member organisations. It is encouraging to reflect on the digital advancements that have been delivered in the past 12 months, including enhanced support channels to our Service Desk, Cisco Umbrella, VDI platform and advanced digital telephony within Primary Care and developing our core infrastructure as the foundation to the member organisation digital strategies and supporting the What Good Looks Like framework.

During the first nine months that the ICBs (HWE & BLMK) have been in existence, transitioning into their respective new organisations, HBL ICT as their service provider has played a significant role in delivering their digital migration plans, ensuring that they can operate effectively.

**Financial position**

At the end of Q4 2022/23 HBL ICT successfully met the control total specified by the Partnership Board, based upon a new 'Activity Based Costing' model incorporating inflation and cost improvement targets, resulting in a small surplus at the end of the fiscal year.

**Cyber security**

Cyber security continues to be a significant threat globally, which needs to be constantly manged to protect our business and patient data. However, due to the investments in developing a highly secure, resilient, and robust IT infrastructure, underpinned by tight control processes and patching regime, the HBL Partnership continues to deliver a highly available service. A further defence that has recently been introduced is MFA (Multi-Factor Authentication) to all our email accounts as we know that email systems present a significant threat if not manged diligently.

Since the start of the conflict in Ukraine, the threat of cyber security events has increased significantly. In response, HBL ICT has increased its defences with the development of a new 'Security Operations Centre' to provide proactive management and monitoring of all services working with strategic 3rd Party Suppliers and NHS Digital. This includes being part of the NCSC (National Cyber Security Centre) early warning system which is a government organisation that monitors suspicious activity across any system that is externally accessible from the public internet.

# Summary Of Performance 2022/23

## Performance Analysis

The purpose of the performance analysis section is for the ICB to provide a detailed performance summary of how the ICB measures its performance and provide more detailed performance analysis on identified key performance measures such as constitutional standards outlined below.

Herts and West Essex ICB is responsible for the performance and oversight of NHS Services across the Integrated Care System. The following summarises our performance against key **constitutional standards** and commitments in the **NHS Long Term Plan**, **Operational Plan** and **Oversight Framework**. For further detail on the Oversight Framework, please see page 23. Increased demand and workforce challenges have affected the performance of our health system against some of the key national standards.

The number of GP appointments that were attended increased throughout 2022/23, with the proportion of face-to-face appointments delivered also increasing, reaching over 70% in the second half of the year.

| Primary Care | Target | Q1 | Q2 | Q3 | Q4 | 2022/23 |
|---|---|---|---|---|---|---|
| **Number of GP appointments attended** | **N/A** | 1,835,506 | 1,906,314 | 2,160,090 | 2,079,566 | 7,981,476 |
| **Proportion of Face-to-Face appointments** | **N/A** | 63.9% | 67.6% | 70.9% | 72.1% | 68.8% |

## NHS 111 Services

NHS 111 services are measured by the numbers of calls to the service that are answered within 60 seconds and the number of calls that are abandoned after 30 seconds. Demand into the NHS 111 service continued at higher levels than pre-COVID-19 across 2022/23 and saw a significant increase in December 2022 with the national Strep A alert. Performance declined across the year and continued below standard.

| NHS 111 | Target | Q1 | Q2 | Q3 | Q4 | 2022/23 |
|---|---|---|---|---|---|---|
| **Calls answered within 60 seconds** | **95%** | 56.8% | 48.4% | 41.1% | 43.8% | 47.7% |
| **Calls abandoned after 30 seconds** | **5%** | 8.7% | 22.9% | 31.7% | 14.6% | 19.2% |

## Urgent 2 Hour Community Response Times

Urgent Community Response services are a commitment in the NHS Long Term Plan to provide urgent care to people in their homes if their health or wellbeing suddenly deteriorates. Services were required to reach at least 70% of patients referred to them within two hours by December 2022. Performance achieved standard throughout 2022/23, however did decline gradually over the year.

| Urgent 2 Hour Community Response | Target | Q1 | Q2 | Q3 | Q4 | 2022/23 |
|---|---|---|---|---|---|---|
| To reach patients within 2 hours | 70% | 92.2% | 88.2% | 82.3% | 77.1% | 84.4% |

## Response times to ambulance calls

Ambulance services are measured on the time it takes from receiving a 999 call to a vehicle arriving at the patient's location. There are four categories of call with associated required average response times outlined in the table below.
Performance declined over the first 3 quarters of the year and continued below standard in all response categories throughout 2022-23. However, a significant improvement in performance was seen in quarter 4, with all response categories at an improved position compared to the beginning of the year.

| EEAST Ambulance Response for ICS | Target | Q1 | Q2 | Q3 | Q4 | 2022/23 |
|---|---|---|---|---|---|---|
| C1 People with life threatening injuries and illness | <7 minutes | 09:53 | 10:32 | 11:04 | 09:12 | 10:10 |
| C2 Emergency calls | <18 minutes | 56:05 | 01:08:14 | 01:30:07 | 49:00 | 01:05:52 |
| C3 Urgent calls | <120 minutes | 06:45:08 | 08:59:38 | 10:20:26 | 05:11:12 | 07:49:06 |
| C4 Less urgent calls | <180 minutes | 10:51:52 | 15:09:30 | 15:28:25 | 08:05:04 | 12:23:43 |

## A&E four-hour operational standard

There is a national requirement that 95% of patients attending A&E are treated, admitted, or transferred within 4 hours of arrival. Over 2022/23 the total number of A&E attendances continued above pre-COVID-19 levels putting pressure on A&E departments and flow through the system. Performance continued below the 95% standard across 2022/23.

| Treated / Admitted / Transferred in under 4 Hours | Target | Q1 | Q2 | Q3 | Q4 | 2022/23 |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| **HWE ICS*** | **95%** | **65.67%** | **66.15%** | **61.93%** | **65.25%** | **64.72%** |
| **ENHT**** | | **65.85%** | **65.30%** | **62.35%** | **63.26%** | **64.20%** |
| **PAH**** | **95%** | **62.43%** | **56.92%** | **52.59%** | **52.26%** | **56.16%** |
| **WHTHT**** | | **60.25%** | **66.03%** | **61.51%** | **68.48%** | **63.97%** |

*Commissioner footprint: All HWE ICS patients treated at any provider e.g. Addenbrookes
***Provider footprint: All patients treated by HWE provider regardless of commissioner**

# Referral to Treatment Times (RTT)

Under the NHS Constitution there is a performance standard related to patients waiting for treatment; the standard being that 92% of patients on an incomplete pathway should be seen within 18 weeks. In response to COVID-19, routine elective treatments were stood down at peak times throughout 2020/21 and 2021/22 which caused an increase to numbers on elective waiting lists and the length of time to treatment. National elective recovery targets were put in place during 2022/23 to:

- Reduce the number of patients waiting over 104 weeks to zero by January 2023 (with the exception of patient choice);
- Reduce the number of patients waiting over 78 weeks to zero by end of March 2023 (with the exception of patient choice).

HWE ICB delivered the 104-week recovery ambition however, did not reach the zero target for 78 weeks by March 2023. The table below also details the 18-week RTT performance for HWE ICS patients for 2022/23 which continued below standard (note, data is snapshot at quarter end).

| RTT Waiting Times | | Target | Q1* | Q2* | Q3* | Q4* |
|---|---|---|---|---|---|---|
| **104 weeks** | Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 104 weeks from referral by **January 2023** | **0 by Jan 23** | **37** | **10** | **11** | **6**** |
| **78 Weeks** | Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more 78 weeks from referral by **March 2023** | **0 by March 23** | **921** | **902** | **1,006** | **484** |
| **18 Weeks** | Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral | **92%** | **58.40%** | **54.89%** | **54.26%** | **56.84%** |

*snapshot at quarter end
**breaches due to Patient choice

# Diagnostics

Under the NHS Constitution there is a performance standard related to patients accessing diagnostic testing; the standard being that 99% of tests are undertaken less than 6 weeks from request. In response to COVID-19, routine diagnostics were stood down at peak times throughout 2020/21 and 2021/22 which caused an increase to numbers on waiting lists and the length of time to access diagnostics. Across 2022/23, referral rates for diagnostics continued at increased levels to pre-COVID-19. The table below details the Diagnostic performance for HWE ICS patients for 2022/23 which remains below standard (note, data is a snapshot at quarter end).

| Diagnostic Waiting Times | | Target | Q1* | Q2* | Q3* | Q4* |
|---|---|---|---|---|---|---|
| **6 Weeks** | Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request | **99%** | **67.36%** | **66.53%** | **63.26%** | **68.48%** |

*snapshot at quarter end

# Waiting times for cancer treatment

The NHS Constitution sets out rights for patients with suspected cancer. There are a number of government pledges on cancer waiting times.

In 2022/23, the ICS delivered the standard of a maximum 31-day wait for subsequent treatment where the treatment was an anti-cancer drug regime. Performance across the remaining cancer standards continued below target across 22/23.

**Table: Cancer waiting times for all ICS patients (across all Providers)**

| Cancer Waiting Times for ICS | | Target | Q1 | Q2 | Q3 | Q4 | 2022/23 |
|---|---|---|---|---|---|---|---|
| **Two Week Waits** | Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP | **93%** | **79.10%** | **74.58%** | **81.28%** | **87.45%** | **80.54%** |
| | Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) | **93%** | **57.96%** | **67.11%** | **75.63%** | **89.75%** | **71.91%** |
| **28 Day Faster Diagnosis Standard (FDS)** | A maximum 28-day wait from urgent GP referral to be diagnosed with, or have cancer ruled out, all 2ww referrals | **75%** | **64.79%** | **67.68%** | **70.91%** | **73.57%** | **69.31%** |
| **31 Day Waits** | Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers | **96%** | **92.61%** | **94.33%** | **94.65%** | **94.05%** | **93.92%** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Maximum 31-day wait for subsequent treatment where that treatment is surgery | 94% | 84.77% | 86.33% | 82.87% | 85.23% | 84.78% |
| | Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime | 98% | 100% | 98.97% | 99.20% | 98.29% | 99.07% |
| | Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy | 94% | 94.94% | 91.03% | 90.63% | 91.19% | 92.00% |
| **62 Day Waits** | Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer | 85% | 67.49% | 66.40% | 68.46% | 61.65% | 65.95% |
| | Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers | 90% | 71.67% | 68.67% | 71.74% | 71.54% | 70.81% |
| | Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) | 85% | 72.61% | 68.06% | 73.94% | 67.88% | 70.85% |

# Mental Health Services

The NHS Long Term Plan sets out a national ambition to eliminate inappropriate out of area placements for acute mental health inpatient care; an 'out of area placement' happens when a person is admitted to a unit that does not form part of the usual local network of services. With increased demand on Menta Health Services, the number of Out of Area Bed Days have increased across 2022/23 for HWE service users.

There is also a focus in the long term plan on supporting people with Dementia. HWE fell short of their dementia diagnosis target throughout 2022/23.

| Mental Health Services | | Target | Q1 | Q2 | Q3 | Q4 | 2022/23 |
|---|---|---|---|---|---|---|---|
| **Acute MH Inpatient Care** | **Number of Out of Area Bed days** | **0** | **2,370** | **2,777** | **4,074** | **3,400** | **12,621** |
| **Dementia** | **Dementia Diagnosis Rate** | **66.6%** | **61.35%** | **61.86%** | **62.22%** | **62.27%** | **61.89%** |

Our key risks in delivering our plans in 2023/24 are:

• Workforce: having a sustainably recruited workforce, ensuring we fill current establishment vacancies in the harder to recruit areas; midwifery, scientific and technical, and Allied Healthcare roles

• Industrial action: the impact from strikes has shown to have a significant impact on care, and the loss of activity during strike days. If industrial action continues for a prolonged period in 2023/24 this will reduce our ability to meet our elective recovery objectives.

Our Joint forward plan will set out our ICB medium term vision and key deliverables and will be published in Summer 2023/24.

### Learning Disability Services

Our Learning Disability programme is about making health and care services better so that more people with a learning disability, autism or both can live in the community, with the right support, and close to home.

**Annual Health Check end of year data** April 2022 - March 2023 indicates 79.4% delivery across the ICB with all areas achieving over 75%. In comparison national delivery was 78.1% and East of England 73.3%. It should be noted that figures may be adjusted slightly following a validation process currently being undertaken comparing national and local data.

In Hertfordshire priority has been given to supporting practices to engage and support 'hard to reach' patients through 2022/23 in line with national expectations. Various pilot projects across the ICS have focused on improving uptake and quality of Annual Health Checks with some good practice examples identified and shared.

The new LeDeR Learning from Lives and Deaths policy has been fully implemented across the ICS. Leadership and Steering Groups have been established covering Hertfordshire and west Essex respectively, with representation from key NHS and social care partners to share learning quickly and put actions into place. The voice of people with lived experience, families and carers and are helping to shape our LeDeR work.

# Improving Quality

**Quality Assurance Model and Oversight Framework**

The Quality Assurance Model implemented by the Integrated Care System (ICS) is aligned to the National Quality Board's 'A shared commitment to quality', and includes the following key principles and recommendations regarding:

- A shared single view of quality
- How to work together to deliver quality
- Delivering quality care in systems, the seven steps, and

- Delivering quality care in systems; the key principles

The above is also laid out within the **ICS Quality Strategy**, which has been developed with system partners including patients and was approved by the ICB Board in May 2023.

**Patient safety**

**National Patient Safety Strategy**

Hertfordshire and West Essex ICB has continued to progress implementation of key areas within the National Patient Safety Strategy, working with our ICS system partners to focus on the NHS England priorities that were updated in January 2023.

Key areas progressed include:

- implementation of the ICB Patient Safety Specialist role
- recruitment of our two ICB Patient Safety Partners. These are patients who work closely with the ICB to specifically support improvements in patient safety across our local system
- ongoing development of the Patient Safety Specialist Network for all Patient Safety Specialists across Hertfordshire and west Essex
- the roll out of Level 1 and Level 2 national patient safety training
- ongoing work to support our local Medical Examiner Offices with the roll out of the Medical Examiner system for non-coronial community deaths
- ongoing preparation to implement the new Patient Safety Incident Response Framework (PSIRF) in line with the NHS England timeframe of September 2023.

Our relevant ICB Committees and ICB Board have been updated on progress against the national priorities throughout 2022/23.

**Patient Safety: Serious Incidents and Never Event Data**

Herts and West Essex Integrated Care Board (ICB) have had 237 Serious Incidents reported since the inception of the ICB in July 2022 to year end. Serious Incidents (SI) are reported to the ICB by organisations commissioned to provide care within the ICB area and organisations outside of the area caring for our citizens. For example, a person who lives within Herts and West Essex receiving care in Cambridge.

Of these Serious Incidents, eight were classified as Never Events (3.3%) –all occurred within acute care settings. Immediate safety actions were taken to protect patients after each incident and a full investigation is underway for each case. Never Events remain open with the ICB until all learning from the investigations has been implemented and reviewed as embedded.

**Patient Experience and complaints**

The ICB Patient Experience Team have received 977 enquires since July 2022 to year end. The team are working across the ICB in order that no patient or family experiences a "wrong door" with their concerns.

The majority of queries, 698, have been managed by the team as informal concerns/queries (patient advice and liaison queries) some of the queries are complex, the team support the patient and the provider with gaining resolution. The team have recorded 83 formal complaints.

The team work together with patients and their families to identify the best route for a resolution or answer to the concern and in some cases the facilitation of a discussion between the patient/family and the relevant clinical staff results in a more expedient and satisfying conclusion than a formal response.

The team have received 120 queries from Members of Parliament on behalf of their constituents in relation to both general and highly specific health concerns. The team manage these concerns in order to provide a response the MP can share with the specific constituent and use to inform their wider health discussions.

The main themes of people's concerns have been access to services in primary and secondary care. The ICB is working with professionals in both sectors to improve access and options for patients and their families and to prevent negative experiences of healthcare within Hertfordshire and west Essex.

In line with system partners, from January 2023 the team are approaching people who raise queries to share their demographic data. This is in order to gain a better understanding of whether there are groups of the population who may not use our service, so improvements can be made. To date there is insufficient data to share meaningful conclusions.

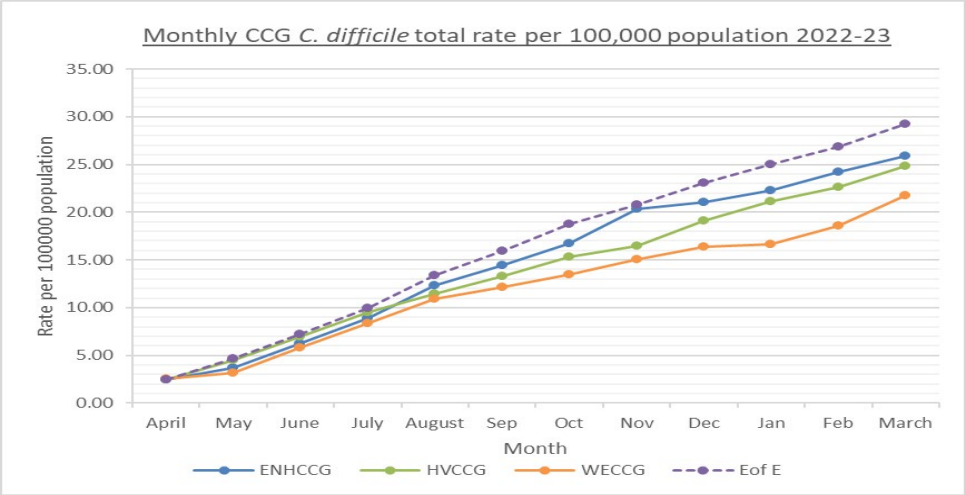
**Infection Prevention and Control (IPC)**

Over the last 3 years the COVID-19 pandemic has created unprecedented challenges for Infection Prevention and Control (IPC) within health and social care services. Despite decreasing COVID-19 cases, we have continued to support a significant number of COVID-19 outbreaks within Hertfordshire and West Essex health services (total of 231 outbreaks since 1st April 2022 – 31st March 2023. Local organisations have been supported to implement the transition to a risk-based approach to managing COVID-19.

In addition, there have been another 29 reported outbreaks which included including norovirus, MRSA, respiratory and carbapenemase-producing Enterobacteriaceae (CPE). Support has also been provided in relation to other incidents involving organisms/conditions including Mpox, group A Streptococcus, Influenza and Scabies.

We have also undertaken a number of IPC external peer reviews within local trusts and used local expertise to make recommendations to improve IPC practice**.**

This year we have further developed system wide arrangements for IPC, strengthening relationships amongst a wide range of health and social care partners, including NHS Trusts, primary care, public health, care homes, independent hospitals and hospices etc.




**Safeguarding Children and Adults**

The HWE ICB Executive Lead, Safeguarding Children's and Safeguarding Adults teams fulfil the strategic and operational requirement of working in partnership with Essex and Hertfordshire Safeguarding Children and Adult Boards. The Health Executive Forum (HEF) and Safeguarding Children Network (SCN) support the Essex partnership. Multiagency collaboration through the respective executive committees, subgroups, and Child Death Overview Panel (CDOP) facilitates the ICB duty of partnership working, in accordance with legislation and statutory guidance. The Partnership consists of Health, Local Authority and Police who work to strategic and operational plans to keep babies', children, young people and families (BCYPF) safe in West Essex and Hertfordshire.

An internal audit of safeguarding demonstrated there is reasonable assurance that the control and risk management framework is effective in its design and application, however there is opportunity for further improvement in the design and/or application of the control framework. Recommendations in regard to appraisal, training and disclosure and barring system (DBS) are accepted with implementation of a new appraisal system launched in April 2023, safeguarding training mapping against level 4 and 5 and consideration of DBS every three years.

The Looked After Children workplan reflects the priorities outlined within babies, children, young people and families in the Integrated Care Systems (2022) in relation to inequalities and transition for this vulnerable cohort. Partnership developments include an escalation pathway for Looked After Children at risk of placement breakdown, separated migrant children and unaccompanied asylum-seeking young people. This has been developed and shared across the system in response to learning from complex cases where children awaiting specialist placements have required a place of safety within acute units for lengthy periods.

The Domestic Abuse Toolkit published in 2022 provides Primary Care practitioners with information to support individuals and families within their communities addressing recommendations from Domestic Homicide Reviews (DHRs).

The ICB team contributes to the reports[2] and business plans[3][4][5] of Hertfordshire and Essex safeguarding children and adult Boards. The annual reports[6][7] were presented to ICB Quality Committee in January 2023, links to the reports and business plans are referenced at the base of this page.

**Improving the health of people with a learning disability**

The NHS Long Term Plan set an ambition that by 2023/24, at least 75% of people aged 14 or over with a learning disability will have had an annual health check (AHC) with their GP each year.

**Maternity / Local Maternity and Neonatal system (LMNS)**

The National Maternity Review Better Births report (2016)[1] sets out a vision for maternity services to provide a safe and personalised service, based around the needs of the woman and her family. The Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of organisations and professionals to lead and deliver across national work streams. Implementation of joint Maternity and Neonatal workstreams for transformation locally are supported through the LMNS.

The LMNS groups together providers and covers the geographical footprint of the Hertfordshire and West Essex Integrated Care System (ICS). Nationally there are 42 LMNSs providing planning and leadership to transform maternity services in alignment with the NHS Long Term Plan (2019)[2]. Each LMNS works collaboratively, sharing governance, learning and resources and is supported and overseen by national, regional, and local stakeholders.

The LMNS is monitored against the annual NHS England programme of deliverables across multiple workstreams through the LMNS Partnership Board, with quarterly reporting regionally; to NHS England; and to the HWE ICB Quality Committee.

East and North Herts Hospital Trust (ENHT) received a CQC inspection report in January 2023 where Maternity Services were rated 'Inadequate'. Areas for improvement relate to training, staffing, infection control, risk assessment and maintenance of equipment and facilities. A CQC Improvement Plan has been developed by the Trust to respond to the areas of concern identified. Maternity Board has been established to ensure oversight of the improvement work in addition to ENHT Maternity Improvement Committee. A number of areas of work are already underway and the Trust has established collaborative working and information sharing with the Maternity Voice Partnership.

Progress has made in many areas during 2022/23:

[2] *hscp-annual-report-2021-22-final.docx (live.com)*
[3] *HSCP Arrangements (hertfordshire.gov.uk)*
[4] *escb-business-plan-2022-1-page-website-16622.pdf*
[5] *HSAB Strategic Business Plan 2022-2024 (hertfordshire.gov.uk)*
[6] *annual-report-2020-21.pdf (escb.co.uk)*
[7] *Hertfordshire Safeguarding Adults Board*

- **Equity and equality** – The LMNS has developed a five-year equity and equality action plan for maternity based on the gap analysis of the needs across Herts and west Essex. The plan was co-produced with service users and has been aligned to national reports to ensure the 81 actions capture changes that are required to enhance our service provision for black and brown women, those living in deprived areas and those that have protected characteristics.
- **Smoke free pregnancy** – PAHT, ENHT and WHTHT all successfully launched the new enhanced smoke free pregnancy service on 17 October 2022. Pregnant women are being provided with additional support during their pregnancy to achieve a smokefree pregnancy.
- **Pelvic Health** The new Perinatal Pelvic Health Service (PPHS) had a soft launch across the system on 31 October 2022.
- **Coproduction** Ongoing work to increase ethnic and minority group representation in our Maternity Voices Partnerships (MVPs) has seen a good increase in new service users joining the groups.
- **Postnatal improvement -** System wide co-produced infant feeding strategy has been developed with service users and ratified at the January LMNS Partnership Board.
- **Digital -** The LMNS and 3 Acute Trust digital strategies have been written that align to the organisations' and the ICB digital strategies.

The greatest challenge within the ICS continues to be related to workforce, and this area accounts for all three risks on the LMNS risk register. The ICB is held a system wide workshop in March, including wider stakeholders, to consider innovative ways to work as a system to improve our vacancy, retention and absenteeism rates.

**Mental Health**

Adult Mental health has been the focus of significant work for ICB and system partners to meet the increasing demand on service provision within the wider context of workforce challenges for all parts of the system, alongside recovery following the COVID-19 Pandemic. Within this context there has been significant progress working collaboratively in both Essex and Hertfordshire to ensure the focus on oversight and assurance of quality, safety and patient experience continues.

A collaborative agreement has been implemented following considerable work to review and learn from historical commissioning arrangement in Essex, and there is now a pan-Essex approach to the oversight and assurance of quality within Mental Health Services delivered by Essex Partnership University Foundation Trust (EPUT) and enabling more effective sharing of information and insight and reducing unnecessary duplication of work, and creating opportunities to be innovative in working to gain assurance, and to identify further opportunities to improve services for our population.

Work with EPUT has been carried out in partnership with the two other ICBs who, along with HWE ICB, collectively span Essex (Suffolk and North East Essex ICB, and Mid and South Essex

ICB). The ICB team has also worked closely with EPUT and Essex Partners to support the development of the Southend, Essex and Thurrock Mental Health Strategy.

The greater collaboration and closer working in Essex has also been a catalyst to identify opportunities to share learning more broadly across the ICS footprint working with our other Providers of Mental Health Services (HPFT and NELFT).

Work has been ongoing to carry out assurance visits to both inpatient and community mental health settings during 2022/23 and this work will continue to be developed during the next year, to ensure that good practice and opportunities for improvement are proactively addressed.

# Reducing Health Inequality

Hertfordshire and West Essex ICB is committed to taking action on the inequalities experienced by the population that we serve. The ICB supports a number of initiatives which aim to improve social inclusion, reduce isolation and improve mental wellbeing in some of the most disadvantaged communities, and in those living with long-term conditions.

While most of our population enjoys good health and have better health outcomes compared with the rest of the country, we know that significant health inequalities exist and some of our residents are dying from illnesses such as circulatory diseases, cancer and respiratory diseases at a younger age than we would expect.

Those at high risk include people who are socio-economically disadvantaged; those with protected characteristics, for example people from a Black, Asian or minority ethnic background and those who are socially excluded, for instance the homeless, armed forces veterans and people from a Gypsy, Roma or Traveller background.

Reducing health inequalities is a feature of ICB Transformation Programmes aiming to reduce both inequalities in access to health services and reducing inequalities in outcomes achieved. Equality Impact assessments are embedded into the transformation activities of the ICB.

**Population Health**

Like most health systems, variation exists in Herts and west Essex between and within our communities, with people living in higher levels of deprivation experiencing higher levels of disability, disease, frailty and poorer health outcomes. In recognition of this the Office for Health Improvement and Disparity has stated in the ICS Improving Population Health Outcomes the national ambition is to:

- add an additional five years to Healthy Life Expectancy by 2035
- narrow the gap between the highest and lowest decile by 2030

HWE healthy life expectancy is 65.4 years for males and 65.7 years for females and overall average life expectancy of 81 for males and 84 for females. Life expectancy ranges are disparate across the ICS, with Harlow being 78.6 years and 81.3 for Male and Female respectively versus Uttlesford being 82.6 and 85.4 (females in St Albans also share the same life expectancy as Uttlesford), the highest across HWE. A mechanism within the Herts & West Essex Outcomes Framework will be introduced to monitor Healthy Life Expectancy for the ICB.

**Core20Plus5 Connectors Project**

The Connectors programme is one of a number of funded initiatives that support focused action across Integrated Care Systems to reduce healthcare inequalities across five priority clinical themes and contribute to wider steps to reduce health inequalities, including the wider determinants of health. You can read more about the **Connectors Programme**.

**Innovation in Health Inequalities Project**

This year the ICB has worked with the Academic Health Science Network in delivering a project[8] to address health outcomes in areas of deprivation and focus on Core20Plus population. This project is being led by Stevenage North PCN with the support of Community Development Action. The aim of the project is to address the gap in prevalence, and reported diagnosis, of Atrial Fibrillation in minority ethnic communities in Stevenage.

Read more about the **Eastern Academic Health Science Network**.

**Research Engagement Network Development**

Working with the Innovation Research and Life Sciences team at NHS England and the AHSN, the ICB has been working on a project called “Towards a more inclusive participation in research across the Hertfordshire and West Essex Integrated Care System”.

Acknowledging the current lack of inclusion, this project aims to allow all individuals and communities the opportunity to be involved, and supported, in research.

We will engage with our communities and listen to their experience to identify priorities, opportunities and barriers, this is supported by Healthwatch Hertfordshire and Essex.

We will obtain examples from a project and research participant perspective. These will help identify engagement and improvement opportunities.

The first phase of this project is drawing to a close, with a public event planned in June to offer some outcomes from a researcher and public survey and also set out next steps for

phase two, which has wide reaching stakeholder support from all research active organisations in HWE ICB.

**Harlow Levelling Up**

Herts and West Essex ICB is continuing to play a leading role in the development of the Harlow Levelling Up programme. Having led work in 2022 to map and connect the more than 80 multi-agency schemes and projects that can help realise the potential of the town, by tackling inequalities and creating opportunities for people and businesses, the ICB is now a member of a taskforce to prioritise activity and drive the programme forward.

A multiagency group has been formed, focusing initially on skills and employment and health and wellbeing. Compared with similar places elsewhere, the number of people in work in Harlow is relatively good, but many are in low-paid jobs because they lack skills.

One in four adults have no qualifications at all. A key priority is improving school attainment and removing barriers to better jobs, such as affordable childcare. Employment and other socio-economic factors can have a major impact on our health and wellbeing, those behind the Levelling Up programme want to work on these two key areas together.

**Anchors Network**

As well as the Harlow Levelling Up programme, Herts and West Essex ICB is also playing an active role in the Essex Anchors Network. Over 30 public sector organisations are part of the network, which aims to create prosperity and a better quality of life for the county's population by creating local job and business opportunities and collective action around use of estates and climate change.

Mentoring schemes and health and wellbeing are other areas of activity. A subgroup of the Essex Anchors Network is the West Essex Anchors Group. This is currently focusing on bringing employers and colleges closer together to specify the type of skills needed for the future. The group is also looking to improve opportunities for work placements and apprenticeships.

## The role of Hertfordshire and Essex Health and Wellbeing Boards

Health and wellbeing boards are responsible for commissioning a Joint Strategic Needs Assessment (JSNA) for the local population and setting the Joint Health and Wellbeing Strategy.

These strategies set key countywide strategic priorities, the priorities of member organizations and system partners, agreed outcomes and how progress and assessment will be measured and a small number of key strategic priorities for action, where there is an opportunity for partners including the NHS, local authority, education, and the voluntary and community sector to 'have a real impact' through local initiatives and action. The overall aim of the strategy is that we see an improvement in health and wellbeing

outcomes for people of all ages and a reduction in health inequalities by having a focus on supporting poor health prevention and promoting health improvement

The overall ambition of the Health and Wellbeing Boards is to reduce the gap in life expectancy, increase years of healthy life expectancy and reduce the differences between health outcomes in our population.

The Health and Wellbeing Boards bring together the NHS, public health, adult social care and children's services, including elected representatives from the County and District Councils, Healthwatch and the Police and Crime Commissioner, to plan how best to meet the needs of the population and tackle local inequalities in health.

The ICB works with partners, taking a joined-up approach to tackle the causes of poor health as well as supporting people to make healthier lifestyle choices and improving healthcare.

The **Essex Joint Health and Wellbeing Strategy 2022-2026** identifies five key overarching priority areas:

- Improving mental health and wellbeing
- Physical activity and healthy weight
- Supporting long term independence
- Alcohol and substance misuse
- Health inequalities and the wider determinants of Health

The **Hertfordshire Health and Wellbeing Strategy 2022-2026** is based around these four life stages:

- Starting well
- Developing well
- Living and working well
- Ageing well

# Preparing For Emergencies

The ICB has a responsibility in law to be fully prepared and able to respond effectively in the event of an incident which challenges the capacity or capability of the local health system.

In 2022/23 we achieved an overall rating of substantial compliance with **NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR) -** the individual assessment ratings for each standard are shown below:

| Domain | Self-assessment rating |
|---|---|

| | |
|---|---|
| Governance | Full Compliance |
| Duty to assess risk | Full Compliance |
| Duty to maintain plans | Partial Compliance |
| Command and Control | Full Compliance |
| Training and exercise | Full Compliance |
| Response | Full Compliance |
| Warning and informing | Partial Compliance |
| Co-operation | Partial Compliance |
| Business Continuity | Full Compliance |
| **Overall rating** | Substantial Compliance |

Following our transition to an ICB it was identified that further work was needed in order to refine processes for responding to countermeasures and mass casualty incidents, as well as incident responses involving more than one Local Heath Resilience Partnership. Our Social Media policy also needed further review which is why HWE ICB self-assessed as being partially compliant in some areas for 2022/23.

In 2022/23 we have focused on the transition of our processes from three CCGs into one ICB, setting up the System Control Centre, developing a three-year plan for meeting our statutory objectives and identifying and the management of a number of incidents (including the COVID-19 pandemic, industrial action, asylum seeker temporary accommodation and vaccines, and severe weather responses).

In 2023/24 we will further refine our approach and move away from individual organisation plans to a whole system plans for pandemics and counter measures.

# SUSTAINABLE DEVELOPMENT

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term, even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012).

To fulfil our legal duties under the Health and Care Act for the role we play relating to climate change, the ICS has created a Green Plan which you can read on the **ICS website**.

System leadership is in place to drive the collaborative approach to the Green Plan programme to ensure business continuity. Progress towards the delivery of the Green Plan continues to be made, current gaps remain. The financial resource to meet the significant financial commitments of the Green Plan continues to be an area of focus.

A carbon footprint reduction initiative will be delivered over three years, with regular progress updates and interim targets and will include reducing energy consumption, increasing renewable energy sources, and reducing waste. These targets will be regularly reviewed and updated.

**ICB Sustainability Data ReportingEnergy used (consumption in kWh)[9]**

| | 2022/23 |
|---|---|
| **Gas (natural) consumed** | 382,205 kWh |
| **kg CO2e[10]** | 76,441 |
| **Electricity consumed** | 443,124 kWh |
| **kg CO2e[11]** | 85,691 |
| **Total Cost (All Energy Supplies)** | £82,945 |

**Travel**

During this period, the total spent on business travel costs was £39,689.80. We can improve local air quality and improve the health of our community by promoting active travel to staff and to the patients and public who use our services. ICB staff can claim cycle mileage for their business travel and the ICB has joined the government's 'cycle to work' scheme. This allows staff to purchase a bike and cycle safety equipment as a tax-free benefit.

| Financial Year | Total Pedal Cycle Mileage claimed as expenses (miles) | Total Travel Mileage (cars) claimed as expenses (miles) | Average Whole Time Equivalent (WTE) staff employed | Average Travel Mileage (cars) per WTE staff employed | Total kg CO2e from Travel Mileage (cars) Estimated using figures for the average car of unknown fuel type, see here. |
|---|---|---|---|---|---|
| 2022-23 | 0 | 80,854 | 795 | £49.92 | 14,113.87 |

90% of lease car fleet vehicles available through the ICB scheme are categorised as 'Ultra Low' and 'Zero Emission'.

[10] Greenhouse gas reporting: conversion factors 2022 - GOV.UK (www.gov.uk)

**Waste Disposal and Recycling**

| | General Waste (£) | General Waste (Tonnes) | Recycling (£) | Recycling (Tonnes) | Confidential (£) | Confidential (Tonnes) | Waste Disposal Spend £ |
|---|---|---|---|---|---|---|---|
| 2022/23 | 1203 | 5.6 | 1275 | 2.3 | 563.95 | 4.5 | 3042 |

**Water and Sewage Cost**

| | 2022-23 |
|---|---|
| Water costs (£) | 3612 |

# REVIEW OF FINANCIAL PERFORMANCE

## Summary

Hertfordshire and West Essex Integrated Care Board's Annual Accounts are included within this Annual Report. The accounts have been prepared in accordance with directions issued by the Department of Health and Social Care and NHS England.

Integrated Care Boards have a statutory duty to keep their expenditure on each of day-to-day operational costs (revenue costs), administration costs and capital costs within the resources allocated to them for each of these cost headings. These are similar responsibilities to the ones Clinical Commissioning Groups had.

In 2022/23 there is added complexity because allocations were made for the full year, but CCGs continued to exist in the first quarter of the year and ICBs were only established on 1 July 2022. To overcome this, allocations made to ICBs were for the full year minus what each of its predecessor CCGs had spent in the first quarter of the year. This meant that the responsibility for staying within resource allocations fell entirely to the ICBs.

NHS England also set other financial rules for ICBs in 2022/23. These were:

- to comply with the mental health investment standard by increasing spending on mental health services by a prescribed minimum percentage
- to comply with the minimum percentage increase in contributions to the Better Care Fund.

Additionally, Integrated Care Boards and their partner Trusts and Foundation Trusts, making up the Integrated Care Systems system, have a statutory duty to keep their expenditure on revenue and capital within the resources allocated. This means that financial performance is assessed for each organisation separately and in aggregate.

The Trusts and Foundation Trusts making up the Hertfordshire and West Essex Integrated Care System, for the purpose of financial performance are:

- East and North Hertfordshire NHS Trust
- Hertfordshire Community NHS Trust
- Hertfordshire Partnership University Partnership NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- West Hertfordshire Hospitals NHS Trust

For ICBs, financial performance is considered by comparing expenditure to resource allocations issued and authorised for spending.

For NHS Trusts and Foundation Trusts financial performance is considered by comparing revenue expenditure to income received and capital expenditure compared to the allocated capital resource limit. Trusts receive income from a number of sources including Hertfordshire and West Essex ICB, other ICBs, NHS England and non-NHS sources.

## ICB funding

The funding allocated to the Hertfordshire and West Essex ICB for the period 1 July 2022 to 31 March 2023 is as set out in the table below. This included a sum of £16.7m related to previous years' underspends achieved by its predecessor CCGs, but which was not released by NHS England for spending in 2022/23. The total authorised for spending by the ICB was therefore £2,224,585,000.

| Description | Total for the Year £000 | CCGs spending £000 | Allocation for the ICB £000 |
|---|---|---|---|
| Programme Costs | 2,626,831 | 605,367 | 2,021,464 |
| Primary Care Delegated Functions | 249,176 | 55,215 | 193,961 |
| Administration Costs | 32,323 | 6,460 | 25,863 |
| Total Funding | 2,908,330 | 667,042 | 2,241,288 |
| Previous Underspends not released | (16,703) | | (16,703) |
| **Total available for spending** | **2,891,627** | **667,042** | **2,224,585** |

## Financial performance

As set above there were a number of financial duties and rules that ICBs and the wider System had to comply with.

The most challenging performance requirement was to keep revenue expenditure within resource allocation/income. The greatest challenge was for the Trusts, with aggregate deficits being seen earlier in the year and recovery actions failing to make much impact. This led to deficits being forecast and the ICB having to review its own expenditure to achieve system financial balance.

During the year additional funding was received for higher than originally planned staff pay increases, for excess inflation and supply chain pressures leading to higher drug costs. This helped the overall position, but the Trusts ended the year with an aggregate deficit of

£18.641m. The ICB achieved an underspend of £.759m meaning the System overall was in balance with a small underspend.

The other financial requirements were all achieved in 2022/23, with performance on each requirement set out in the table below.

| Duty | ICB Perfomance | ICS Performance |
|---|---|---|
| Revenue Expenditure does not exceed allocations/income | ✓ **Achieved Underspend of £.759m** | ✓ **Achieved Underspend of £358,000** |
| Capital resource use does not exceed resource allocation | **Not applicable (no capital received)** | ✓ **Achieved Underspend of £549,000** |
| Revenue administration expenditure does not exceed allocation | ✓ **Achieved Underspend of £1,456,000** | **Not applicable** |
| Mental Health Investment Standard | ✓ **Achieved Increase of 6.85% compared to required 6.78%** | **Not applicable** |
| Better Care Fund minimum contribution increase | ✓ **Achieved Increase by required 5.66%** | **Not applicable** |

## Looking forwards to 2023/24

While the ICB had a strong financial performance in 2022/23, this was partially the result of additional non-recurrent funding received during the year and the utilisation of reserves. The position at the end of 2022/23 is more fragile than at the start of the year.

In addition to this the financial settlement for 2023/24 is poorer than 2022/23 with funds associated with COVID-19 being significantly reduced. The headline efficiency challenge for the NHS in 2023/24 has doubled compared with 2022/23 to 2.2%, but realistically efficiencies in excess of 5% are likely to be required for the System to achieve the NHS planning and priorities guidance including to achieve financial balance.

Financial performance requirements in 2023/24 remain as in 2022/23 with the Mental Health Investment Standard requiring an increase in expenditure of 6.81% and the minimum increase in contributions to the Better Care Fund being 5.66%.

For the ICB both Continuing Healthcare and GP prescribing remain the highest financial risks.

Continuing Healthcare is a volatile area of spend and there has been an increase in the average cost of care packages, both as a result of the increase in the national living wage in 2023/24, but also because of the complexity of need of patients.

GP Prescribing is a risk area with supply chain and other issues leading to more drugs having national concession pricing leading to significant cost pressures. Additionally new drugs and guidance published can put pressure on an already stretched prescribing budget.

Pressures are also continuing at the Trusts and their financial positions are also likely to add risk to overall System balance.

The drive for productivity improvements and greater efficiencies continues, but it is likely that 2023/24 will be a difficult year financially.

## Review of statutory duties

Hertfordshire and West Essex Integrated Care Board has reviewed all of the statutory duties and powers conferred on us by the National Health Service Act 2006 (as amended) and other associated legislative and regulations.

We are clear about the legislative requirements associated with each of the statutory functions for which we are responsible, including any restrictions on delegation of those functions.

## Spend over £5m

As a commissioning organisation, we do not directly care for patients. Acute hospital services - where a patient receives short-term treatment for a severe injury or illness, an urgent medical condition, or during recovery from surgery - are provided for our residents by NHS hospital and community trusts, NHS foundation trusts and other independent providers of health services.
The healthcare organisations with whom the ICB spent more than £5m in 2022/23 – together with the broad categories of care they provided - are set out here:

| Provider | Service category |
|---|---|
| West Hertfordshire Teaching Hospital NHS Trust | Acute |
| East and North Hertfordshire NHS Trust | Acute |
| Princess Alexandra Hospital NHS Trust | Acute |
| Hertfordshire Community NHS Trust | Community |
| East of England Ambulance Service NHS Trust | Ambulance |

| | |
|---|---|
| Central London Community Healthcare NHS Trust | Community |
| Hertfordshire Partnership University NHS Trust | Mental Health |
| Essex Partnership University NHS Foundation Trust | Community and Mental Health |
| HUC Ltd | Integrated Urgent Care |
| Spire Healthcare | Independent Sector Provider |
| Ramsay Healthcare - Rivers Hospital | Independent Sector Provider |
| BMI Healthcare | Independent Sector Provider |
| Community Health and Eyecare | Non-NHS Provider (Community Ophthalmology Service) |
| Royal Free London NHS Foundation Trust | Acute |
| Cambridge University Hospitals NHS Foundation Trust | Acute |
| Bedfordshire Hospitals NHS Foundation Trust | Acute |
| Barts Health NHS Trust | Acute |
| University College London Hospitals NHS Foundation Trust | Acute |
| Mid and South Essex Hospitals NHS Foundation Trust | Acute |
| Buckinghamshire Healthcare NHS Trust | Acute |
| North Middlesex University Hospital NHS Trust | Acute |
| Moorfields Eye Hospital NHS Foundation Trust | Acute |
| Guy's And St Thomas' NHS Foundation Trust | Acute |
| Royal National Orthopaedic Hospital NHS Trust | Acute |
| Barking, Havering and Redbridge University Hospitals NHS Trust | Acute |
| Imperial College Healthcare NHS Trust | Acute |
| London North West University Healthcare NHS Trust | Acute |
| South North East Essex NHS Trust | Mental Health |
| Health Care Resource Group | Community |
| Excel Care Ltd | Care home Provider |

# ACCOUNTABILITY REPORT

Dr Jane Halpin
Accountable Officer

Signed 7th June 2024

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 2022 to 30 June 2022 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.

# PART ONE: CORPORATE GOVERNANCE REPORT

# GOVERNANCE STATEMENT

## Introduction and context

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

The Hertfordshire and West Essex ICB's statutory functions are set out under the National Health Service Act 2006 (as amended). This has been attached below and covers the following ICB financial period 1 July – 31 March 2023, plus the period up to the signing of the Annual Report & Accounts by the Accountable Officer.

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.
Between 1 July 2022 and 31 March 2023, the Integrated Care Board 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 Hertfordshire and West Essex 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 Hertfordshire and West Essex ICB's Accountable Officer Appointment Letter.
I am responsible for ensuring that the Hertfordshire and West Essex ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity and prepare the accounts on a going concern basis. 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

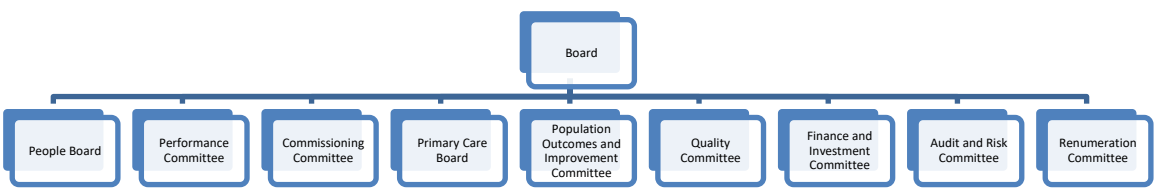
The main function of the Board is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

## Modern Slavery Act

The ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

## Governance Structure

The Board has created the statutorily required Audit Committee and Remuneration Committee.  Additionally, the Board has established a Quality Committee, Finance and Investment Committee, Commissioning Committee, Performance Committee, People Board, Population Outcome and Improvement Committee and a Primary Care Board.



**Board**

The Board is responsible for developing a plan and allocating resource to meet the health and care needs of the population. Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan. Establishing governance arrangements to support collective accountability for whole-system delivery and performance. Arranging for the provision of health services including contracting arrangements, transformation, development of PCN's, working with local authority VCSE sector and partners to put in place personalised care for people. The Board meet regularly, every other month in both public and private sessions. The highlights of the work of the Board during the year can be found from page 4.

**Audit and Risk Committee**

The Audit and Risk Committee is a committee of the Board. It provides assurance to the Board that the organisation's overall internal control and governance system operates in an adequate and effective way. The committee's work focuses on the adequacy of the controls on finance and risk management. It does this by reviewing the assurance framework, strategic and operational risk and obtaining independent assurance on controls. It also oversees internal and external audit arrangements, for both financial and non-financial systems. As part of its role the committee reviews audit reports and monitors implementation of recommendations. Members also undertake in-depth analysis of specific risks. During its work, activities and areas of review throughout the year, the committee ensured that any areas of particular concern were brought to the Board's attention through the Governance Report.

The work of the **Audit and Risk Committee** during this reporting period has included:

- Approval of a detailed internal audit programme of work consistent with the needs of the organisation;
- Scrutinising the findings from internal audits and recommendations for improvement and monitored progress with the implementation of the recommendations;
- Scrutinising external audit reports, including the report to those charged with governance;
- Reviewing the ICB's Corporate Risk Register and the Board Assurance Framework and providing assurance to the Board that it accurately records the strategic risks to the ICB's objectives with the measures and controls to manage them;
- Monitoring progress with the Counter Fraud Workplan and discussing outcomes of the work;
- Review of the annual report and financial statements prior to submission with particular focus on changes in and compliance with accounting policies, practices and estimation techniques;

• Reviewed and challenged assurance reports and updates on areas covered under the Committee terms of reference, including information governance and risk.

**Primary Care Board**

The role of the Primary Care Board is to provide oversight of primary care services transformation and innovation using a population health management approach to the development and integration of services. The committee oversees the system approach to the transfer of primary and community dental and community optometry services to the ICB. The committee oversees the continuing development of PCNs (Primary Care Networks), strengthening the development of the neighbourhood approaches and links with district councils and local community organisations and is responsible for leading the implementation of the Fuller Review recommendations.

The work of the **Primary Care Board** during this reporting period has included:

- Oversight of Primary Care risks and mitigation
- Oversight of the GP Patient Survey and action plan
- Receiving Healthwatch engagement projects and associated action plans
- Oversight of the Primary Care Strategy development
- Receiving updates from Patient Participation Groups and committing continued support
- Receiving the primary care workforce training plan
- Receiving Primary Care workforce deep dive
- Receiving the Evaluation of Respiratory Hubs
- Receiving updates on Primary Care Transformation, Estates, and Digital transformation.

**Quality Committee**

The Quality Committee is a committee of the Board. It works to ensure that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything the organisation does. It is responsible for providing assurance and information on quality to allow the Board to fulfil its role and responsibilities in relation to quality. It also reports on quality related risks to the Audit and Risk Committee. The committee takes on overall responsibility for leading the organisation's patient care, quality and safety agenda and reports directly to the Board on these matters. To support it in this role the committee involves a patient representative to provide an invaluable patient perspective.
The work of the **Quality Committee** during this reporting period has included:

• Discussion on and oversight of the implementation of the new Patient Safety Incident Response Framework (PSIRF) introduced by NHS England, which was welcomed by the Committee for its system-based quality improvement approach. Regular reports on implementation of PSIRF in parallel as the new system is implemented, the Committee has continued to receive regular Serious Incidents and Never Event reports;

- Receiving integrated performance and quality reports from across the system, which enabled the Committee to review how acute, community, mental health and primary care providers across the system are performing and how performance and quality concerns are being addressed. The Committee is focussed on improving the quality of performance reports to enable ICB decision-making and improving outcomes for our population.
- Receiving assurance reports and deep dive reports on the maternity and neonatal system and serious incident themes;
- Receiving deep dive reports on Mental Health in acute settings and system support;
- Providing strong direction that the patient voice is heard across the system.

**Remuneration Committee**

The Remuneration Committee is a committee of the Board. It makes recommendations to the Board on determinations about pay and remuneration for all 'Very Senior Managers', and Board members, including GPs and Lay Members of the Integrated Care Board. A Very Senior Manager typically has Executive Director level responsibility and reports to the Accountable Officer. No individual is involved in determining their own remuneration.

**Finance and Investment Committee**

The Finance and Investment Committee is a committee of the Board. It provides the Board with assurance that it can meet all its statutory and mandatory financial duties and obligations as efficiently as possible to address the greatest need and tackle inequalities. The committee ensures there are effective plans in place regarding financial allocations with a specific focus on reducing inequalities, prevention of ill-health, and improving population health and well-being. The committee ensures an effective assurance framework is in place to proactively oversee system productivity and efficiency and reviews performance at a system, place, and organisational level and monitors the delivery of financial plans and performance targets.

The work of the **Finance and Investment Committee** during this reporting period has included:

- Receipt of ICB and system finance reports with year end forecasts;
- Scrutinising presentations on the system medium term financial plan;
- Discussions on updates on current key procurement and contracting issues and on the system capital position and progress of key projects;
- Reviewing progress in terms of system transformation and efficiency activities;
- Reviewing capital updates and plans;
- Review of the finance risk register.

**People Board**

People Board is a committee of the Board and is responsible for ensuring delivery of the NHS people promise. The committee ensures there is a clear understanding of the current and future workforce, building workforce capacity and capability to meet population health needs. The committee supports the system to develop inclusive, innovative new working practices, provides workforce leadership, provides effective integrated workforce and oversees the system delivery of the requirements of the People Plan through effective multi-disciplinary working incorporating health, social care, education and VCFSE system partners. The committee oversees the system workforce transformation programme leadership development and broader social and economic development.

The work of the **People Board** during this reporting period has included:

- Oversight of workforce risks and mitigation
- Oversight of system workforce transformation programmes
- Holding a workforce Urgent and Emergency Care/Discharge workshop to refine understanding of key issues and development of EUC workforce strategy
- Analysis of workforce data to support 23/24 operational planning
- Receiving People Strategy 2023-2025
- Receiving deep dives on Primary Care workforce, VCSFE workforce and Staff retention
- Exploring workforce productivity

**Population Health and Outcomes Committee**

Population Health and Outcomes Committee is a committee of the Board, providing oversight, direction, and assurance to the Board to oversee and deliver system wide strategic objectives and associated outcomes for improving population health, preventing ill health, reducing health inequality, and promoting physical and mental health and wellbeing. The committee works to ensure that the ICB and system partners leverage their impact on social and economic growth, in all communities and makes recommendations on services where there is the biggest opportunity for improvement in outcomes for our population, providing oversight to the development of the anchor programme.

The work of the **Population Outcome and Improvement Committee** during this reporting period has included:

- Receiving updates from the VCFSE Alliance
- Oversight of the ICB Outcomes Framework development
- Oversight of the Population health management steering group, Research steering group and ICB Health Inequalities Group
- Oversight of the ICBs approach to segmentation

- Exploring the impact of addictions and violence on the HWE ICS health system
- Oversight of the Business Intelligence and Population Health Management platform development

**Performance Committee**

Performance Committee is a committee of the Board. The Committee ensures oversight of the delivery of key performance standards by commissioned providers, performance of the system against the NHS Outcomes Framework and progress with improving wider outcome measures of population health including evaluation of health services provision, provider resilience, and the performance management of system providers and health care partnerships. The committee focuses on driving improvements in performance at system, place, and service level and provides oversight and challenge on NHS constitutional standards, CQC requirements, Operational Planning Guidance, transformation programmes, workforce performance and delivery and EPRR.

The work of the **Performance Committee** during this reporting period has included:

- Oversight of performance risks and mitigation
- Receiving performance reports and performance improvement activities and related transformation work
- Receiving deep dives on Primary Care, Urgent and Emergency Care (UEC) winter plan and Planned Care
- Receiving updates on performance against the operational plan

**Commissioning Committee**

The Commissioning Committee is a committee of the Board. It provides oversight and seeks assurance that the operational arrangements in place across the ICB to support the commissioning of services/care to the local population are in line with the agreed system and place strategic plans and that delegated or joint services with NHSE/I are delivering in line with agreed principles. The committee oversees the process for the further delegation of commissioning functions to the ICB and provides the health oversight and assurance needed to support the delivery of the joint commissioning agenda with Local Government.

The work of the **Commissioning Committee** during this reporting period has included approval of:

- ASD post diagnosis support for people within Essex
- Approval of an ICB wide EUC dashboard
- Continued use of Consultant Connect across the ICB
- ADHD service provision
- Cataract Surgery services
- Early intervention vehicle to support a reduction in emergency admissions
- Continuation of the Virtual Ward model

- Alcohol Care Team
- Child death review process
- Continuous Glucose monitoring policy and extension of the fertility policy
- Overseeing and approving the Prescribing Committee recommendations

## Board Attendance for 2022/23

Members' attendance records are detailed in the following table:

| **Number of meetings held during 2022-23** | | | **6** |
|---|---|---|---|
| **Name:** | **Title** | **Member/** | **Attendance** |
| Paul Burstow | ICB Chair (Chair) | Member | 6/6 |
| Ruth Bailey | ICB Non-Executive Member (Deputy Chair) | Member | 5/6 |
| Jane Halpin | ICB Chief Executive Officer | Member | 5/6 |
| Alan Pond | ICB Chief Finance Officer | Member | 5/6 |
| Jane Kinniburgh | ICB Director of Nursing | Member | 4/6 |
| Rachel Joyce | ICB Medical Director | Member | 4/6 |
| Gurch Randhawa | ICB Non-Executive Member | Member | 6/6 |
| Thelma Stober | ICB Non-Executive Member | Member | 6/6 |
| Catherine Dugmore | ICB Non-Executive Member | Member | 5/6 |
| Owen Mapley | ICB Partner Member (Local Authority – HCC) | Member | 5/6 |
| Lucy Wightman | ICB Partner Member (Local Authority – ECC) | Member | 4/6 |
| Nicolas Small | ICB Partner Member from Primary Medical Services | Member | 6/6 |
| Prag Moodley | ICB Partner Member from Primary Medical Services | Member | 3/6 |
| Ian Perry | ICB Partner Member from Primary Medical Services | Member | 4/6 |
| Karen Taylor | ICB Partner Member (Mental Health Trust) | Member | 6/6 |
| Elliot Howard-Jones | ICB Partner Member (Community Trust) | Member | 6/6 |
| Lance McCarthy | ICB Partner Member (Acute Trust) | Member | 4/6 |
| Joanna Marovitch | ICB Board Member – VCSFE Representative | Member | 1/2 |
| Joanna Marovitch | VCSFE Representative | Regular Participants | 3/4 |

| | | | |
|---|---|---|---|
| Avni Shah | ICB Director of Primary Care Transformation | Regular Participants | 6/6 |
| Elizabeth Disney | ICB Director of Operations | Regular Participants | 6/6 |
| Tania Marcus | ICB Chief People Officer | Regular Participants | 6/6 |
| Beverly Flowers | ICB Director of Strategy | Regular Participants | 4/6 |
| Frances Shattock | ICB Director of Performance | Regular Participants | 6/6 |
| Adam Lavington | ICB Director of Digital Transformation | Regular Participants | 5/6 |
| Phil Turnock | ICB Managing Director of HBL ICT | Regular Participants | 3/6 |
| Michael Watson | Chief of Staff | Regular Participants | 6/6 |

* Chair of Primary Care Board

** Vice Chair of Primary Care Board

### Audit and Risk Committee

| **Number of meetings held during 2022-23** | | **5** |
|---|---|---|
| **Member Name:** | **Title:** | **Attendance:** |
| Catherine Dugmore* | ICB Non-Executive Director | 5 |
| Gurch Randhawa | ICB Non-Executive Director | 4 |

* Chair of Audit and Risk Committee

### Primary Care Board

| **Number of meetings held during 2022-23** | | | **5** |
|---|---|---|---|
| **Name:** | **Title** | **Member/Atte** | **Attendance** |
| Nicolas Small* | ICB Partner Member from Primary Medical Services (Chair) | Member | 5 |
| Prag Moodley | ICB Partner Member from Primary Medical Services | Member | 3 |
| Ian Perry | ICB Partner Member from Primary Medical Services | Member | 4 |
| Avni Shah | ICB Director of Primary Care Transformation | Member | 5 |
| Elliot Howard-Jones | ICB Partner Member (Community Trust) | Member | 3 |
| Gurch Randhawa | ICB Non-Executive Member | Member | 4 |
| Elizabeth Disney | ICB Director of Operations | Member | 2 |
| Rachel Joyce | ICB Medical Director | Member | 4 |

| | | | |
|---|---|---|---|
| Rami Eliad | ICB Primary Care Lead | Member | 2 |
| Rob Mayson | ICB Primary Care Lead | Member | 2 |
| Amik Aneja | ICB Primary Care Lead | Member | 2 |

## Quality Committee

| **Number of meetings held during 2022-23** | | **5** |
|---|---|---|
| **Member Name:** | **Title** | **Attendance:** |
| Thelma Stober | ICB Non-Executive Director (Chair) | 5 |
| Nicolas Small | ICB Partner Member from Primary Medical Services (Deputy Chair) | 3 |
| Jane Kinniburgh | ICB Director of Nursing | 4 |
| Rachel Joyce | ICB Medical Director | 3 |
| Sharon McNally | Acute Hospital Representative, Princess Alexandra Hospital Trust | 1 |
| Tracey Carter | Acute Hospital Representative, West Herts Teaching Hospital Trust | 2 |
| Jane Skippen | Community Representative, Central London Community Healthcare Trust | 1 |
| Cath Slater | Community Representative, Hertfordshire Community Trust | 1 |
| Natalie Hammond | Mental Health Representative, Essex Partnership University Trust | 2 |
| Sarah Dixon | Primary care Representative | 2 |
| Lucy Rush | Local Authority Lead from Hertfordshire County Council | 2 |
| Jon Dickinson | Local Authority Lead from Essex County Council | 3 |
| Sam Crawford | Local Authority Lead from Essex County Council | 1 |
| Neil Tester | Healthwatch Hertfordshire** | 3 |
| Jane Brown | Healthwatch Hertfordshire** | 2 |
| Justin Jewitt | Patient Safety Partner | 3 |
| Meg Carter | Patient Safety Partner | 1 |
| Mary Emson | Safeguarding Lead for Children and Families | 4 |

** Alternating attendance

## Remuneration Committee

| **Number of meetings held during 2022-23** | | **3** |
|---|---|---|
| **Name:** | **Title** | **Attendance:** |
| Ruth Bailey* | ICB Non-Executive Member (Chair) | 3 |
| Nicolas Small | ICB Partner Member from Primary Medical Services (Vice Chair) | 3 |
| Paul Burstow | ICB Chair | 3 |
| Thelma Stober | ICB Non-Executive Member | 3 |
| Owen Mapley** | ICB Partner Member (Local Authority – HCC) | 1/1 |

| | | |
|---|---|---|
| Ian Perry** | ICB Partner Member from Primary Medical Services | 2/2 |

** Owen Mapley was a member for one committee meeting and then stood down. Ian Perry then stood up as a member therefore attendance is noted differently to the rest.

**Finance and Investment Committee**

| Number of meetings held during 2022-23 | | 5 |
|---|---|---|
| **Member Name:** | **Title** | **Attendance:** |
| Paul Burstow | HWE ICB Chair | 2 |
| Owen Mapley | Chief Executive, Hertfordshire County Council | 4 |
| Alan Pond | Chief Finance Officer | 5 |
| Catherine Dugmore | ICB Non-Executive Director | 4 |
| Lance McCarthy | Acute Trust Partner Member | 5 |
| Karen Taylor | Mental Health Trust Partner Member | 2 |
| Ian Perry | Primary Medical Services Partner Member | 1 |

* Chair of Finance and Investment Committee (July to September 2022)

** Chair of Finance and Investment Committee (October 2022 onwards)

**Performance Committee**

| Number of meetings held during 2022-23 | | | 5 |
|---|---|---|---|
| **Name:** | **Title** | **Member /Attendee** | **Attendance:** |
| Thelma Stober* | ICB Non- Executive Director | Member | 5 |
| Frances Shattock | ICB Director of Performance and Delivery | Member | 5 |
| Jane Kinniburgh | ICB Director of Nursing | Member | 2 |
| Tania Marcus | ICB Chief People Officer | Member | 5 |
| Avni Shah | ICB Director of Primary Care Transformation | Member | 5 |
| Sharn Elton | Place Director, East and North Herts | Member | 1 |
| Matt Webb | Place Director, South West Herts | Member | 3 |
| Toni Coles | Place Director, West Essex | Member | 2 |
| Richard Hammond | Managing Director, ENHT | Member | 5 |
| Jane Shentall | Director of Performance, WHTHT | Member | 5 |
| Elizabeth Kerby | Head of Performance & Planning, PAHT | Member | 1 |
| Marion Dunstone | Chief Operating Officer, HCT | Member | 4 |
| Nicole Rich | Director West Essex for Community Health Services, EPUT | Member | 3 |
| Cathy Walker | Interim Chief Operating Officer, CLCH | Member | 1 |
| Rachel Joyce | ICB Medical Director | Member | 4 |
| Jane Halpin | Chief Executive Officer | Member | 2 |
| Simon Wood | Regional Director of Strategy and Transformation | Member | 4 |
| Nicolas Small | Partner Member, Primary Medical Services | Member | 1 |
| Leanne Fishwick | Interim Director of Operations: Hertfordshire, CLCH | Member | 4 |
| Hakan Akozek | Chief Information Officer | Member | 3 |

| | | | |
|---|---|---|---|
| Ruth Bailey | ICB Non-Executive Director | Member | 3 |
| Catherine Dugmore | ICB Non-Executive Director | Member | 3 |

* Chair of Performance Committee

### People Board

| Number of meetings held during 2022-23 | | | 4 |
|---|---|---|---|
| **Name:** | **Title:** | **Member/ Attendee** | **Attendance:** |
| Ruth Bailey* | Non-Executive Director | Member | 4 |
| Catherine Dugmore | Non-Executive Director | Member | 4 |
| Tania Marcus | Chief People Officer | Member | 4 |
| Mark Edwards | ICB Workforce Transformation Lead | Member | 4 |
| Emily Carter | ICB Associate Director for Education, Culture and OD | Member | 1 |
| Andrew McMenemy | Chief People Officer, West Hertfordshire Teaching Hospital Trust | Member | 1 |
| Tom Pounds | Chief People Officer, East and North Hertfordshire NHS Trust | Member | 2 |
| Lorraine Hammond | Director of ED and Inclusion, Essex Partnership Foundation University Trust | Member | 3 |
| Ogechi Emeadi | Director of People, OD & Communications, Princess Alexandra Hospital Trust | Member | 2 |

* Chair of People Board

### Population Outcome and Improvement Committee

| Number of meetings held during 2022-23 | | | 5 |
|---|---|---|---|
| **Name:** | **Title** | **Member/Attendee** | **Attendance:** |
| Gurch Randhawa* | Non-Executive Member | Member | 5 |
| Rachel Joyce | Medical Director | Member | 5 |
| Ruth Bailey | Non-Executive Member | Member | 3 |
| Beverley Flowers | Director of Strategy | Member | 4 |
| Joanne Marovitch | CEO, Hertfordshire Mind Network and Chair of the VCFSE Alliance | Member | 2 |
| Karen Taylor | CEO Hertfordshire Partnership University NHS Foundation Trust, and ICB MHLDA Partner Member | Member | 1 |
| Jim McManus | Executive Director of Public Health, Hertfordshire County Council | Member | 2 |
| Lucy Wightman | Director of Wellbeing, Public Health & Communities, Essex County Council | Member | 1 |

* Chair of Population Outcome and Improvement Committee

### Commissioning Committee

| Number of meetings held during 2022-23 | 5 |
|---|---|

| Name: | Title | Member/Attendee | Attendance: |
|---|---|---|---|
| Gurch Randhawa* | Non-Executive Member | Member | 5 |
| Alan Pond | Chief Finance Officer | Member | 4 |
| Thelma Stober | Non-Executive Member | Member | 5 |
| Matt Webb | Place Director, South West Herts | Member | 4 |
| Sharn Elton | Place Director, East and North Herts | Member | 2 |
| Catherine Dugmore | Non-Executive Member | Member | 5 |
| Elizabeth Disney | Director of Operations | Member | 5 |
| Beverley Flowers | Director of Transformation | Member | 5 |
| Avni Shah | Director of Primary Care Transformation | Member | 5 |
| Christine Moss | Associate Medical Director, WE HCP | Member | 3 |
| Helen Maneuf | Operations Director Older People, Herts County Council | Member | 2 |
| Elliot Howard Jones | Partner Member, HCT | Member | 2 |

* Chair of Commissioning Committee

## UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, the ICB follows the principles in the code that are most relevant to it given its size and nature but does not comply with the code as a whole. The Governance Statement discusses the most relevant parts of the code where the ICB has complied.

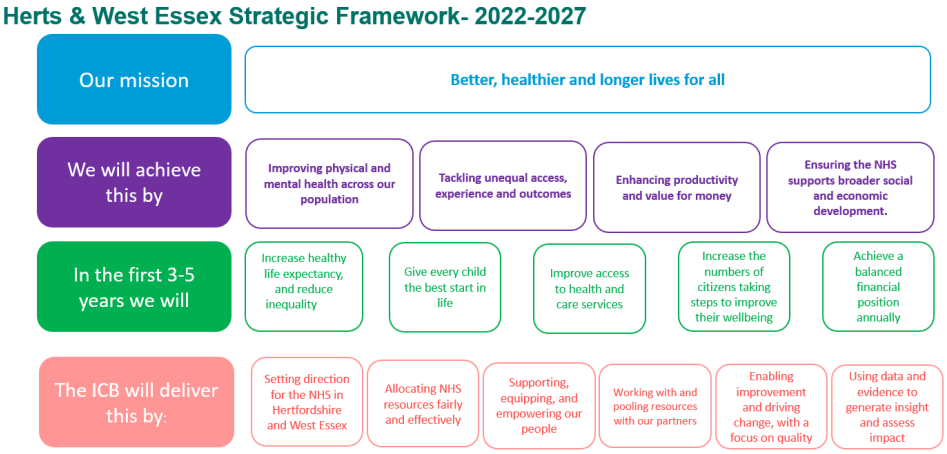
## Discharge of statutory functions

The ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation 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 allocated to a lead Executive Director. The ICB commissioned our internal auditors to conduct a statutory duty mapping exercise, this highlighted some areas for improvement. Plans to ensure that all directorates and their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties robustly are underway.

## Risk management arrangements and effectiveness

In November, the Board approved the HWE ICB Strategic Framework with five Strategic Objectives to set out clear priorities for the ICB over the next five years and to which ICB

risks are aligned.




The ICB risk management standards are informed by guidelines from ISO31000:2018 on managing risk, thereby focusing on the following components:

- Principles – Sustaining a dynamic and continuously improving risk management system that is customised, innovative, dynamic, structured, and inclusive
- Framework – Senior management leads the proactive integration of risk management on all levels across the ICB
- Processes – Systematic review and application of policies and practices that support open communication, consultation, and risk reporting.

The Risk Management Framework, which supports robust and effective risk management at all management levels, embeds the principles of risk management into its governance and leadership culture by establishing a Risk Review Group with meetings every two months to engage and support its senior leadership team in managing existing and emerging risks to which the ICB is exposed.

Within the Risk Management Framework, the risk is defined as "the effect of uncertainty on objectives". The components supporting and sustaining risk management across the ICB were developed, including the Strategic Framework.

DatixWeb – a web-based risk management system by RLDatix, allows an all-in-one solution that assists in managing and addressing risks, controls, and action plans, simple and easily managed procedures.

The risk management system provides a centralised repository for all ICB risks and an overview of the entire risk assessment process, allowing users to see the current risk status quickly. With this system in place, risks are reported quickly, available, accessible, and a live risk register can be produced. This has enhanced the quality of decision-making and aligned business functions across the ICB, resulting in proactive risk identification and assessment culture. The technology forms an integral part of the ICB's system control risk management.

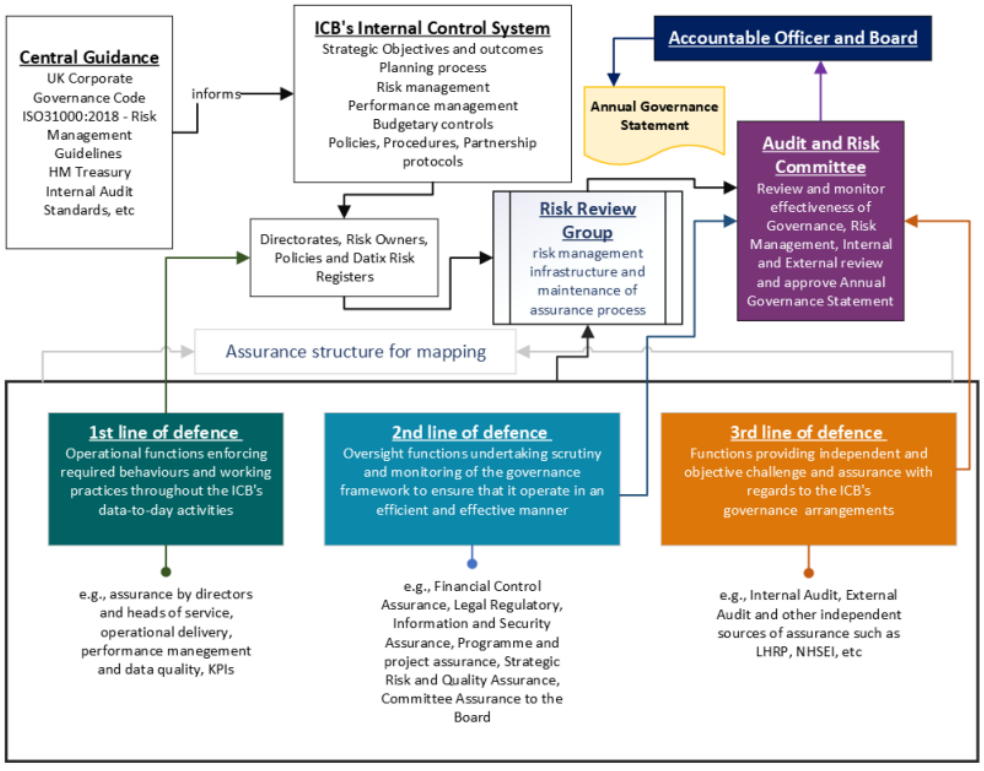
The following are the ICB's risk escalation levels:

- Corporate Risk Register: this is a repository for risks scored 12 and above. All risks scoring 12 and above are escalated automatically onto the Corporate Risk Register. These risks are reported to the ICB's Board at its meetings in public

- Directorate, and Project Risk Registers: risks scored below 12 are monitored on these registers

By early 2023-24, the ICB's Board will determine the nature and extent of the risks it is willing to take in achieving its Strategic Objectives, referred to as risk appetite and a programme of strategic risk identification and review will be undertaken.

The Board sets the Strategic Objective and then seeks to gain assurance around the operation of controls and processes to deliver those objectives. It also identifies the leadership and responsibilities for risk management. Assurance is gained through the 'Three Lines of Defence' of the assurance process below:




## Committee effectiveness

Board members have undertaken mandatory training throughout the year annual mandatory training enables the members to regularly keep their knowledge and skills up to date. Further board development has been undertaken which included risk management, making data count, working together as a board, Strategic Objectives and Priorities and a

facilitated development programme. In addition, each member is allocated sufficient time to discharge their respective duties and responsibilities effectively.

The Audit and Risk Committee supports the Board and the Accountable Officer by reviewing the internal controls, the level of assurances to gain confidence about the reliability and quality of these assurances. The scope of the committee's work is defined in the terms of reference, and the Committee reviews the work of Internal Audit and External Audit and Financial Reporting.

## Capacity to handle risk

The Board delegates to the Chief of Staff and Executive team primary ownership and responsibility for operating risk management and control. It is management's job to provide leadership and direction to the employees regarding risk management and control the organisation's overall risk-taking activities in line with the agreed level of risk appetite. The Chief of Staff has overall responsibility for risk management within the organisation. The Director of Nursing and Quality has delegated responsibility for clinical risk, and the Chief Finance Officer has delegated responsibility for financial risk and information risk. The Board determines the amount and type of risk that the ICB is willing to take to achieve its strategic objectives. This risk appetite is influenced by a number of key factors, including (but not limited to) the overall level of risk and the economic, regulatory and operational landscape.

Strategic risks are identified by the Executive team based on the Strategic Objectives and informed by other sources. The Integrated Care Board is an active member of the Health and Wellbeing Board and regularly participates in the County Council's scrutiny meetings to discuss local health issues. This joint activity level enables stakeholders to work with the organisation to understand and manage any risks that may impact them. The highest-scoring risks are published for Board, providing a further opportunity for public engagement with stakeholders in risks that impact them.
Executive Directors are responsible for ensuring that key and emerging strategic risks are identified, assessed and managed. They also monitor the effectiveness of risk assessment, mitigating actions and assurances in place. The Directorate teams are responsible for reviewing their work areas to identify risks to achieve objectives and actions to mitigate these.

Members of the Board have attended specific training and development in risk management. Risk management training is also mandatory for all managers and staff. As of 31 March 2023, the risk management training compliance for the ICB was 86.31%.

## Risk assessment

Risk assessment is the overall process of risk identification, risk analysis and risk evaluation, starting with the ICB setting its strategic objectives to which risks are identified. It is

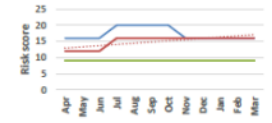
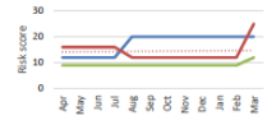
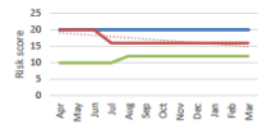
conducted systematically, iteratively and collaboratively, drawing on the knowledge and views of stakeholders to recognise and describe risks that might help or prevent the ICB from achieving its strategic objectives.

The risk analysis within the risk assessments reviews the nature and characteristics of the risk. This includes articulating the causes, possible events and impact of uncertainty using the 'if', 'then' and 'resulting in' structure to ensure a clear risk statement. The risk sources, the likelihood of events and consequences, the nature and magnitude of consequences, complexity and connectivity, the effectiveness of existing controls, and the confidence levels gained for the assurance are discussed and challenged. Gaps in controls and assurance are evaluated and further actions identified and implemented. If the residual risk is not acceptable, further actions are identified and assigned to named individuals and timescales for implementation are agreed.

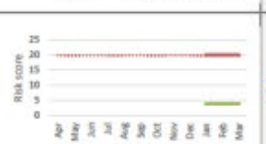
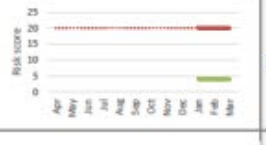
Corporate risks are monitored and reviewed every two months by the Risk Review Group. Its outcomes are documented and reported to the Audit and Risk Committee. Any feedback is communicated to the risk leads at the Risk Review Group meeting to improve and assist interaction with those responsible and accountable for risk management activities.

Staff across the organisation use the Risk Management Policy. It contains the risk scoring matrix and descriptors, which helps staff to ensure that risks are scored consistently so that priority can be given to the risks that could hinder the achievement of objectives. It also details the process by which risks are managed and escalated to the Corporate Risk Register. The Assurance Framework details the risks that, at a strategic level, could have an impact on achieving the organisation's objectives.

| SO IDs | 2022/27 STRATEGIC OBJECTIVES | No of risks |
|---|---|---|
| SO1 | Increase healthy life expectancy and reduce inequality | 4 |
| SO2 | Give every child the best start in life | 1 |
| SO3 | Improve access to health and care services | 7 |
| SO4 | Increase the number of citizens taking steps to improve their well-being | 3 |
| SO5 | Achieve a balanced financial position annually | 3 |

| RISK ID | SO ID | RISK LEAD | RISK DESCRIPTION | | CURRENT SCORE | Current risk score directional movement | | ASSURANCE LEVEL | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 18 records | | Initials | Directorates | | L x C = RS | Initial — Current — Target | | 1st line | 2nd line | 3rd line |
| 123 | SO1 | AR, SG | Medical | If GPs or doctors within the Trust prescribe high doses of opioid analgesics for chronic pain (especially above 120mg oral morphine equivalent) which are not regularly reviewed in line with up-to-date national guidance (also due to long waiting times for referral to specialist services), then there is a risk that patients would continue to be prescribed very high doses of opioid analgesics, sometimes inappropriately which do not provide any additional clinical benefit and can increase patient harm and mortality resulting in potentially serious harm to patients including dependency, reduction of quality of life and reputational damage to the ICB. | 16 |  | ↔ | Substantial | Substantial | Substantial |
| 124 | SO1 | AR, SG, SC | Medical | If external factors cause prices of medicines to increase (for example due to national medicines shortages causing price increases) and when NICE technology appraisals and guidance are implemented (legal infrastructure around implementation) then the ICB may overspend on the annual prescribing budget (despite QIPP targets being met) resulting in an additional significant financial burden on the ICB.<br>Linked to risk 307 (finance and contract) | 25 |  | ↑ | Reasonable | Reasonable | Limited |
| 346 | SO3 | ME, DW, CH | Nursing and Quality | If the ICB is ineffective in supporting our acutes to progress from RI to Good, and the Trusts fail to adequately address current and emerging quality issues. Then- there is a risk relating to the quality and safety of care provided. Resulting in- harm to patients(N&Q). | 16 |  | ↔ | Substantial | Substantial | Reasonable |
| 351 | SO3 | JB, MH, GS, AY | Operations | If there is a pandemic flu/Influenza type disease (pandemic), infectious outbreak or disease including<br>- Localised legionella or meningitis outbreak<br>- Major outbreak of a new or emerging infectious disease<br>Then- this will cause additional pressure on healthcare services and organisational business continuity issues.<br>Resulting in- the increased potential for compromised patient care and safety and organisational business continuity failures(EPRR) | 16 |  | ↔ | Substantial | Substantial | Substantial |

| RISK ID | SO ID | RISK LEAD | | RISK DESCRIPTION | CURRENT SCORE | Current risk score directional movement | | ASSURANCE LEVEL | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 18 records | | Initials | Directorates | | L x C = RS | Initial Current Target | | 1st line | 2nd line | 3rd line |
| 455 | SO3 | CH, AS | Nursing and Quality | IF there is a lack of information from NHSE&I regarding delegation of functions to the ICB including timescales and expectations, THEN there is a risk that relevant Teams will have inadequate time to prepare for the delegation of primary care quality oversight and improvement, primary care complaints, additional safeguarding and IPC requirements etc, RESULTING IN a lack of robust processes being in place to maintain oversight of quality and safety, and provide a responsive services. Transition Workstream Risk Register Ref: R029 | 16 |  | ↔ | Limited | Reasonable | Limited |
| 485 | SO1 | SG, RA, AK | Medical | If HWE ICB publish updated summary guidance based on national recommendations for managing patients with gender dysphoria (GD), on the assumption GPs would prescribe and monitor medicines outside of license with limited support from specialist teams then there could be renewed concern expressed by GPs that there is still no support for them to prescribe and monitor medicines outside of license in a very vulnerable group of people resulting in patient safety risk and patients not receiving the support they need. | 16 |  | ↔ | None | None | None |
| 486 | SO3 | AR, SG, AK | Medical | If HWE ICB do not publish a decision on continuous glucose monitoring (CGM) following the publication of NICE guidelines NG 17, NG 18 and NG 28 published 01/04/22 then healthcare professionals will continue to receive patient enquiries on when can they access the technology and the ICB will continue to receive PALS complaints from patients and their MPs resulting in reputational damage including MP letters, patient complaints, FOI requests and Patha Kar, NHSE Diabetes Lead tweets damaging messages about organisations which are slow in the uptake of diabetes technologies. | 16 |  | ↔ | Reasonable | None | None |
| 498 | SO1 | ME | Strategy | If the Integrated Care System does not address the workforce supply issues within key hot-spot areas as well as broader entry/support roles performance issues will continue to be effected. | 16 |  | ↔ | None | None | None |
| 526 | SO2 | MP, RF, KC | Nursing and Quality | If the demand for children's community services continues to increase then statutory requirements will not be met resulting in delays to accessing care, poor patient experience and poorer patient outcomes (wellbeing and educational)The main services impacted include: Community Paediatrics incl. ASD/ADHD, Children's Therapies (OT/SLT), Community Allergy and Dietetics, Community Audiology, Special School Nursing. | 16 |  | ↔ | Reasonable | Reasonable | Reasonable |
| 530 | SO3 | DW, KC, RC | Nursing and Quality | If a number of organsiations across the HWE ICB are issued with CQC notices and/or are rated as Requires Improvement, Inadequate and/or are placed in Special Measures then those organsiations are not achieving the levels of quality and safety expected. As a result patient experience, patient outcomes and patient safety will be negatively impacted with the number of complaints and serious incidents increasing and poorer outcomes reported. Organisational reputation may also be affected which could impact attracting a skilled and experienced workforce. | 16 |  | ↔ | Reasonable | Reasonable | Limted |
| 534 | SO5 | JS | Finance & Contract | If the ICB does not have a formal contract in place with the controlling organisation of Jacob and Gardens, it may not be possible to hold the provider to account on the serious patient safety and quality concerns flagged by HCC. | 16 |  | ↔ | Limted | None | None |
| 577 | SO5 | SS | Chief of Staff | If senior management and the Board are not able to effectively discharge their duties, then the ICB will be unable to achieve its strategic goals, resulting in decreased operational efficiency and productivity, quality of care for patients, stakeholder trust and confidence in the ICB; financial loss; and reputational damage | 16 |  | ⇅ | None | None | None |

| RISK ID | SO ID | RISK LEAD | | RISK DESCRIPTION | CURRENT SCORE | Current risk score directional movement | | ASSURANCE LEVEL | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 18 records | | Initials | Directorates | | L x C = RS | Initial Current Target | | 1st line | 2nd line | 3rd line |
| 578 | SO5 | SS | Chief of Staff | If the Board fails to maintain sufficient oversight of the Integrated Care Board's (ICB) processes, then regulatory breaches may occur, resulting in negative consequences such as financial penalties, reputational damage, and decreased stakeholder trust and confidence. | 16 |  | | None | None | None |
| 582 | SO4 | MJ, TP | Operations | If patients are not assessed with a management plan and treated, admitted and/or discharged out of the Emergency Department within 4hrs then patients will be waiting for long periods resulting in an increased risk of harm to those in the department with a serious illness/condition that requires a quick response. Delays could also negatively impact performance targets, causing reputational risk. | 16 |  | | None | None | None |
| 608 | SO4 | AS | Performance | If: UEC targets are not met Then: there is an immediate risk to patients health and wellbeing Resulting in: significant risk patient outcomes. Additionally there is a reputational risk to the ICB which carries a risk of NHSE interventions. | 20 |  | | Reasonable | Reasonable | None |
| 609 | SO4 | AS | Performance | If: Mental Health targets are not met Then: there isa risk to patients Resulting in: potential deterioration of patients health and wellbeing | 20 |  | | Limted | Reasonable | Reasonable |
| 610 | SO3 | AL | Performance | Elective recovery If: waiting lists are not reduced, there a risk to patient health and outcomes. Then: patients conditions may worsen Resulting in: deterioration of patient health. Additionally there is a reputational risk to the ICB which carries a risk of NHSE interventions. | 16 |  | | Reasonable | Reasonable | None |
| 616 | SO3 | GN, PS | Operations | There is currently no formal arrangement of out of hours cover for Ophthalmology patients. If patients require urgent treatment after 5:00 pm on weekdays or at weekends or on bank holidays, then they will be unable to access commissioned services until the next available services day, resulting in the possibility of a deteriorating condition and more sever consquences for the patient. | 20 |  | | None | None | None |

## Other sources of assurance

*Internal Control Framework*

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

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

*Internal Audit*

The organisation uses an internal audit function to monitor the internal controls in operation to identify areas of weaknesses and make recommendations to rectify them. The system is embedded in the activity of the organisation through an annual Internal Audit Work Plan. West Midlands Ambulance Service currently provides the Internal Audit services for the organisation. The Head of Internal Audit reports independently to the Chair of the Audit and Risk Committee. It provides objectivity and independent assurance on the effectiveness of its internal control system, including the application of the Risk Management Framework. The annual Head of Internal Audit Opinion provides independent overarching assurance to the organisation.

*Annual audit of conflicts of interest management*

The requirement for CCGs to report on their internal audit of conflicts of interest (via returns to NHS England) has fallen away with the formal establishment of ICSs in July 2022.
While the Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own Conflicts of Interest policy, which should be included in ICB's governance handbook, NHS England's engagement with local stakeholders suggests nationally-commissioned basic training would be of value to avoid unnecessary duplication across systems. NHS England will provide updated national e-learning modules on managing conflicts of interest in the context of the new ICB arrangements and also explore developing additional guidance on conflicts of interest in consultation with ICB Chairs.

The ICB has systems in place to provide assurance that on an annual basis their registers of interest are accurate and up to date. You can view the registers here: **Declarations of interest and gifts and hospitality register - Herts and West Essex ICS**

*Data Quality*

NHS Digital publishes data quality reports monthly for Admitted Patient Care, Outpatient, A&E/Emergency Care Data Set, Maternity in acute hospitals; these are reviewed by the information team. The ICB has access to the national Hospital Episode Statistics data, through MedeAnalytics, to undertake bespoke comparative data analysis to be compared alongside any national benchmarking reports such as Right Care. The quality of the data used by the ICB and to inform the Board is acceptable.

*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 a Data Security and Protection toolkit and the annual submission process provides assurances to the integrated care board, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. Risks to data security are managed through a series of management, technical, operational and privacy controls.

*Data Security and Protection Toolkit*

The Data Security and Protection Toolkit is an online self-assessment tool that all organisations must complete if they have access to NHS patient data and systems to provide assurance around the controls, they have in place to manage information risk. The toolkit enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. The ICB has assessed its position against the Toolkit and is on track for completion by June 2023. Policies and processes for the management of information have been agreed at the Board.

We place high importance on ensuring robust information governance systems and processes to help protect patient confidentiality 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 ensure that all staff members undertake mandatory information governance training annually, and ensure they know their roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. The Chief Finance Officer is the Senior Information Risk Owner and continues to embed an information risk culture throughout the organisation. The Chief of Staff is the Data Protection Officer, in line with the General Data Protection Regulation. The Director of Nursing is the Caldicott Guardian and provides oversight to ensure personal data is processed in accordance with Caldicott Principles.

*Business Critical Models*

HWE ICB can confirm that an appropriate framework and environment are in place to provide quality assurance of business-critical models. There are several aspects of the 2013 MacPherson review which are of relevance to the ICB to increase the robustness of the modelling work we undertake, as well as providing assurance to the relevant committee and board of the level of confidence which can be taken from the modelling estimates.

All models have appropriate quality assurance of their inputs, methodology and outputs in the context of the risks their use represents. All models are managed within a framework that ensures that appropriately specialist staff are responsible for developing and using the models as well as quality assurance. There is a single Senior Responsible Owner (SRO) for each model through its life cycle and clarity from the outset on how quality assurance (QA) is to be managed. Business cases using results from models summarise what QA processes have been undertaken, including the extent of expert scrutiny and challenge. They also confirm if the SRO is content that the QA process is compliant and appropriate with any model limitations, risks, and the major assumptions are understood and applied in generating in generating the model outputs. This includes end-users of any model prepared.

The ICB's data provider, Arden and GEM CSU, has all requirements necessary to ensure quality assurance of business-critical models included in their Service Level Agreement (SLA).

The ICB uses activity models that are based on official government produced information; for example, population demographics, provided by the Office for National Statistics (ONS). As a nationally recognised body, it is assumed that the ONS will have undertaken quality assurance processes about the construction of these models.

The ICB currently uses a risk stratification model which is made available through GEMIMA and is included in the **list of risk stratification approved organisations**. This model is used to identify a discrete group of patients at risk of being admitted to the hospital as an emergency, who may be better looked after through local community or primary care services. The ICB has also developed a model to calculate the elderly frailty index (EFI) using primary care data.

The organisation does not use any other sophisticated models, beyond those described above, but is currently undertaking further analysis to develop new risk stratification models using the wider range of data that is now available through the data integration and pseudonymisation at source project.

*Third Party Assurances*

The ICB has contracts with MedeAnalytics to provide Business Intelligence support as a Data Processor. As a third-party supplier, assurance is provided by satisfactory completion of the

annual Data Security and Protection Toolkit and they have registered and paid a data protection fee to the Information Commissioners Office (ICO). In addition, there is a confidentiality clause in the contract between the ICB and Mede/Analytics and they have been audited by NHS Digital with an assessment of minimal risk of inappropriate exposure and/or access to data provided by NHS Digital. The audit also identified a number of areas of good practice.

The ICB also has a contract with NHS Arden and GEM Commissioning Support Unit (AGEM CSU) to provide Data Services for Commissioning (DSCRO) services. As a third-party supplier assurance is provided by satisfactory completion of the Data Security and Protection Toolkit and they are entered on the Data Protection Register with the ICO. Further assurance is provided by the inclusion of a confidentiality clause in the contract between the ICB and AGEM CSU.

The organisation does not have any other contracts with third party suppliers who have access to and process patient identifiable data. All other third-party contractors are assessed on an annual basis and contract clauses included where appropriate.

*Nationally Outsourced Services*
The ICB receives some administrative services from nationally commissioned organisations and in 2022/23 also received Service Auditor Reports on these services, which it reviews:

- Electronic Staff Record system provided by NHS Business Services Authority and IBM UK Ltd
- Finance and accounting services provided by NHS Business Services Authority
- GP payments to providers of General Practice services in England provided by NHS Digital
- Prescription payments provided by NHS Business Services Authority (BSA)
- Primary Care Support England services for processing GP and pharmacy payments and pensions administration provided by Capita

## Control issues

According to the Head of Internal Audit Opinion, the Board can have reasonable assurance since the controls on which the ICB relies to manage issues are appropriately designed, consistently applied, and operating effectively.

**Review of economy, efficiency and effectiveness of the use of resources**

To ensure the Integrated Care Board resources are used economically, efficiently and effectively the ICB has implemented processes, which are described below:

- *the ICB has reviewed detailed financial policies, which set out the systems to be adhered to in order to ensure that resources are used efficiently*
- *developed and implemented strategic and operational plans, which include an agreed annual budget approved by the Board*
- *corporate wide process for the development and review of business cases for investment. Processes include assessment of value for money and contribution to the achievement of ICB objectives*
- *reports on finance and quality presented on a two monthly basis to the Board, with actions identified when performance is off track*
- *implementation of an internal audit programme that is targeted at the strategic risks and key financial control processes*
- *annual fraud risk assessment undertaken by an independent party, providing recommendations for key actions*
- *comprehensive fraud and bribery policies agreed and in place with local counter fraud specialist delivering an agreed work plan*
- *requirement as part of mandatory training that all staff undertake counter fraud and bribery training*
- *training for staff to be Speak up Inclusion Champions*
- *training for more staff to be Mental Health First Aiders*
- *NHS Right Care allows the organisation to compare the amount we spend, the health services we commission and the health of our population against that of other areas in England. These comparisons help the ICB to identify whether our population is receiving high quality, efficient and effective health services*
- *regular reporting to the Board on financial planning, in-year performance monitoring and central management costs*

**Counter fraud arrangements**

The Integrated Care Board commissions West Midlands Ambulance Service (WMAS) to provide the counter fraud provision by way of a nominated lead local counter fraud specialist (LCFS). The LCFS is accredited by the NHS Counter Fraud Authority and qualified to undertake the duties of that role.

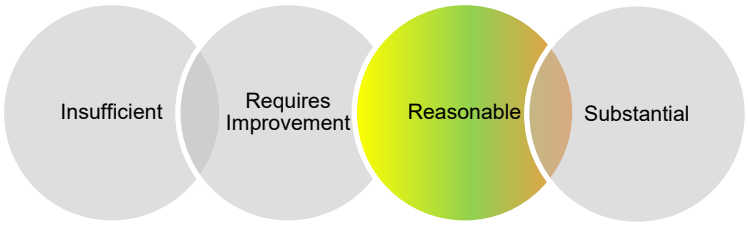
WMAS provides the Integrated Care Board with a LCFS Annual Report, which details all work undertaken in respect of counter fraud activities for the reporting year and measures each task as specified in the NHS Counter Fraud Authority Standards for NHS Commissioners: Fraud, Bribery and Corruption. The LCFS work plan is designed to meet the requirements set

out in the standards and each task is designed to provide compliance with each of the standards described. The LCFS work plan is designed to address the locally and nationally identified fraud risk areas in conjunction with the Chief Finance Officer.

The Chief Finance Officer holds Board level responsibility for the delivery of the LCFS work and provides the support to the LCFS in achieving this. The LCFS works with the Chief Finance Officer in submitting the annual NHS Counter Fraud Authority Self-Review Tool. An action plan is produced on the findings of this tool which is monitored at Audit and Risk Committee for any areas not deemed as fully compliant with the standards.

Please see page 82 of this report for the ICBs 'whistleblowing' procedures.

## Head of Internal Audit opinion




Following completion of the planned audit work for the period for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisations objectives and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the particular objectives at risk.

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

| Area of Audit | Level of assurance given |
|---|---|
| Assurance mapping | N/A not an assurance piece of work |
| Financial Governance | N/A not an assurance piece of work |
| System Performance management Processes | Reasonable |
| Safeguarding | Reasonable |
| EPRR | Substantial |
| Safe Practice - Cyber Security | Reasonable |
| Patient, carer and resident engagement | Reasonable |
| Recruitment/ pre-employment checks and establishment control | Reasonable |
| Key financial systems | Reasonable |
| Data Security and Protection Toolkit | *Requires Improvement |
| Management of Conflicts of Interest, Gifts and Hospitality | Reasonable |
| Payroll | **Requires Improvement |
| Risk Management and Assurance Framework | Reasonable |

***Data Security and Protection Toolkit**

There were 4 medium priority and 1 low priority recommendations, all of which have been completed. Completion of actions are reported to Audit and Risk Committee to ensure improvement of the system is in place.

****Payroll**

There were 5 medium priority recommendations, 3 of which have been completed, 1 which was not agreed and 1 which is in progress and not yet due for completion. Monitoring of progress and completion of actions are reported to Audit and Risk Committee to ensure improvement of the system is in place.

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

My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, the Executive Directors and senior management within the Integrated Care Board who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the External Auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Integrated Care Board achieving its principal objectives have been reviewed.

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

- Board
- Audit and Risk Committee
- Quality Committee
- Internal Audit
- External Audit

## Conclusion

As Accountable Officer, and based on the review processes outlined above, I can confirm that the Governance Statement is a balanced reflection of the actual controls position and there are no significant internal control issues identified for the Integrated Care Board.

Dr Jane Halpin
Accountable Officer
Date Signed: 7th June 2024

## EXIT PACKAGES AND COMPENSATION FOR LOSS OF OFFICE AGREED IN THE FINANCIAL YEAR (SUBJECT TO AUDIT)

In 2022-23, there was one exit package totalling £46,667 relating to a compulsory redundancy.

# Part two: remuneration and staff report

### Remuneration report

The information on pages 75 and 76 is not subject to audit, except for 'payments to past senior managers'.

### Remuneration Committee

The committee met three times during 2022/23, attendance registers can be found at page 56

### Remuneration of very senior managers

The Accountable Officer of the ICB is paid a salary in excess of £150,000 per annum. This has been approved by NHSE/I and the National Remuneration Committee considering senior manager pay and benchmarking was undertaken with similar sized organisations to ensure that salaries are competitive and in line with that of similar systems.

### Policy on remuneration of senior managers (not subject to audit)

The ICBs Remuneration Committee used the remuneration guidance provided by NHS England to inform its decisions regarding the pay of all very senior managers. We can confirm that the pay of all our very senior managers is within the pay ranges identified in the guidance, any additional payments have been agreed on a post-by-post basis for additional responsibilities and complexity, as assessed by the Remuneration Committee.

### Senior managers performance related pay (not subject to audit)

The Remuneration Committee has agreed that there will be no performance related pay for senior managers.

## Payments to past senior managers (subject to audit)

There have been no payments to past senior managers.

**Employee benefits and staff numbers (subject to audit)**

| | 2022-23 (9 months to 31 March) | | |
|---|---|---|---|
| **Employee benefits** | **Total £'000** | **Permanent Employees £'000** | **Other £'000** |
| Salaries and wages | 31,408 | 28,992 | 2,416 |
| Social security costs | 3,244 | 3,244 | 0 |
| Employer Contributions to NHS Pension scheme | 4,445 | 4,445 | 0 |
| Other pension costs | 9 | 9 | 0 |
| Apprenticeship Levy | 135 | 135 | 0 |
| Termination benefits | 47 | 47 | 0 |
| **Total employee benefits expenditure** | **39,288** | **36,872** | **2,416** |

**Average number of people employed (subject to audit)**

| | 2022-23 (9 months to 31 March) | | |
|---|---|---|---|
| | **Total Number** | **Permanently employed Number** | **Other Number** |
| **Total for ICB** | **699.6** | **670.6** | **29.0** |

## Salaries and allowances in 2022/23 (audited sections)

## Salaries and allowances in 2022/23

**Remuneration for members of the Board - Salaries and allowances July 2022 - March 2023**
**Table 1: Single total figure (Subject to Audit)**

| | | | 2022-23 | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Name** | **Role** | **Note** | **Salary (bands of £5,000)** | **Expense payments (taxable) to nearest £100** | **Performance pay and bonuses (bands of £5,000)** | **Long term performance pay and bonuses (bands of £5,000)** | **All pension related benefits (bands of £2,500)** | **TOTAL (bands of £5,000)** |
| | | | **£000** | **£** | **£000** | **£000** | **£000** | **£000** |
| Jane Halpin | Accountable Officer | 1,5,7 | 170-175 | 200 | 0 | 0 | 0 | 170-175 |
| Paul Burstow | ICB Chair | 1 | 45-50 | 0 | 0 | 0 | 0 | 45-50 |
| Alan Pond | Chief Finance Officer | 1,5,8 | 130-135 | 0 | 0 | 0 | 0 | 130-135 |
| Rachel Joyce | Director of Clinical & Professional Services | 5 | 115-120 | 0 | 0 | 0 | 25-27.5 | 140-145 |
| Jane Kinniburgh | Director of Nursing & Quality | 1,5 | 110-115 | 0 | 0 | 0 | 0 | 110-115 |
| Elizabeth Disney | Director of Operations | 5,7 | 100-105 | 100 | 0 | 0 | 40-42.5 | 140-145 |
| Beverley Flowers | Director of Strategy | 5 | 110-115 | 0 | 0 | 0 | 47.5-50 | 160-165 |
| Adam Lavington | Director of Digital Transformation | | 85-90 | 0 | 0 | 0 | 30-32.5 | 120-125 |
| Tania Marcus | Chief People Officer | 7 | 100-105 | 100 | 0 | 0 | 52.5-55 | 150-155 |
| Avni Shah | Director of Primary Care Transformation | 5,9 | 100-105 | 100 | 0 | 0 | 37.5-40 | 135-140 |
| Frances Shattock | Director of Performance | 5 | 100-105 | 0 | 0 | 0 | 22.5-25 | 125-130 |
| Toni Coles | Managing Director (WE) | 1 | 90-95 | 0 | 0 | 0 | 0 | 90-95 |
| Sharn Elton | Managing Director (ENH) | 5 | 95-100 | 0 | 0 | 0 | 25-27.5 | 125-130 |
| Matthew Webb | Managing Director (SWH) | | 90-95 | 0 | 0 | 0 | 40-42.5 | 130-135 |
| Dr Prag Moodley | Partner Member-Primary Medical Services | 2 | 80-85 | 0 | 0 | 0 | £NIL | 80-85 |
| Dr Ian Perry | Partner Member-Primary Medical Services | 2 | 45-50 | 0 | 0 | 0 | £NIL | 45-50 |
| Dr Nicholas Small | Partner Member-Primary Medical Services | 3 | 65-70 | 0 | 0 | 0 | 0 | 65-70 |
| Catherine Dugmore | Lay Member | 4,6 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| Ruth Bailey | Lay Member | 4,6 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| Professor Gurch Randhawa | Lay Member | 4,6 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| Thelma Stober | Lay Member | 4,6 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |

**Notes**

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Note 1 - Members who chose not to be covered by the pension arrangements during the reporting period.

Note 2 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practioner Pension Scheme". The ICB must make the post non pensionsable on the payroll and submit a GP Solo form with the employer's pension contribution of 14.3% plus an administration levy of 0.08% to the NHS Pension Authority. The salary banding above comprises of gross payment plus employer pension contribution, where applicable.

Note 3 - The GP member chose not to be covered by the Practitioner pension arrangements during the reporting period.

Note 4 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Note 5 - Salary includes a pay award paid after the demise of the CCGs which includes remuneration for the period April-June 2022. This has resulted in higher salary bandings for Jane Halpin and Beverley Flowers and higher total bandings for Frances Shattock and Sharn Elton.

Note 6 - Salary includes remuneration for the period of June when members were involved in the ICB set-up pre start date of 1 July.

Note 7 - The taxable benefits relate to the re-imbursement of mileage incurred on official duties. The benefit arises from the mileage allowance payments made to all staff, to reimburse them for expenses related to the use of their own vehicle for business travel. Hertfordshire & West Essex ICB pays the rate per mile set out in Agenda for Change, which exceeds the HMRC "approved mileage allowance payments" rate of 45p a mile. The excess amount is taxable and is disclosed above.

Note 8 - For transparency the member opted out of the pension scheme as at 30 June 2022.

Note 9 - The taxable benefit relates to the member having a lease car with a taxable benefit as stated. The member has a salary sacrifice arrangement for their vehicle which has the effect of reducing the salary paid during 2022-23.

Note 10 - The following are Partner Members on the Board but because neither they or their employing organisation receive remuneration in respect of their Board attendance and associated activities no further disclosure is required.

Elliot Howard-Jones - Chief Executive, Hertfordshire Community NHST

Lance McCarthy - Chief Executive, Princess Alexandra Hospital NHST

Karen Taylor - Chief Executive, Hertfordshire Partnership University NHS FT

Owen Mapley - Chief Executive, Hertfordshire County Council

Lucy Wightman - Director of Wellbeing, Public Health & Communities, Essex County Council

# 2022/23 Fair Pay Disclosure (audited element of remuneration report)

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. These ratios provide a reference point to infom movements in the gap between the workforce and the highest paid director.

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

The banded remuneration of the highest paid director/Member in Hertfordshire and West Essex ICB in the financial year 2022-23 was £225K to £230K). This was 4.74 times the median remuneration of the workforce, which was £47,947.

| YEAR | 25th Percentile total remuneration ratio | Median total remuneration ratio | 75th Percentile total remuneration ratio |
|---|---|---|---|
| **2022-23** | **227,500:36,515** | **227,500:47,947** | **227,500:60,652** |
| | **6.23** | **4.74** | **3.75** |

Average employees salary and allowances in 2022/23 was £51,450. In 2022-23 no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £1,544 to highest paid director. Remuneration for the lowest paid employee relates to a time commitment below the normal contractual hours, and therefore the annualised FTE calculation reflects the different terms.

# PENSIONS BENEFITS 2022/23 (SUBJECT TO AUDIT)

**Table 2: Pensions Benefits**

**Table 2: Pension Benefits July 2022 – March 2023**

| Name | Role | Note | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2023 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2022 | Real increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2023 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Jane Halpin | Accountable Officer | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Paul Burstow | ICB Chair | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Alan Pond | Chief Finance Officer | 1,2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Rachel Joyce | Director of Clinical & Professional Services | | 0-2.5 | 0-2.5 | 50-55 | 120-125 | 1,093 | 41 | 1,203 | 0 |
| Jane Kinniburgh | Director of Nursing & Quality | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Elizabeth Disney | Director of Operations | | 2.5-5 | 0-2.5 | 10-15 | 5-10 | 89 | 15 | 130 | 0 |
| Beverley Flowers | Director of Strategy | | 2.5-5 | 2.5-5 | 50-55 | 105-110 | 982 | 53 | 1,103 | 0 |
| Adam Lavington | Director of Digital Transformation | | 0-2.5 | 0 | 15-20 | 0 | 148 | 14 | 188 | 0 |
| Tania Marcus | Chief People Officer | | 2.5-5 | 2.5-5 | 20-25 | 35-40 | 318 | 41 | 400 | 0 |
| Avni Shah | Director of Primary Care Transformation | | 2.5-5 | 0-2.5 | 40-45 | 75-80 | 595 | 29 | 672 | 0 |
| Francis Shattock | Director of Performance | | 0-2.5 | 0 | 5-10 | 0 | 29 | 9 | 60 | 0 |
| Toni Coles | Managing Director (WE) | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sharn Elton | Managing Director (ENH) | | 0-2.5 | 0 | 65-70 | 135-140 | 1,134 | 32 | 1,230 | 0 |
| Matthew Webb | Managing Director (SWH) | | 2.5-5 | 0-2.5 | 45-50 | 90-95 | 745 | 40 | 838 | 0 |
| Dr Prag Moodley | Partner Member-Primary Medical Services | 3 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Dr Ian Perry | Partner Member-Primary Medical Services | 3 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Dr Nicholas Small | Partner Member-Primary Medical Services | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Catherine Dugmore | Lay Member | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Ruth Bailey | Lay Member | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Professor Gurch Randhawa | Lay Member | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Thelma Stober | Lay Member | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Notes**

The real increase in pension, lump sum and cash equivalent transfer values shown above have been apportioned to reflect the period the ICB has been in operation.

The total accrued pension, lump sum and cash equivalent transfer value are as at 31 March 2023.

Note 1 - Members who chose not to be covered by the pension arrangements during the reporting period.

Note 2 - The member opted out of the pension scheme 30 June 2022

Note 3 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practitioner Pension Scheme". The CCG must make the post non-pensionable on the payroll and for GPs who are members of the Practitioner scheme, submit GP SOLO forms to reflect the employers pension contribution of 14.3% plus 0.08% administration levy to the NHS Pensions Authority .

Note 4 - Member who chose not to be covered by Practitioner pension arrangements during the reporting year.

Note 5 - As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions.

Note 6 - As part of the changes to public pension schemes, both the 1995 and 2008 Sections of the 1995/2008 Scheme closed on 31 March 2022. All active members of th 1995/2008 Scheme were automatically moved to the 2015 Scheme on 1 April 2022.

Note 7 - NHS employees contribute towards their pension benefits. In 2022/23 to 30 September contribution rates were 14.5% of salary where the individual earned in excess of £111,377 and 13.5% where the individual earned between £70,631 and £111,377. From 1 October 2022 new tiers and employee contribution rates were phased in based on actual pensionable earnings instead of whole time equivalent earnings. Employee contribution rates were 13.5% where individuals earned in excess of £72,031.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

Note 8 - Cash equivalent transfer values (CETV)

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 membership of the pension scheme. This may be more than 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.

Note 9 - The real increase in CETV reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

For transparency the table below shows the total pension benefits for 2022-23 where the Senior Manager was appointed as a Director in more than one of the Hertfordshire and West Essex CCGs and ICS for the period April - June 2022 and where a sharing arrangement existed.

Total Pensions Benefits (Full Year Effect)

| Name | Role | Real increase in pension at pension age (bands of £2,500) | Real increase in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2023 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2022 | Real increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2023 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|---|
| Jane Halpin | Accountable Officer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Alan Pond | Chief Finance Officer | 0 | 0 | 75-80 | 120-125 | 1,301 | 15 | 1,361 | 0 |
| Elizabeth Disney | Director of Operations (from 6 June) | 2.5-5 | 0-2.5 | 10-15 | 5-10 | 89 | 16 | 130 | 0 |
| Rachel Joyce | Director of Clinical & Professional Services | 2.5-5 | 2.5-5 | 50-55 | 120-125 | 1,093 | 55 | 1,203 | 0 |
| Jane Kinniburgh | Director of Nursing & Quality | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Avni Shah | Director of Primary Care Transformation | 2.5-5 | 0-2.5 | 40-45 | 75-80 | 595 | 39 | 672 | 0 |
| Frances Shattock | Director of Performance & Delivery | 2.5-5 | 0 | 5-10 | 0 | 29 | 12 | 60 | 0 |

## Off-payroll engagements

**Table 1: Length of all highly paid Off-payroll engagements (not subject to audit)**

For all off-payroll engagements as of 31 March 2023, for more than **£245** per day

| **Number of existing engagements as of 31 March 2023** | **31** |
|---|---|
| Of which… the number that have existed: | |
| for less than one year at time of reporting | 23 |
| for between one and two years at time of reporting | 5 |
| for between 2 and 3 years at time of reporting | 3 |
| for between 3 and 4 years at time of reporting | 0 |
| for 4 or more years at time of reporting | 0 |

**Table 2: Off-payroll workers engaged at any point during the financial year (not subject to audit)**

**For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2022 and 31 March 2023, for more than £245 per day**

| No of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023 | 20 |
|---|---|
| Of which… | |
| No. not subject to off-payroll legislation | 0 |
| No. subject to off-payroll legislation and determined as in-scope of IR35 | 20 |
| | |

| | |
|---|---|
| No. subject to off-payroll legislation and determined as out of scope of IR35 | 0 |
| The number of engagements re-assessed for compliance or assurance purposes during the year | 0 |
| Of which: no. of engagements that saw a change to IR35 status following review | 0 |

**Table 3: Off-payroll board member/senior official engagements (not subject to audit)**

**For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023**

| | |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year | 3 |
| Total no. of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility' during the financial year. This figure must include both on payroll and off-payroll engagements | 21 |

The three off payroll engagements in table 3 relate to GP Board members working under a contract for services.

## EXPENDITURE ON CONSULTANCY

The total spend on consultants in 2022/23 is shown within the accounts from page 102

# Staff report

Please note that sections subject to audit will be identified as such in their heading. All other sections are not subject to audit.

### Trade union facility time

Union representatives have a statutory right to reasonable paid time off from employment to carry out trade union duties and to undertake trade union training. Union duties must relate to matters covered by collective bargaining agreements between employers and trade unions and relate to the union representative's own employer, unless agreed otherwise in circumstances of multi-employer bargaining, and not, for example, to any associated employer.

Union representatives and members also have a statutory right to reasonable unpaid time off when taking part in trade union activities. Employers can also consider offering paid time off.

Activities can be, for example, taking part in:

- branch, area or regional meetings of the union where the business of the union is under discussion
- meetings of official policy making bodies such as the executive committee or annual conference
- meetings with full time officers to discuss issues relevant to the workplace.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1st April 2017 and put in place the provisions in the Trade Union Act 2016 requiring relevant public sector employers to publish specified information related to facility time provided to trade union officials. The specified information is provided in Tables 1-4 below.

**Table 7: Relevant union officials**

| Number of employees who were relevant union officials during 2022/23 |
|---|
| 2 |

**Table 8: Percentage of time spent on facility time**

| Percentage of time | Number of employees |
|---|---|
| 0% | |
| 1-50% | 2 |
| 51%-99% | |
| 100% | |

**Table 9: Percentage of pay bill spent on facility time**

| Description | Figures |
|---|---|
| Total cost of facility time | £5,535.80 |
| Total pay bill* | £36,736,297.08 |
| Percentage of the total pay bill spent on facility time | 0.02% |

* total pay bill includes permanent employees only and includes apprenticeship levy deduction

**Table 10: Paid trade union activities**

| | |
|---|---|
| Time spent on paid trade union activities as a percentage of total paid facility time hours | 18.74% |

# About our staff

As at 31 March 2023, Hertfordshire and West Essex ICB employed a total of 795 staff (668.35 full time equivalents). These figures include all Board members and eight staff on external secondment to partnership organisations. In 2022/23 our staff turnover was 9.17%.

The table below details how many senior managers are employed by the ICB by banding (as at 31 March 2023).

| Agenda for Change Band | Headcount | FTE |
|---|---|---|
| 8a | 118 | 107.65 |
| 8b | 87 | 83.33 |
| 8c | 41 | 39.40 |
| 8d | 35 | 33.63 |
| 9 | 5 | 5 |
| Very Senior Manager (VSM) | 16 | 16 |
| Medical & Dental (M&D)[12] | 91 | 21.6 |

# Equality and Diversity

**The Equality Act 2010: The Public Sector Equality Duty**

Section 149 of the Equality Act 2010 states that a public authority must have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Throughout 2022/23, Hertfordshire and West Essex ICB engagement approach was fully cognisant of this duty and it will continue to promote equality of opportunity for the

[12] This figure includes GPs who are Board members, GPs who are offering clinical support to the ICB in another capacity, such as clinical leads, public health doctors and clinical fellow, plus Named GPs who perform a safeguarding role.

population of Hertfordshire and west Essex in the context of all its commissioning engagement activities in the future.

The ICB met statutory responsibilities around data publication and will meet the NHS requirements in using the NHS Equality Delivery System (EDS) and the Workforce Race Equality Standard (WRES) as tools to enable us to review our equality and diversity work and identify where improvements can be made.

**NHS Workforce Race Equality Standards (WRES)**

The ICB is required to implement WRES in respect of its own workforce. It is recognised that the small size of many ICBs means that the interpretation of the indicators should be approached with caution. Following the interpretation and publication of the WRES data, an action plan was produced and is being implemented within the ICB.

**The ICB's profile for staff-declared ethnicity appears in the table below (on 31 March 2023)**

| Ethnic Origin | Headcount | % |
|---|---|---|
| White – British | 468 | 58.9% |
| White – Irish | 16 | 2% |
| White - Any other White background | 31 | 3.9% |
| White English | 3 | 0.4% |
| Mixed - White and Black Caribbean | 5 | 0.6% |
| Mixed - White and Black African | 1 | 0.1% |
| Mixed - White and Asian | 3 | 0.4% |
| Mixed - Any other mixed background | 5 | 0.6% |
| Mixed - Chinese and White | 1 | 0.1% |
| Mixed - Other/Unspecified | 2 | 0.3% |
| Asian or Asian British - Indian | 67 | 8.4% |
| Asian or Asian British - Pakistani | 20 | 2.5% |
| Asian or Asian British - Bangladeshi | 10 | 1.3% |
| Asian or Asian British - Any other Asian background | 14 | 1.8% |
| Asian Sri Lankan | 2 | 0.3% |
| Asian British | 1 | 0.1% |
| Black or Black British - Caribbean | 20 | 2.5% |
| Black or Black British - African | 46 | 5.8% |
| Black or Black British - Any other Black background | 2 | 0.3% |
| Chinese | 6 | 0.8% |
| Any Other Ethnic Group | 7 | 0.9% |
| Unspecified | 39 | 4.8% |
| Not Stated | 26 | 3.2% |
| **Total** | 795 | **100.00%** |

**Equality and Diversity Action Planning and the NHS Equality Delivery System (EDS)**

| |
|---|
| EDS Organisation Rating (overall rating): Developing |
| Organisation name(s): Herfordshire and west Essex ICB |
| Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**<br>Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**<br>Those who score **between 22 and 30,** adding all outcome scores in all domains, are rated **Achieving**<br>Those who score **31 and above,** adding all outcome scores in all domains, are rated **Excelling** |

**Disability**

The ICB holds the **Disability Confident** award (up to 2 November 2023) which recognises our commitment to recruiting and developing disabled employees. This award replaces the 'Positive About Disabled People' (PADP) award.

The Inclusive Career Development Programme has been developed to implement a consistent framework of leadership development for colleagues in Bands 2-4 from across the ICS for equality groups currently underrepresented in leadership roles, including those with disabilities; to support career progression. The programme includes the completion of a service improvement project within the participants work area that aims to improve patient outcomes, improved system performance and personal/professional learning. The first cohort of the programme began on September 2022.

The ICB recognises the benefits of a diverse workforce and is committed to supporting applicants and employees with a disability to be part of its workforce, and values their contribution to delivery of patient care, the Disability in the workplace policy underpins these principles. The policy outlines the ways in which the ICB will meet it's duties under the Equality Act to make reasonable adjustments, the ICB encourages the use of health passports to support colleagues with disabilities.

The ICB runs EDI training and awareness sessions including within the corporate induction programme for all new starters. 'Lunch and learn' training and awareness sessions and support to individual colleagues and teams upon request.

At 31 March 2023, 86.5.% of staff have declared they have no disability, with 3.9% declaring a disability and the remaining 9.6% declaring they do not wish to disclose.

**Gender Profile**

### Gender Profile – overall workforce (at 31 March 2023)

| Gender | % |
|---|---|
| Female | 71 |
| Male | 29 |

### % gender by pay band (at 31 March 2023)

| Agenda for Change (AfC) | Male (%) | Female (%) |
|---|---|---|
| Band 3 | 0.1 | 0.3 |
| Band 4 | 0.9 | 6.1 |
| Band 5 | 4.0 | 7.5 |
| Band 6 | 2.4 | 9.8 |
| Band 7 | 5.2 | 12.3 |
| Band 8A | 2.8 | 12.1 |
| Band 8B | 3.3 | 7.7 |
| Band 8C | 1.5 | 3.6 |
| Band 8D | 1.5 | 2.9 |
| Band 9 | 0.1 | 0.5 |
| Medical & Dental | 5.8 | 7.2 |
| Very Senior Managers (VSM) | 0.8 | 1.3 |

### Gender breakdown (as at 31 March 2023)

| **Board members, VSM and Medical and Dental staff** | | | |
|---|---|---|---|
| **Male** | | **Female** | |
| Headcount | % | Headcount | % |
| 52 | 6.5 | 67 | 8.4 |
| **Bands 8a and above** | | | |
| **Male** | | **Female** | |
| Headcount | % | Headcount | % |
| 73 | 9.2 | 213 | 26.8 |
| **All other bands (band 7 and below)** | | | |
| **Male** | | **Female** | |
| Headcount | % | Headcount | % |
| 100 | 12.6 | 290 | 36.5 |

## Gender pay gap reporting regulations

The ICB will be required to publish gender pay gap information next year (2024). Find further information on Gender pay gap reporting: guidance for employers on the GOV.UK website.

You can also search and compare gender pay gap data for relevant employers.

## Religion and beliefs

The declared religion or belief of ICB staff at 31 March 2023 appears in the table below:

| Religious Belief | Headcount | % |
|---|---|---|
| Atheism | 106 | 13.5 |
| Christianity | 285 | 35.8 |
| Hinduism | 28 | 3.5 |
| Islam | 29 | 3.6 |
| Jainism | 5 | 0.6 |
| Judaism | 5 | 0.6 |
| Not Disclosed | 248 | 31.2 |
| Other | 46 | 5.8 |
| Sikhism | 5 | 0.6 |
| Unspecified | 38 | 4.8 |
| **Total** | 795 | 100.00% |

## Sexual Orientation

The declared sexual orientation of CGG staff at 31 March 2023 appears in the table below:

| Sexual Orientation | Headcount | % |
|---|---|---|
| Bisexual | 10 | 1.3% |
| Gay or Lesbian | 11 | 1.4% |
| Heterosexual or Straight | 552 | 69.4% |
| Not Disclosed | 174 | 21.9% |
| Other sexual orientation not listed | 4 | 0.5% |
| Undecided | 2 | 0.3% |
| Unspecified | 42 | 5.2% |
| **Grand Total** | 795 | 100.00 |

## Sickness absence data

Sickness absence data relating to the year 2022/23 extracted from ESR:

| | |
|---|---|
| **Total days lost:** | 5111.9 days (equivalent calendar days) |
| **Total absence (FTE)** | 4951.5 days out of a total of 264,462.90 available FTE days |
| **Average absence per employee:** | 6.4 days (average of total days lost by ICB employee headcount) |
| **Of total days lost, long term absence episodes:** | 1.06% |
| **Long term days total:** | 2731.2 days (included in total days lost) |

The ICB's sickness absence rate for 2022/23 was 2.01%

This figure is based on the total full time equivalent days available to work during 2021/22 and how much of the full time equivalent workforce was absent. The absence rate covers calendar days lost and will include weekends where absence dates cover Saturday and/or Sunday.

# People Services

## Staff Policies

The HR Shared Service continues to develop and refresh policies for use across the ICB via the Policy Forum. The Forum has HR, management, staff-side and staff representatives from across ICB and works together to adopt best practice in people management policy across the organisations.

## Whistleblowing

The ICB has in place a Freedom to Speak Up policy which provides staff with information and reassurance regarding their rights and responsibilities in reporting concerns. It sets out clearly how staff can report in confidence, good faith and without fear of retribution. As part of this policy, the ICB has a nominated Freedom to Speak Up Guardian; Shawn Butler and a Board level lead; Frances Shattock to oversee the effectiveness of this process.

During 2022/23, Freedom to Speak Up Champions helped to keep staff safe and supported. Including the Board Member there are 42 trained champions based at the ICB, from different directorates, levels and backgrounds.

### Training and Development

The compliance rate for mandatory training as at 31 March 2023 is 86.3%. Non-compliance is being addressed via system alerts to relevant staff and their managers, regular mandatory training reporting to directors and managers can view a dashboard of their teams' compliance in real time on My ESR.

The ICB has introduced a new online appraisal system to help simplify the process and support an emphasis on the quality of the appraisal conversation to provide meaningful appraisals supporting wellbeing, individual development and both individual and team effectiveness.

During 2021/22 a wide range of optional learning and development opportunities were offered to staff via the MindTools web portal and face-to-face through the HR ODL shared service. The ICB has 197 users registered with MindTools.

### Apprenticeship Levy

During the year, staff were also able to make use of the Apprenticeship Levy to access professional development qualifications.

Employers with annual pay bills in excess of £3 million are required to pay 0.5 % of their pay-bill into the scheme. This means that HWE ICB has an annual Levy budget of approximately £135k.

### Health and safety

The ICB is fully committed to protecting the health, safety and welfare of all its staff and providing a secure and healthy environment in which to work. The ICB recognises its legal obligations under the Health and Safety at Work Act 1974, to ensure the health, safety and welfare of its staff, so far as is reasonably practicable. The ICB also accepts such responsibility for other persons who may be affected by its activities.

## Employee consultation and communications

### Joint Partnership Forum

The Joint Partnership Forum meets regularly and is a chance for staff and union representatives to discuss key issues affecting their working lives with executive members and make plans for improvements.

This year the forum works to address key issues that were raised in previous years' national staff surveys, which included implementation of disability passports

Other actions taken to support the workforce included:

- development of organisational values – The Herts and West Essex Way
- delivery of workshops and webinars to support positive culture, team working, compassionate culture and civility
- developed an online staff recognition resource.

## Staff Survey

The 2022 NHS National Staff Survey has demonstrated that there has been significant improvement in the following areas:

- Staff being satisfied with opportunities for flexible working
- The ICB being committed to help balance work and home life
- Appraisals left staff feeling the organisation values their work, and helped them do their job

The results also highlighted the following priority areas for improvement

- Satisfaction with the level of pay
- The proportion of staff who reported bullying and harassment
- Having shared objectives
- Feeling like their line manager listened to the challenges they face
- The proportion of staff having received an appraisal

A number of workshops were held by staff side representatives during March 2023. Staff Partnership Forum members have engaged with staff across the organisation and, as a result, a working group has been established to develop the Staff Survey action plan

The full reports can in the **NHS Staff Survey.**

# Staff health and wellbeing

The ICB is fully committed to the health and positive wellbeing of its employees. The emphasis in this area has been especially important during the challenges of the past year and the ICB understands that a healthy and happy workforce is crucial to delivering improvements in patient care. Staff are supported through various initiatives to support health and wellbeing including:

- Mental Health First Aiders, there are 42 within the ICB who proactively offer support to colleagues
- Learning through webinars and online presentations
- Lunch and Learn sessions run every two weeks by the Organisational Learning and Development (ODL) team.

Professional support includes:

- Employee Assistance Programme
- Hertfordshire and Essex Here for You Service
- My Health My Way

The ICB is also recognised as a Menopause-Friendly Employer. Staff and management awareness sessions have been run by the ICB Menopause Advocate.

There are support services for staff living with Long COVID-19 or menopause.

We also have a registered mental health nurse who supports staff with cognitive behaviour therapy (CBT) and coping with anxiety.

# Equality of opportunity for staff

The ICB is committed to challenging inequalities in the workplace and improving opportunities for all of our staff.

The ICB was awarded the Carer Confident Accomplished Employer certification. This work supports staff who are carers to balance their working and caring responsibilities.

A flexible working policy is in place to support colleagues' work-life balance. The ICB holds the Disability Confident award which recognises our commitment to recruiting and developing disabled employees. The ICB recognises the benefits of a diverse workforce and is committed to supporting applicants and employees with a disability to be part of it's workforce, and values their contribution to delivery of patient care. The Disability in the Workplace policy underpins these principles.

The Executive team made an anti-racism pledge looking inwards at staff but also in relation to services provided for all of the communities we serve.


The ICB has an active and growing BAME Network which aims to empower staff from Black, Asian or minority ethnic backgrounds to engage with the organisation in a meaningful way and to discuss ways in which the experience and opportunities within the ICB can be improved. This group supports individuals and looks to support organisational change where needed.

ICB staff working in bands 2 to 4 are able to take part in the Hertfordshire and West Essex Inclusive development career programme which is open to anyone from a Black, Asian and minority ethnic background and disabled people, working in clinical and non-clinical roles. The programme runs over six months and delegates are able to undertake a service improvement project learning new skills and knowledge to help with their career progression. There are plans to expand this successful programme to bands 5 to 7 in 2023/24.

# Part Three: Parliamentary Accountability and Audit Report

Hertfordshire and West Essex Integrated Care Board is not required to produce a Parliamentary Accountability and Audit Report, which would require disclosure on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. However, it can confirm that there have been no such items that require this disclosure during 2022/23

## INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD

### Opinion on financial statements

We have audited the financial statements of NHS Hertfordshire and West Essex Integrated Care Board (the ICB) for the period ended 31 March 2023, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as interpreted and adapted by the 2022-23 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2022-23.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Hertfordshire and West Essex ICB as at 31 March 2023 and of its net expenditure for the period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2022-23; and
- have been prepared in accordance with the National Health Service Act 2006.

### *Basis for opinion on financial statements*

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

### Other information

The Accountable Officer is responsible for the other information. The other information 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, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

**Opinion on regularity**

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 in the financial statements conform to the authorities which govern them.

***Basis for opinion on regularity***

We carried out our work on regularity in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) issued by the Public Audit Forum. Our responsibilities in this respect are further described in the Auditor's other responsibilities section of our report. We believe the evidence obtained from this work, in conjunction with the evidence we have obtained in our audit of the financial statements, is sufficient and appropriate to provide a basis for our opinion on regularity.

**Opinion on information in the Remuneration and Staff Report**

We have also audited the information in the Remuneration and Staff Report that is subject to audit, described in that report as having been audited.

In our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with Department of Health and Social Care's Group Accounting Manual 2022-23.

**Matters on which we are required to report by exception**

We are required to report to you if, in our opinion, we identify any significant weaknesses in the arrangements that have been made by the ICB for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

We have completed our work on the ICB's arrangements. We have not identified any significant weaknesses in the ICB's arrangements for the period ended 31 March 2023.

**Other matters on which we report by exception**

We are required to report to you if:

- in our opinion the Governance statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the ICB under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

**Responsibilities of the Accountable Officer**

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that

they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the ICB has been informed of an intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the ICB exercises its function effectively, efficiently and economically, which includes putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

The Accountable Officer is also responsible for the propriety and regularity of the public finances for which the Accountable Officer is answerable.

**Auditor's responsibilities for the audit of the financial statements**

In respect of our audit of the financial statements 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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

**Extent to which the audit was capable of detecting irregularities, including fraud**

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Our procedures included the following:

- inquiring of management, the ICB's head of internal audit, the ICB's local counter fraud specialist and those charged with governance, including obtaining and reviewing supporting documentation in respect of the ICB's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the ICB's controls relating to Managing Public Money requirements;
- discussing among the engagement team and involving relevant internal and or external specialists, including forensic specialists regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: expenditure recognition, management override through posting of unusual journals and bias in estimates, and manipulation of the administration expenditure performance through journal reclassifications and misallocation of expenditure; and
- obtaining an understanding of the ICB's framework of authority as well as other legal and regulatory frameworks that the ICB operates within, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the ICB. The key laws and regulations we considered in this context included the National Health Service Act 2006, as amended by Section 27 of the Health and Social Care Act 2012, whereby the ICB must ensure that its revenue resource allocation in any financial period does not exceed the amount specified by NHS England.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the ICB Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; reviewing errors identified during our audit and assessing whether they are indicative of management bias;
- in addressing the risk of fraud in expenditure recognition, testing the accounting treatment of an increased sample of payments around the period end; testing an increased sample of accruals to supporting evidence confirm a liability existed at period end; testing an increased sample of accruals to post period payments or other supporting evidence to verify their accuracy; testing the expenditure recognised with healthcare providers to agreed contracts and their performance against conditions; testing differences with NHS counter parties identified in the agreement of balances schedules; and
- in addressing the risk of fraud in the administration expenditure performance reported against the revenue resource allocation, testing the basis and appropriateness of journals which impacted administration expenditure, monthly analysis of administration expenditure to identify outliers and investigate further, testing the classification and split of items sampled in our expenditure testing.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, and obtain sufficient assurances that 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 in the financial statements conform to the authorities which govern them, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

**Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

**Auditor's other responsibilities**

In addition to our audit of the financial statements we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial statements conform to the authorities which govern them.

As set out in the Matters on which we report by exception section of our report there are certain other matters which we are required to report by exception.

**Certificate**

We certify that we have completed the audit of the accounts of for NHS Hertfordshire and West Essex Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

**Use of our report**

This report is made solely to the Members of the Board of NHS Hertfordshire and West Essex Integrated Care Board, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015.

Our audit work has been undertaken so that we might state to the Members of the Board 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 ICB and the Members of the Board of NHS Hertfordshire and West Essex Integrated Care Board, as a body, for our audit work, this report, or for the opinions we have formed.

Rachel Brittain
Key Audit Partner

For and on behalf of BDO LLP, local auditor
London, UK

Date 07 June 2024

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

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**Statement of Comprehensive Net Expenditure for the period ended 31 March 2023**

| | Note | 2022-23 (9 months to 31 March) £'000 |
|---|---|---|
| Revenue from contracts with customers | 2 | (9,016) |
| Other operating income | 2 | (7,168) |
| **Total operating income** | | **(16,184)** |
| Staff costs | 3 | 39,288 |
| Purchase of goods and services | 4 | 2,197,062 |
| Depreciation | 4 | 969 |
| Provision expense | 4 | 1,243 |
| Other Operating Expenditure | 4 | 1,449 |
| **Total operating expenditure** | | **2,240,011** |
| **Net Operating Expenditure** | | **2,223,827** |
| Finance expense | | **1** |
| **Net expenditure for the period** | | **2,223,828** |
| **Total Comprehensive Expenditure for the period ended 31 March 2023** | | **2,223,828** |

The notes on pages 106 to 108 form part of this statement

**Statement of Financial Position as at 31 March 2023**

| | Note | 31 March 2023 £'000 | Note 1 July 2022 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 7 | 972 | 1,428 |
| Right-of-use assets | | 260 | 773 |
| Trade and other receivables | 8 | 77 | 215 |
| **Total non-current assets** | | **1,309** | 2,416 |
| **Current assets:** | | | |
| Trade and other receivables | 8 | 20,662 | 10,871 |
| Cash | 9 | 1,087 | 3,117 |
| **Total current assets** | | **21,749** | 13,988 |
| **Total assets** | | **23,058** | 16,404 |
| **Current liabilities** | | | |
| Trade and other payables | 10 | (197,864) | (138,707) |
| Lease Liabilities | | (284) | (609) |
| Provisions | | (7,420) | (6,630) |
| **Total current liabilities** | | **(205,568)** | (145,946) |
| **Total Assets less Current Liabilities** | | **(182,510)** | (129,542) |
| **Non-current liabilities** | | | |
| Lease Liabilities | | 0 | (176) |
| Provisions | | (218) | (384) |
| **Total non-current liabilities** | | **(218)** | (560) |
| **Assets less Liabilities** | | **(182,728)** | (130,102) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (182,728) | (130,102) |
| **Total taxpayers' equity:** | | **(182,728)** | (130,102) |

Note

The balances shown represent aggregated closing positions from NHS East and North Hertfordshire CCG, NHS Herts Valleys CCG and NHS West Essex CCG transferred to the ICB.

The notes on pages 106 to 108 form part of this statement

The financial statements on pages 102 to 121 were approved by the Audit and Risk Committee on behalf of the Board on 24th May 2024 and signed on it's behalf by:

Jane Halpin
Accountable Officer
7th June 2024

**Statement of Changes In Taxpayers' Equity for the period ended 31 March 2023**

| | General fund £'000 |
|---|---|
| **Changes in taxpayers' equity for 2022-23 (9 months to 31 March)** | |
| **Balance at 1 July 2022** | |
| Transfers by absorption from other bodies | (130,166) |
| **Changes in NHS Integrated Care Board taxpayers' equity for 2022-23 (9 months to 31 March)** | |
| Net operating expenditure for the financial year | (2,223,828) |
| **Net Recognised NHS Integrated Care Board Expenditure for the Financial Year including balance brought forward from previous year** | **(2,353,994)** |
| Net funding | 2,171,266 |
| **Balance at 31 March 2023** | **(182,728)** |

The notes on pages 106 to 108 form part of this statement

## Statement of Cash Flows for the period ended 31 March 2023

| | Note | 2022-23 (9 months to 31 March) £'000 |
|---|---|---|
| **Cash Flows from Operating Activities** | | |
| Net operating expenditure for the financial period | | (2,223,828) |
| Depreciation | 4 | 969 |
| Movement in trade & other receivables | 8 | (9,654) |
| Movement in trade & other payables | 10 | 59,143 |
| Provisions utilised | | (666) |
| Increase in provisions | | 1,244 |
| **Net Cash Outflow used in Operating Activities and before Financing** | | **(2,172,792)** |
| **Cash Flows from Financing Activities** | | |
| Grant in Aid Funding Received | | 2,171,266 |
| Repayment of lease liabilities | | (504) |
| **Net Cash Inflow from Financing Activities** | | **2,170,762** |
| **Net Decrease in Cash** | 9 | **(2,030)** |
| **Cash at the Beginning of the Financial Period** | 9 | **3,117** |
| **Cash at the End of the Financial Period** | | **1,087** |

The notes on pages 106 to 108 form part of this statement

**Notes to the financial statements**

Foreword

An establishment order was issued by NHS England on 30 June 2022 dissolving Clinical Commissioning Groups (CCGs). NHS East and North Hertfordshire CCG, NHS Herts Valleys CCG and NHS West Essex CCG were dissolved on that day and all assets and liabilities of those CCGs were transferred to NHS Hertfordshire and West Essex ICB from 1 July 2022. These accounts have therefore been prepared for the nine months from 1 July 2022 to 31 March 2023.

## 1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the 2022-23 Group Accounting Manual (GAM) issued by the DHSC. The accounting policies contained in the GAM 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 GAM 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 the going concern basis.

The Health and Social Care Act established the creation of ICBs on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. The financial statements for this ICB are therefore prepared on a Going Concern basis as they will continue to provide the services for a period of at least 12 months from the date the accounts were authorised for issue.

### 1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

### 1.3 Transfer of Functions

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

For transfers of assets and liabilities from those CCG bodies that ceased to exist on 1 July 2022, DHSC has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in the Statement of Changes in Taxpayers' Equity rather than the Statement of Comprehensive Net Expenditure. As such, other than for the Statement of Financial Position whereby the closing positions of the CCGs are aggregated and shown as at 30 June 2022, comparative figures for the previous year have not been provided as the ICB did not exist in 2021-22.

### 1.4 Pooled Budgets

The ICB has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 with Hertfordshire County Council (HCC) and Cambridgeshire and Peterborough ICB (formerly CCG) for the provision of a number of services, including:

(1) Services under the Better Care Fund (BCF). Although the BCF consists of a number of commissioning arrangements, only services jointly-commissioned with HCC, including the protection of social care services, are relevant to the pooled policy.

(2) Mental Health and Learning Disability Services which are jointly-commissioned.

(3) Equipment Services.

(4) Intermediate Care Services.

An assessment has been carried out of these arrangements under the appropriate accounting standards and they are deemed to meet the definition of being under joint control under IFRS 11 Joint Arrangements. Under this type of arrangement, a joint operation is considered to be in place and this means that the ICB recognises:

· its assets, including its share of any assets held jointly;
· its liabilities, including its share of any liabilities incurred jointly;
· its revenue from the sale of its share of the output of the joint operation;
. its share of the revenue from the sale of the output by the joint operation; and
· its expenses, including its share of any expenses incurred jointly.

**Notes to the financial statements**

1.5 **Revenue**

The main source of funding for the ICB 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, and to the extent that, performance occurs, and is measured at the fair value of the consideration received. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred. The main source of income for the ICB is in the provision of Information and Technology Services. The majority of these services are subject to service level agreements over a period of twelve months and cover a range of activity such as, but not limited to, network maintenance, provision of data lines, servers, storage capacity, digital telephony and help desk facilities to various NHS organisations. Recognition of this income stream will be on an ongoing basis over time rather than on a percentage completion based upon performance obligations.

There is also a secondary source of income in respect of funds received from Health Education England for workforce development programmes of the Integrated Care System (ICS) of which this ICB is part of, and also from contributions received from other ICS partner organisations for functions hosted by the ICB. These income streams are recognised in the period they are received.

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 are recognised in the period in which the service is received from employees.

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

1.6.2 **Retirement Benefit Costs**

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

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

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

1.7 **Other Expenses**

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

1.8 **Property, Plant & Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:
· it is held for use in delivering services or for administrative purposes;
· it is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
· it is expected to be used for more than one financial year;
· the cost of the item can be measured reliably; and
· the item has a cost of at least £5,000; or
· collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

**Notes to the financial statements**

· items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 **Measurement**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

1.8.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 **Depreciation and Impairments**

Depreciation is charged to write off the costs or valuation of property, plant and equipment less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

At each reporting period end, the ICB checks whether there is any indication that any of its tangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 **Cash**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

1.11 **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.

1.12 **Financial Liabilities**

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

1.13 **Losses and 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).

**Notes to the financial statements**

## 2 Other Operating Revenue

| | 2022-23 (9 months to 31 March) Total £'000 |
|---|---|
| **Revenue from contracts with customers** | |
| Non-patient care services to other bodies | 8,503 |
| Other revenue | 513 |
| **Total Income from sale of goods and services** | 9,016 |
| | |
| **Other operating income** | |
| Non cash apprenticeship training grants revenue | 46 |
| Other non contract revenue | 7,122 |
| **Total Other operating income** | 7,168 |
| | |
| **Total Operating Income** | **16,184** |

The recognition of revenue is over time. Other operating income is derived from the rendering of services.

### 2.1 Disaggregation of Income - Income from sale of goods and services (contracts)

| 2022-23 (9 months to 31 March) | Non-patient care services to other bodies £'000 | Other Contract Income £'000 | Total £'000 |
|---|---|---|---|
| Source of Revenue | | | |
| NHS | 8,470 | 428 | 8,898 |
| Non NHS | 33 | 85 | 118 |
| **Total** | **8,503** | **513** | **9,016** |

## 3. Employee benefits

| 3.1 Employee benefits | 2022-23 (9 months to 31 March) Total £'000 |
|---|---|
| Salaries and wages | 31,408 |
| Social security costs | 3,244 |
| Employer Contributions to NHS Pension scheme | 4,445 |
| Other pension costs | 9 |
| Apprenticeship Levy | 135 |
| Termination benefits | 47 |
| **Gross employee benefits expenditure** | **39,288** |

### 3.3 Pension costs

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

In order that the defined benefit obligations recognised in the NHS Pension scheme 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:

a) 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

**4. Operating expenses**

| | 2022-23 (9 months to 31 March) Total £'000 |
|---|---|
| **Purchase of goods and services** | |
| Services from other CCGs and NHS England | 120 |
| Services from foundation trusts | 287,977 |
| Services from other NHS trusts | 1,044,140 |
| Purchase of healthcare from non-NHS bodies | 405,982 |
| Purchase of social care | 30,894 |
| Prescribing costs | 182,352 |
| GP Primary Care Services | 197,616 |
| Supplies and services – clinical | 118 |
| Supplies and services – general | 28,534 |
| Consultancy services | 896 |
| Establishment | 10,495 |
| Transport | 1,429 |
| Premises | 3,206 |
| Audit fees (Note 1) | 206 |
| Other non statutory audit expenditure | |
| · Other services (Note 2) | 31 |
| Other professional fees (Note 3) | 622 |
| Legal Fees | 693 |
| Education and training | 1,705 |
| Non cash apprenticeship training grants | 46 |
| **Total Purchase of goods and services** | **2,197,062** |
| | |
| **Depreciation** | |
| Depreciation (Note 4) | 969 |
| **Total Depreciation** | **969** |
| | |
| **Provision expense** | |
| Provisions | 1,243 |
| **Total Provision expense** | **1,243** |
| | |
| **Other Operating Expenditure** | |
| Chair and Non Executive Members | 142 |
| Grants to Other bodies | 519 |
| Expected credit (gain) on receivables | (5) |
| Other expenditure | 793 |
| **Total Other Operating Expenditure** | **1,449** |
| | |
| **Total operating expenses** | **2,200,723** |

Note 1

Audit fee is shown inclusive of VAT and the net amount was £171.7k.

Limitation on auditor's liability for external audit work carried out for 2022-23 is £1million.

Note 2

This represents fees for non audit assurance services of the Mental Health Investment Standard. This is shown inclusive of VAT and the net estimated amount is £34.8k.

Note 3

Other professional fees includes the sum of £109k for Internal Audit Fees. Internal audit fees is shown net of VAT.

Note 4

This relates to depreciation of £455k for Property, Plant and Equipment and £514k for Right-of-Use assets.

**5 Better Payment Practice Code**

| Measure of compliance | 2022-23 (9 months to 31 March) Number | 2022-23 (9 months to 31 March) £'000 |
|---|---|---|
| **Non-NHS Payables** | | |
| Total Non-NHS Trade invoices paid in the Year | 43,564 | 685,017 |
| Total Non-NHS Trade Invoices paid within target | 42,648 | 678,578 |
| **Percentage of Non-NHS Trade invoices paid within target** | 97.90% | 99.06% |
| | | |
| **NHS Payables** | | |
| Total NHS Trade Invoices Paid in the Year | 1,215 | 1,344,846 |
| Total NHS Trade Invoices Paid within target | 1,145 | 1,339,623 |
| **Percentage of NHS Trade Invoices paid within target** | 94.24% | 99.61% |

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

**6 Net Movement on Transfer by Absorption**

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

For transfers of assets and liabilities from those CCG bodies that ceased to exist on 1 July 2022, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in the Statement of Changes in Taxpayers' Equity rather than the Statement of Comprehensive Net Expenditure.

| | 2022-23 (9 months to 31 March) £'000 |
|---|---|
| Transfer of property plant and equipment | 1,428 |
| Transfer of Right of Use assets | 773 |
| Transfer of cash and cash equivalents | 3,117 |
| Transfer of receivables | 11,085 |
| Transfer of payables | (138,709) |
| Transfer of provisions | (7,013) |
| Transfer of Right Of Use liabilities | (785) |
| Total transfer from NHS England Group Entities (CCGs) | (130,104) |
| Transfer of PUPOC provision | (47) |
| Transfer of PUPOC liability | (15) |
| Total transfer from NHS England Parent Entity | (63) |
| **Net movement on transfers by absorption recognised in Statement of Changes in Taxpayers' Equity** | **(130,166)** |

**7 Property, plant and equipment**

| 2022-23 (9 months to 31 March) | Information technology £'000 | Furniture & fittings £'000 | Total £'000 |
|---|---|---|---|
| **Cost or valuation at 1 July 2022** | 0 | 0 | 0 |
| Disposals other than by sale | (153) | 0 | (153) |
| Transfer from other public sector body by Absorption | 3,684 | 596 | 4,280 |
| **Cost/Valuation at 31 March 2023** | **3,531** | **596** | **4,127** |
| **Depreciation 1 July 2022** | 0 | 0 | 0 |
| Disposals other than by sale | (153) | 0 | (153) |
| Charged during the year | 417 | 38 | 455 |
| Transfer from other public sector body by Absorption | 2,413 | 440 | 2,853 |
| **Depreciation at 31 March 2023** | **2,677** | **478** | **3,155** |
| **Net Book Value at 31 March 2023** | **854** | **118** | **972** |
| Purchased | 854 | 118 | 972 |
| **Total at 31 March 2023** | **854** | **118** | **972** |
| **Asset financing:** | | | |
| Owned | 854 | 118 | 972 |
| **Total at 31 March 2023** | **854** | **118** | **972** |

The ICB did not hold any revaluation reserve balance for property, plant & equipment in 2022-23 (9 months to 31 March)

## 7a Leases

### 7a.1 Right-of-use assets

| 2022-23 (9 months to 31 March) | Buildings £'000 |
|---|---|
| **Cost or valuation at 1 July 2022** | 0 |
| Transfer from other public sector body by Absorption | 952 |
| **Cost/Valuation at 31 March 2023** | **952** |
| | |
| **Depreciation 1 July 2022** | 0 |
| Charged during the year | 514 |
| Transfer from other public sector body by Absorption | 178 |
| **Depreciation at 31 March 2023** | **692** |
| | |
| **Net Book Value at 31 March 2023** | **260** |

The ICB did not hold any revaluation reserve balance for Right-of-use assets in 2022-23 (9 months to 31

### 7a.2 Lease liabilities

| | |
|---|---|
| Interest expense relating to lease liabilities | (3) |
| Repayment of lease liabilities (capital and interest) | 504 |
| Transfer from other public sector body | (785) |
| **Lease liabilities at 31 March 2023** | **(284)** |

### 7a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

| 2022-23 (9 months to 31 March) | £'000 |
|---|---|
| Within one year | (284) |
| Between one and five years | 0 |
| **Total** | **(284)** |
| | |
| Included in | |
| Current lease liabilities | (284) |
| Non-current lease liabilities | 0 |
| **Total** | **(284)** |

### 7a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

| 2022-23 (9 months to 31 March) | £'000 |
|---|---|
| Depreciation expense on right-of-use assets | 514 |
| Interest expense on lease liabilities | 3 |

### 7a.5 Amounts recognised in Statement of Cash Flows

| 2022-23 (9 months to 31 March) | £'000 |
|---|---|
| Total cash outflow on leases under IFRS 16 | 504 |

**8 Trade and other receivables**

| | Current 31 March 2023 £'000 | Non-current 31 March 2023 £'000 | (note 1) Current 1 July 2022 £'000 | (note 1) Non-current 1 July 2022 £'000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 11,280 | 0 | 3,281 | 0 |
| NHS prepayments | 172 | 0 | 266 | 0 |
| NHS accrued income | 95 | 0 | 333 | 0 |
| Non-NHS and Other WGA receivables: Revenue | 1,336 | 0 | 578 | 0 |
| Non-NHS and Other WGA prepayments | 5,281 | 77 | 5,558 | 215 |
| Non-NHS and Other WGA accrued income | 1,757 | 0 | 44 | 0 |
| VAT | 720 | 0 | 769 | 0 |
| Other receivables and accruals | 21 | 0 | 42 | 0 |
| **Total Trade and Other Receivables** | **20,662** | **77** | **10,871** | **215** |
| **Total current and non current** | **20,739** | | **11,086** | |

The majority of trade is within the NHS group. As the NHS is funded by Government, no credit scoring is considered necessary.

Note 1 - represents balances transferred in from the three legacy CCGs

**9 Cash**

| | Period from 1 July 2022 to 31 March 2023 £'000 | (note 2) Period from 1 April 2022 to 1 July 2022 £'000 |
|---|---|---|
| **Balance at beginning of the period** | 3,117 | (2,701) |
| Net change in the period | (2,030) | 5,818 |
| **Balance at end of the period** | **1,087** | **3,117** |
| Made up of: | | |
| Cash with the Government Banking Service | 1,087 | 3,116 |
| Cash in hand | 0 | 1 |
| **Balance at end of the period** | **1,087** | **3,117** |

There were no patients' monies held by the ICB in the period.

Note 2 - represents balances transferred in from the three legacy CCGs.

**10 Trade and other payables**

| | Current 31 March 2023 £'000 | (note 3) Current 1 July 2022 £'000 |
|---|---|---|
| NHS payables: revenue | 12,165 | 1,417 |
| NHS accruals | 4,046 | 14,389 |
| Non-NHS and Other WGA payables: Revenue | 32,707 | 17,049 |
| Non-NHS and Other WGA accruals | 130,951 | 91,013 |
| Non-NHS and Other WGA deferred income | 1,452 | 1,654 |
| Social security costs | 566 | 611 |
| Tax | 535 | 643 |
| Other payables and accruals | 15,442 | 11,931 |
| **Total Trade and Other Payables** | **197,864** | **138,707** |

Other payables include £2,619k (£618k employees and £2,001k GP Practices) outstanding pension contributions at 31 March 2023.

Note 3 - represents balances transferred in from the three legacy CCGs.

## 11 Financial instruments

### 11.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB's standing financial instructions and policies agreed by the Board.

### 11.1.2 Liquidity risk

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

### 11.2 Financial assets

| | Financial Assets measured at amortised cost 31 March 2023 £'000 |
|---|---|
| Trade and other receivables with NHSE bodies | 10,705 |
| Trade and other receivables with other DHSC group bodies | 2,608 |
| Trade and other receivables with external bodies | 1,186 |
| Cash and cash equivalents | 1,087 |
| **Total at 31 March** | **15,586** |

### 11.3 Financial liabilities

| | Financial Liabilities measured at amortised cost 31 March 2023 £'000 |
|---|---|
| Trade and other payables with NHSE bodies | 2,893 |
| Trade and other payables with other DHSC group bodies | 13,240 |
| Trade and other payables with external bodies | 179,462 |
| **Total at 31 March** | **195,595** |

## 12 Operating segments

The ICB considers they have only one segment: Commissioning of healthcare services.

| | 2022-23 (9 months to 31 March) £'000 |
|---|---|
| Commissioning of healthcare services | **2,223,828** |

**13 Pooled budgets**

This ICB has entered into a pooled budget with Hertfordshire County Council and Cambridgeshire and Peterborough ICB (formerly CCG). The pool is hosted by Hertfordshire County Council.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the commissioning of services as follows: mental health, learning disabilities, child and adolescent mental health, integrated health and social care community equipment service, residential and nursing care in a number of care homes and social care services complementary to the NHS. The pooled budget only includes that expenditure over which the partners have joint control.

The ICB's share of the income and expenditure handled by the pooled budget were as follows:

| 2022-23 (9 months to 31 March) | Mental Health, Learning Disabilities & CAMHS | | Integrated Equipment Service | | Intermediate Care | | Social Care Services | | All pooled funds |
|---|---|---|---|---|---|---|---|---|---|
| | Total Pooled-Budget | ICB | Total Pooled-Budget | ICB | Total Pooled-Budget | ICB | Total Pooled-Budget | ICB | Total ICB Contribution |
| | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 | 2022-23 (9 months to 31 March) £000 |
| Contribution | 297,423 | 155,495 | 6,072 | 2,935 | 4,945 | 1,833 | 40,290 | 22,771 | 183,034 |
| Expenditure | 297,486 | 155,561 | 5,648 | 2,694 | 4,945 | 1,833 | 42,788 | 22,771 | 182,859 |
| Total Variance | (63) | (66) | 424 | 241 | 0 | 0 | (2,498) | 0 | 175 |

**14 Related party transactions**

**Details of related party transactions with individuals are as follows:**

During the year, other than that declared below, none of the Department of Health and Social Care Ministers, ICB Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the ICB.

Details of payments made by the ICB to the practices and related parties disclosed by the GP Partner members - Primary Medical Services were as follows:

| | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
|---|---|---|---|---|
| Maynard Court Surgery - Dr I Perry | 825 | 0 | 88 | 0 |
| Schopwick Surgery - Dr N Small | 1,569 | 0 | 2 | 0 |
| Stanmore Medical Group - Dr. P Moodley | 4,403 | 0 | 15 | 0 |
| The following are payments made in the normal course of business to GP Federations of which GP practices are shareholders: | | | | |
| Herts Health Ltd. - Dr N Small | 232 | 0 | 0 | 0 |
| Payments were also made to the following Primary Care Networks of which GP practices are members: | | | | |
| Epping Forest PCN - Dr. I Perry | 534 | 0 | 0 | 0 |
| Herts Five PCN - Dr N Small | 1529 | 0 | 0 | 0 |
| Stevenage North PCN - Dr. P Moodley | 953 | 0 | 28 | 0 |
| Payments were made to the following where Board members had declared an interest. | | | | |
| Cambridgeshire Community Services | 226 | 0 | 0 | 0 |
| Haverfield Surgery | 326 | 0 | 0 | 0 |
| Kestrel Nursing Home | 437 | 0 | 87 | 0 |
| King George Surgery | 1882 | 0 | 25 | 0 |
| Stellar Healthcare | 556 | 0 | 20 | 0 |
| Tavistock & Portman NHSFT | 18 | 0 | 0 | 0 |
| St Andrews Healthcare | 1693 | 0 | 121 | 0 |
| South West London ICB | 0 | 69 | 0 | 0 |

The Department of Health and Social Care is regarded as a related party. During the year the ICB has had a number of material transactions with entities for which the Department is regarded as the parent organisation. The ICB has adopted a disclosure level of £15million and the most significant related parties are listed below. In addition, the ICB had a number of material transactions with other local government bodies. Where appropriate, these entities have also been reflected in the list below:

Barts Health NHS Trust
Central London Community Healthcare NHS Trust
East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Hertfordshire Community NHS Trust
West Hertfordshire Hospitals NHS Trust
Bedfordshire Hospitals NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
The Princess Alexandra Hospital NHS Trust
Royal Free London NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Hertfordshire County Council

## 15 Events after the end of the reporting period

From 1 April 2023, NHS England delegated the commissioning functions of community pharmacy, dental and primary care ophthalmology services to the ICB. The ICB has received additional funding of £144.3m in 2023-24 for expenditure on these services.

## 16 Losses and special payments

The total number of losses and special payment cases and their total value, were as follows:

| **Losses**<br>**2022-23 (9 months to 31 March)** | **Total Number of Cases Number** | **Total Value of Cases £'000** |
|---|---|---|
| Administrative write-offs | 1 | 1 |
| Cash losses | 1 | 0 |
| Claims abandoned | 2 | 2 |
| **Total** | **4** | **3** |

| **Special Payments**<br>**2022-23 (9 months to 31 March)** | **Total Number of Cases Number** | **Total Value of Cases £'000** |
|---|---|---|
| Compensation payments (on accruals basis) | 1 | 83 |
| **Total** | **1** | **83** |

## 17 Financial performance targets

The ICB has a number of financial duties under the NHS Act 2006 (as amended).
The ICB performance against those duties was as follows:

| | **2022-23 (9 months to 31 March)**<br>**Target**<br>**£'000** | **2022-23 (9 months to 31 March)**<br>**Performance**<br>**£'000** |
|---|---|---|
| Expenditure not to exceed income | 2,240,769 | 2,240,012 |
| Revenue resource use does not exceed the amount specified in Directions | 2,224,585 | 2,223,828 |
| Revenue administration resource use does not exceed the amount specified in Directions | 25,863 | 24,407 |
| Revenue administration resource pay award for agenda for change staff for 2022-23 does not exceed the amount specified in Directions | 1,666 | 1,627 |

**Acronyms used in the Annual Accounts**

| | |
|---|---|
| CCG | Clinical Commissioning Group |
| ICB | Integrated Care Board |
| DHSC | Department of Health and Social Care |
| HMT | H M Treasury |
| GAM | Group Accounting Manual (issued by DHSC) |
| BCF | Better Care Fund |
| IAS | International Accounting Standards |
| IFRS | International Financial Reporting Standards |
| FReM | Government Financial Reporting Manual (issued by HMT) |
| WGA | Whole of Government Accounts (Central and Local Government bodies) |
| GP | General Practitioner |
| VAT | Value Added Tax |
| PUPOC | Previously Unassessed Period of Care (Continuing Healthcare) |