NHS
West Essex
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS

Q1 2022/23

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Dr Jane Halpin,
Accountable Officer

PERFORMANCE REPORT: OVERVIEW OF PERFORMANCE

This section contains a summary of our performance as an organisation during Q1 of 2022/23 plus a flavour of the work we do. You can read more about our work at: www.westessexccg.nhs.uk

ABOUT US

We are the local NHS organisation which plans and pays for the health services used by almost 315,000 people who live in our area. Led by local GPs, the CCG works closely with clinicians, patients and partner organisations to decide how our annual budget of more than £815m should be spent.

We aim to:

- work closely with GPs, patients, partners, managers, community groups and clinical colleagues from all sectors to commission the best possible healthcare for our patients within available resources

- reduce health inequalities and achieve a stable and sustainable health economy by working together, sharing best practice and improving expertise and clinical outcomes for patients

WHAT IS 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 our GP members, the organisations which provide services and local people to put forward new ideas or ways of delivering care.

The CCG as part of the Hertfordshire and West Essex Integrated Care System (ICS) has developed system-wide strategic plans to set out how health and social care organisations will improve the services and care provided to patients whilst remaining within the budgets we are allocated.

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.

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

Our strategic objectives, which guide our work, are available on **our website**. Performance of the organisation is regularly reported to and discussed at the CCG's Board, which met virtually twice during Q1 2022/23. This includes Board meetings in common with East and North Hertfordshire Clinical Commissioning Group and Herts Valleys Clinical Commissioning Group as the organisations move towards integration into the Hertfordshire and West Essex Integrated Care Board in July 2022.

The papers for all CCG Board meetings are published on our **website** and the public can observe meetings online. An Integrated Quality and Performance Report is presented at each meeting, enabling the Board and the public to track how the local health system is performing over time.

We have strong governance arrangements in place to oversee the delivery of the priorities for patient care identified in the CCG's operational plan. We work together with other organisations in our local health and social care system to achieve these priorities, where appropriate. This means that joint decisions can be made to ensure that people are not admitted to hospital when there is a better option for their care. Good partnership working also helps patients to be discharged from hospital in a timely way when it is the right time for them to leave.

You can also read our previous Annual Reports online **here**.

PROVIDING CARE

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 main hospitals our patients use are **The Princess Alexandra Hospital NHS Trust**, **Cambridgeshire University Foundation Hospital Trust** and **Barts Health NHS Trust**

Community services - such as district nursing, therapy and dietetics - are mainly provided to people in their homes, in local clinics, in schools and in our community hospitals. Mental health and learning disability services are also provided by **Essex Partnership University NHS Foundation Trust** who work closely with the CCG to promote greater integration between mental and physical health and social care.

For urgent care, our patients use the Integrated Urgent Care service delivered by **HUC** through NHS 111. There are also minor injuries services at **Herts & Essex Hospital** and **Cheshunt.**

The CCG also commissions community providers to deliver services including termination of pregnancy, vasectomy, in vitro fertilisation (IVF), end of life care, non-emergency patient transport and optometry.

The healthcare organisations with whom the CCG will spend more than £5m in 2022/23 – together with the broad categories of care they provided - are set out here:

Provider	Service category
The Princess Alexandra Hospital NHS Trust	Acute
Cambridgeshire University Foundation Hospital Trust (including Addenbrookes Hospital)	Acute
Barts Health NHS Trust	Acute
Mid and South Essex NHS Foundation Trust	Acute
East of England Ambulance Service NHS Trust	Ambulance and non-emergency patient transport
HUC	Integrated Urgent Care
Essex Partnership University NHS Foundation Trust	Community and Mental Health
West Hertfordshire Teaching Hospitals NHS Trust	Acute
Hertfordshire Partnership University NHS Trust	Mental Health
East and North Hertfordshire NHS Trust	Acute
North East London NHS Foundation Trust	Mental Health
Hertfordshire Community NHS Trust	Community
Barking Havering and Redbridge University Hospitals Trust	Acute
Ramsay Healthcare	Acute

7.7% of the CCG's budget (a total of around £62.4m) is spent on primary care services. More information about our expenditure can be found from page 46.

HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE SYSTEM (ICS)

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 three CCGs in Hertfordshire and west Essex have a joint accountable officer and a shared CCG management team is in place to support this new leadership. The three CCGs remain as separate entities with responsibility for delivering local services and with their own governing bodies and constitutions.

Providers working together

As part of the new ways of working, providers of healthcare are expected to collaborate where possible. This could be where providers of similar services (for example, acute hospital care) work together across the ICS area to provide care for a population or where providers of different types (for example, acute, community and mental health) co-operate to join up care at a very local level.

These provider collaboratives have been developing, and NHS E/I and NHS Improvement will provide further guidance this year.

Some services are already commissioned at county level as part of joint arrangements with Essex County Council. Where it is best to commission services at a county, ICS or regional level, those arrangements will continue.

Chief Executive's Statement on Performance
1 April 2022 – 30 June 2022

This statement covers the period 1 April 2022 to 30 June 2022, at which point the three CCGs in Hertfordshire and West Essex completed their transition to become Hertfordshire and West Essex Integrated Care Board (ICB). The statement focuses on the key priorities and challenges that our organisations faced in their final three months.

Governance overview

On 28 April 2022, the Health and Care Bill, the draft legislation designed to reform health and care services and the way they work together, was granted 'Royal Assent' by the Queen with the measures in the Bill becoming law in the UK, under the Health and Care Act 2022 on 1 July 2022.

The impact of the new legislation will be wide ranging. It is designed to build on the proposals for legislative change set out by NHS England in the Long Term Plan and incorporate the lessons learnt from the pandemic, in order to benefit patients and staff. Systems and structures reformed how health and adult social care work together, with the aim of tackling waiting lists and addressing challenges including a growing and ageing population, the need to support people with chronic conditions and inequalities in health outcomes.

The Integrated Care Board's draft constitution, which sets out how we will govern ourselves and the membership of our board, was reviewed by NHS England and Improvement before it was formally adopted by the ICB on 1 July 2022. As our Integrated Care System evolves and matures over the coming years, the board's membership and constitution will be kept under review, to ensure that they continue to serve the changing needs of our area.

Appointments to the ICB's Board were finalised during May. Our four new independent non-executive members will help to bring independent oversight, a diversity of views and experiences, and constructive challenge to the priorities, plans and performance of the ICB executive team, promoting open and transparent decision-making. We would like to take this opportunity to extend our thanks to the three CCGs' non-executive colleagues whose dedication over many years has contributed to a richer understanding of our communities and their needs. You can read about our board roles on our website: **https://hertsandwestessex.icb.nhs.uk/board**

Hertfordshire and West Essex Integrated Care Partnership development

Alongside the Integrated Care Board, every ICS is required to have an Integrated Care Partnership (ICP). The ICP is a committee, jointly established by the ICB and local authorities with responsibility for social care, which brings together organisations involved with improving the care, health, and wellbeing of the population. The establishment of the ICP has been led by Hertfordshire County Council, working in collaboration with a small group of officers from the ICB and Essex County Council.

ICPs are intended to set the broader direction and strategy for the whole ICS and our ICP will do this by developing an Integrated Care Strategy by December 2022. The strategy will be for the whole population and will set out priorities for action on integration of health and care, and for work on health inequalities and the wider determinants which drive these inequalities.

Supporting our staff through transition

During the period April to end of June 2022, we completed our TUPE consultation, enabling us to transfer staff from the three CCGs into the ICB. Every endeavour was made to ensure our staff were looked after, kept updated and had an opportunity to ask questions and gain clarity. I would like to put on record my thanks, and that of the Board to all our staff for continuing to deliver their work during this time of significant change.

Tackling waiting lists for treatment

Our system continues to prioritise elective treatment to ensure we are seeing and treating patients as quickly as we can. Our focus has been to maximise activity volumes across all three of our hospital trusts and to ensure those who have been waiting the longest receive the care they need.

The national expectation was that by July 2022, those who have been waiting the longest for their treatment, in some cases two years, should have received it. We have significantly reduced the numbers of people who have been waiting the longest for their routine treatment. The small group of local patients who were waiting for treatment for two years have now been treated or offered an alternative hospital for their care, if they would prefer.

To reduce backlogs caused by COVID, there are very challenging targets in place both now and in the future to stretch systems to carry out more elective treatment than they were doing in 2019/20, before the pandemic struck. In the spring, a new 20-bed elective ward opened at Princess Alexandra Hospital and mobile MRI scanners continue to operate in Harlow.

Where appropriate for patients, we have also used our local independent hospitals across the ICS for both diagnosis and treatment. Going forward, we have requested additional funding to help us deliver increased volumes of planned treatments. The aim is to create extra elective facilities hub for simple routine procedures which could include new facilities (work ongoing to refine options) as well as more dedicated elective capacity at Princess Alexandra Hospital NHS Trust, to undertake more complex surgery and keep this separate from urgent and emergency activity which can sometimes impact on the delivery of planned care.

We know there is also increased demand from people for whom the pandemic has delayed getting a diagnosis for their symptoms. We are rapidly building our capacity to provide more diagnostic tests, opening up evening x-ray and ultrasound clinics at our area's new Community Diagnostic Centre (CDC). Key to delivering this extra capacity is people; we are fully aware of the additional pressure this extra workload is putting on staff who have given over and above the demands of their roles throughout the pandemic. Each NHS trust has support in place for staff wellbeing and this offer is being expanded all the time. Work is also underway to recruit internationally for allied health professionals, such as radiographers, and with Health Education England to introduce 'academies' for imaging and endoscopy staff to support the development of the existing and future workforce.

The way we deliver outpatient care has also changed; making greater use of technology and better monitoring practices to improve patients' experiences. We've moved to a model where follow ups with a consultant only need to happen if a patient wants them to. In addition, our hospitals are delivering more virtual appointments with an ambition to offer around a third of consultant appointments in this way by later this year.

Backlogs and additional demand are also impacting on our primary care, community and mental health services. There is similar focus and determination in our community services to deliver more care for patients as quickly as possible, with the impact of increased demand and staff sickness still causing some additional challenges.

To support the wider health and care system at this time of pressure, our community providers have been prioritising care for those with the greatest need, as well as focusing on services which support the health service to deliver urgent and emergency care, such as 'rapid response' teams. Making the best use of remote monitoring technology and 'hospital at home' services is also helping to make sure that people receive their care in the place which will best aid their recovery.

Additional staff and funding are being deployed in service areas including community neurological rehabilitation, children's audiology services and long COVID support, to tackle waiting lists.

Urgent and emergency care

Our urgent and emergency care services remained extremely busy during the spring and early summer with our area's hospitals are continuing to see more patients in emergency departments than usual, with some patients presenting with high acuity. This has led to significant operational pressures. We have worked with partners to develop plans to deliver improvement in urgent care through the ICS Urgent Care Board including:

- Ensuring all possible steps were being taken to ensure people who are medically fit to return home from hospital are discharged quickly including the full use of virtual wards so patients can receive care outside of an acute hospital where that's appropriate.
- Working with ambulance service colleagues on intelligent conveying and improving hospital handovers

A fortnightly urgent and emergency care improvement meeting is now in place and will work to determine priority actions aimed at reducing operational pressure and ensuring preparedness for winter.

Understanding GP practice pressures

Primary care – in particular GP practices – continued to face significant challenges as a result of elective care being paused during the early phases of the pandemic. The CCGs supported practices to deliver the best possible service for patients, providing advice and interventions to relieve pressures where possible. Broadly, it is the case across our area that GP practices are receiving many more patient contacts – by phone, e-Consult and in person – than they did before the pandemic. This is due to a number of factors including:

- patients being understandably reluctant to contact the NHS at the peak of COVID which for some has led to symptoms developing further or becoming more complex and urgent
- the role that GP practices play in ensuring that people can access the tests and specialist input they need for their condition, so as the NHS tackles the backlog of people waiting for diagnostic tests, this increases the volume of administration work required by practice teams

- an increase in the number of people needing help for a range of mental health issues
- people not feeling as confident to manage their minor health issue themselves, as they might have done pre-pandemic and contacting a health professional for advice

GP practices were also operating under national infection prevent and control guidance which has impacted on how care can be delivered. With all this in mind, the three CCGs carried out tailored support visits to practices to help them find solutions to issues that are affecting them and put action plans in place where improvement is needed. As part of these visits, data about A&E attendance and NHS 111 usage rates for each practice were reviewed, alongside the most recent patient survey results, as this information may indicate where there are issues to address, for example patients seeking help elsewhere because they cannot get what they need from their practice.

We know that one of the biggest sources of frustration is the difficulty some patients have in reaching their practice by telephone. So far, 72 practices across Hertfordshire and West Essex have been approved for additional funds to upgrade their telephone lines to a 'cloud-based' system, which has the capability to offer calls backs, queue management and to increase the number of lines available if needed.

Through our 'Digital First Primary Care' programme we are conducting research into how patients want to use online options to both get information from their practice and to have a consultation with a clinician. We are also mindful of digital exclusion and want to ensure that everyone can engage with their practice in a way that suits them.

I would like to thank our colleagues in primary care for their ongoing dedication and commitment to continuing to improve the care offered to their patients.

Our response to the COVID pandemic

During the first quarter of 2022, people most at risk of becoming seriously ill from COVID began receiving new treatments. The antibody and antiviral treatments were offered to high-risk patients who have tested positive for the virus, to reduce the chances of them needing hospital care. Hospitals in our area began to provide the treatment first and this has now been expanded to patients in the community, seven days a week.

Between April and June 2022, our GP practices, the ambulance service which serves our region, our NHS 111 service and our area's acute hospitals were impacted by staff sickness absence related to COVID and had are put in place contingency measures to maintain service delivery.

The ‘spring booster’ phase of the COVID vaccination programme for eligible patients was delivered through a mix of GP practices, local pharmacies and large vaccination centres, with ‘pop up’ clinics in areas of low take up bringing vaccination opportunities into the heart of communities. Parents of 5-11 year olds were also invited to protect their children against COVID with staff at our large vaccination centres going to great lengths to put children and their parents at their ease, with child-friendly activities and settings designed to make sure that being vaccinated is a positive experience for everybody.

Working with People and Communities

Our new strategic approach to working with people and communities was developed with support from stakeholders including Healthwatch Essex and Healthwatch Hertfordshire. We want to ensure that the voices of the people who live in our area and use health, care and voluntary services are heard at the centre of decision making and governance, at every level of our system. The strategy highlights and builds on the good practice, trust and partnership working which has helped to support the population of west Essex and Hertfordshire throughout the many challenges posed by the COVID-19 pandemic.

As our ICS and the partnerships within it develop further, we are pleased that work is continuing with our local voluntary sector to formalise our working relationships and bring together their expertise and experience in a way which ensures we make best use of everyone’s very valuable time and talent. A Voluntary Sector Alliance is in place which will help us to reach out to engage groups who haven’t been involved to date. We plan to encourage a ‘themed’ approach to engagement so the right voices are heard where they are most affected and where people have most skill and experience to share – to save time and make their contribution most effective. We know how keen our voluntary partners are to influence improvements in health and wellbeing for their communities and this alliance brings voluntary partners to the forefront in all we do.

Developments at ‘place’ level

Our area’s three health and care partnerships, which represent the interests of the areas served by the three former Hertfordshire and west Essex CCGs, plus the Hertfordshire-wide collaborative for mental health, learning disabilities and autism, have developed and established their priorities. The ICB’s three place directors are leading engagement with the partnerships to help them deliver on their aims. More information about each health and care partnership can be found on the ICS website: **https://hertsandwestessexics.org.uk/**

THE CCG'S WORK IN 2022/23

The projects on the following pages are some examples of the work we have undertaken to improve patient care over the past three months. There isn't space to include all of our projects here, but you can read and watch more about what we do by visiting our website.

PRIMARY CARE

What are Primary Care Networks?

PCNs are groupings of GP practices that serve populations of between 30,000 and 50,000 registered patients between them.

By working more closely together in groups, together with other health and care staff and patient representatives in their local area, GPs can provide more proactive, personalised, coordinated and joined-up health and social care.

Each PCN has its own list of priorities for their population and may deliver care in a slightly different way.

Although primary care networks will be delivering services, they are also expected to think about the wider health of their population, taking a proactive approach to managing population health and assessing the needs of their local population alongside commissioners like the CCG to identify people who would benefit from targeted, proactive support.

Access to Primary Care

During 2022/23 GP practices have continued delivering a total triage system which was first implemented according to NHSE/I guidance produced in April 2020. This has meant that every patient contacting the practice first provides some information on the reasons for contact and is triaged before making an appointment. Assessment by a healthcare professional over the telephone or online, has enabled many patients to be offered advice and potentially a prescription or referral without the need for a face-to-face appointment where clinically appropriate.

The overall demand on primary care services has risen substantially, long-term conditions requiring monitoring and stabilisation, help whilst waiting on hospital waiting lists for

surgical procedures. This increased demand is reflected in primary care appointment data collected by NHS Digital[1], the total number of appointments attended across WECCG in quarter 1, 2022 rose to 375,076 an increase of 117,543 compared to quarter 1, 2020 representing an overall 31% increase.

These figures do not however include appointments provided in primary care extended access services or respiratory hubs and therefore the total number of appointments offered in primary care is in fact significantly greater.

General practice continued to deliver Extended access appointments during the year; these services provide general practice appointments weekday evenings, weekends and bank holidays.

Appointment data published by NHS Digital during this period indicates that 51% of all appointments were provided on the day that they were requested and that 87% of appointments were offered within 14 days[2]. Considering the high demand for appointments including those of a routine nature, these waiting times highlight how hard local primary care services have been working in order to provide care for our local population which is so important and valued.

East and North Hertfordshire CCG wishes to express its sincere thanks to the entire primary care system for all that has been done and continues to be done in the course of providing excellent care and keeping our local population safe.

Vaccination Programme

Since the implementation of the Covid Vaccination Programme in December 2020, approximately 3,308,559 vaccination doses have been given across the HWE ICS. This includes 1st, 2nd, 3rd and booster doses across all eligible cohorts.

The vaccination programme continues to be delivered through three main delivery models being Primary Care Networks, Community Pharmacies and Mass Vaccination Centres. Hospital Hubs will continue to vaccinate their own staff for the Autumn booster programme.

The Health Inequalities workstream has continued to focus on the increasing the uptake of covid vaccinations within hard-to-reach groups. Pop-up clinics have been set up in areas of low uptake, deprivation etc. as identified by the Health Inequalities workstream in collaboration with local community leaders and Hertfordshire Community Trust. This

[1] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice#latest-statistics
[2] Appointments in General Practice - NHS Digital

model has been successful in increasing the Covid vaccine uptake within the identified groups.

Seasonal Influenza Vaccination Programme

The 2022/23 Season Influenza vaccination programme will be delivered mainly through Primary Care Networks, Community Pharmacies and Hospital Hubs (own staff). NHSE have recommended co-administration of the influenza and Covid vaccines where possible.

Additional Role Reimbursement (ARR) Scheme

The scheme provides funding to support the recruitment of new additional staff to deliver health services, with the intention to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage in general practice.

PCNs are required to submit workforce plans for 22/23 by 31st August 2022; these plans will be reviewed, with a particular focus on forecasting underspend versus budget. PCNs will then be invited to bid for Unclaimed Funding; this is ARR scheme funding that other PCNs are not planning to utilise.

To date the most popular scheme roles include Clinical Pharmacists, Care Co-ordinators, Social Prescribing Link Workers, Health and Well Being coaches and First Contact Physiotherapists.

PCN Development Fund

NHSE provides the ICS with funding to specifically support PCN Development in line with key objectives:

Support development and maturity of PCNs including enhancing integration

Continuing to improve patient access through use of range of technology including telephony if appropriate to the PCN but more importantly engaging and co-designing with patient via patient participation groups.

Improve working conditions for staff including continued support to recruitment, embedding and retention of staff in particular Additional Roles

The ICS invited PCNs to submit plans for 2022/23, with submissions reviewed across the ICS in order to ensure consistency and parity in the approach.

Initial accommodation Centres

Initial accommodation Centres (IAC) provide short-term housing in Hotels for asylum seekers who need accommodation urgently before their support applications have been fully assessed and longer-term accommodation can be arranged by the Home Office dependant on their application being successful. The amount of time people stay in initial accommodation can vary, originally it was for 3 months, but the length of stay has increased.

For West Essex area there are 2 hotels – one in Harlow which is a bridging facility being supported by 1 GP practice, the other is in Bishop Stortford and due to its locality this is being supported by a practice in East & North Herts, as confirmed above. There is a further hotel being considered for use by the Home Office in Epping. If confirmed this will bring the total in West Essex to 3 hotels. In the wider Essex area, there are a further 3 hotels in Chelmsford, Colchester and Wickford (1 mid, 1, north and 1 South). Health, social care and education are already covering and providing services for the Harlow and Stansted accommodation. That adds to the pressure already due to the large number of permitted developments.

All Locally Enhanced service specifications being used across Herts and West Essex to support the Asylum Seeker and Resettlement Schemes are aligned and consistent.

New Funding Guidance has been received for 22/23 which is currently being reviewed as there are changes to how practices report on number of registrations and health assessments. This includes a change in process of how the ICB draw down this funding.

Premises

The Premises Team are working with all practices and PCNs to develop infrastructure plans. NHSE/I launched their national programme of PCN Toolkits, working together with a blend of the data captured, clinical strategies and the infrastructure to support the ongoing demands in primary care will be developed. NHSE/I have advised that this level of detail and planning will be necessary when considering future funding for both capital and revenue schemes.

Workforce numbers have increased in general practice via the ARRS programme with some practices and PCNs struggling to accommodate some of the staff and activities. Many practices and PCNs are working on improved space utilisation and shared space and resources to manage the additional role programmes. Where necessary some PCNs are preparing business cases for the commissioners to consider additional general practice areas. Although remote consultations are on average 30% of the activity which reduces the pressure on space.

The Premises Team continued to strengthen relationships with all local authorities to ensure that health has a place setting in local plans and infrastructure development plans

and the teams have also responded and engaged with local authorities on ambitious housing growth planned across the ICS geography. Developers' contributions have started to be secured in legal agreements towards future healthcare infrastructure.

The team reset the Health & Growth liaison meetings between the ICS and Hertfordshire County Council and will to do the same with West Essex County Council colleagues. This will further strengthen the relationships and open opportunities in the One Public Estate Programmes.

Much work has continued with many practices on improved practice premises whether that be refurbishing and/or extending existing premises or relocating to new practice premises.

The Premises Team continue to support the following practices that have commissioners support and/or approval for new, extended or improved practice premises:

- Chigwell Medical Centre
- Old Harlow Health Centre
- Maynard Court
- Church Langley
- John Tasker House (branch premises at Felsted)
- John Tasker House and Angel Lane Surgeries, a shared site at Great Dunmow
- Loughton Surgery
- Gold Street

Primary Care Network Directed Enhanced Service (PCNDES)

NHSE PCN Plans for 2022/23

NHSE/I published the GP contract arrangements for 2022/23 on 1st March 2022.

The priority now moving forwards is to focus on long term condition management and chronic disease control, access with urgent needs and the Long Term Plan prevention agenda.

Key highlights for PCNs include:

- Confirmation of the increase in Additional Role Reinbursement Scheme (ARRS) funding for 22/23 and PCNs encouraged to maximise available funding.

- DES funding confirmed for Clinical Directors and Core Funding to support running, leadership and management of PCNs
- Combining of funding streams for Extended Hours and Extended Access from 1st October 2022 for delivery by PCNs; with the new service being called Enhanced Access, with the aim of removing variability across the country and improving patient understanding of the service. The Primary Care Team commenced collaborative work with the PCBs to support the submission of initial Enhanced Access plans that each PCN needed to submit by the end of July for commissioner review.
- Limited expansion of the Cardiovascular Disease Prevention and Diagnosis service;
- Anticipatory Care and Personalised Care services are being introduced in a phased approach beginning in April 2022.
- PCNs will have an additional year to implement digitally enabled personalised care and support planning for care home residents with 22/23 being a preparatory year
- Early Cancer Diagnosis service streamlined to respond to clinical feedback
- Investment & Impact Fund (IIF) – The IIF is a financial incentive scheme, focusing on resourcing high quality care in areas where PCNs can contribute significantly towards improving health and saving, improving the quality of care for people with multiple morbidities and helping to make the NHS more sustainable. Three new indicators were announced, focused on Direct Oral Anticoagulants (DOAC) prescribing, and Faecal immunochemical Testing (FIT) for cancer referrals

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.

SUMMARY OF PERFORMANCE – QUARTER ONE OF 2022/23

Prior to the formation of the Hertfordshire & West Essex Integrated Care Board (ICB) on 1 July 2022, the focus for West Essex CCG during its final 3 months of operation was the continued recovery of key **constitutional standards**, commitments in the **NHS Long Term Plan**, **Operational Plan** and **Oversight Framework** and focus on waiting lists that were impacted by the COVID-19 pandemic. Increased demand and workforce challenges have affected the performance of our health system against some of the key national standards. Demand and Capacity plans have been put in place to recover performance during 2022/23 in line with national guidance.

The final Quarter 1 of 2022/23 positions are set out below:

A&E four hour operational standard

The national requirement that 95% of patients attending A&E are treated, admitted or transferred within 4 hours of arrival remains in place, however new national requirements that track full patient journeys from attendance through to discharge or admission are currently being run in parallel.

Performance at Princess Alexandra Hospital remains challenged and failed to achieve the national standard:

A&E	Target	2021/22	Q1
Treated / Admitted / Transferred in under 4 Hours	95%	67.3%	62.4%

A&E attendances have remained consistently above historical average this has coincided with a period of deterioration in performance against the 4hr standard. Estate footprint and size of department, A&E staffing, sickness and isolation, a high level of mental health assessments and bed shortages have impacted this performance.

Focused work streams are in place to improve patient assessment, flow and discharge.

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:

- **C1** People with life threatening injuries and illness (mean response time of 7 minutes)
- **C2** Emergency calls (mean response time of 18 minutes)
- **C3** Urgent calls (90% of calls to be responded to within 120 minutes)
- **C4** Less urgent calls (90% of calls to be responded to within 180 minutes)

West Essex performance at East of England Ambulance Trust remains challenged and failed to achieve the national standards:

EEAST Ambulance Response	Target	2021/22	Q1
C1 People with life threatening injuries and illness	<7 minutes	10:41	11:25
C2 Emergency calls	<18 minutes	54:33	63:39
C3 Urgent calls	<120 minutes	374:46	520:31
C4 Less urgent calls	<180 minutes	504:49	727:54

Demand into ambulance services continued to be a challenge nationally, the Trust has a workforce plan in place to address challenges around staffing levels. During this period, changes have been implemented to local pathways for cohorts of patients to better meet the needs of individual patients

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:

Two-week waits

- A maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms;
- A maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected

28 day Faster Diagnosis Standards (FDS)

- A maximum 28-day wait from urgent GP referral to be diagnosed with, or have cancer ruled out;
- Applicable to all routes urgent suspected cancer, urgent breast symptomatic, and urgent screening referrals in aggregate;
- Applicable from Q3 2021/22. Target introduced initially at a level of 75%;

31 days

- A maximum one month (31-day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers;
- A maximum 31-day wait for subsequent treatment where the treatment is surgery;
- A maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy;
- A maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen

62 days

- A maximum two month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers;
- A maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer;
- Local target; maximum 62-day wait for the first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers).

Table: Cancer waiting times for all West Essex CCG patients[3]

Performance remains challenged, but Quarter 1 has seen improvement in the number of patients receiving their first appointment within 2 weeks, as well as those receiving a diagnosis within 28 days.

62 day performance has reduced, but this is a good indication that the longest waiting patients are now being treated and backlogs are reducing.

[3] **Cancer-Waiting-Times-Commissioner-Time-Series-Apr-2011-Jun-2022-with-Revisions.xlsx (live.com)**

Cancer Waiting Times at CCG level		Target	2021/22	Q1
Two Week Waits	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	74.0%	82.6%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	73.8%	81.3%
28 Day Faster Diagnosis Standard (FDS)	Maximum 28-day wait from urgent GP referral to be diagnosed or have cancer ruled out	75%	67.2%	69.8%
31 Day Waits	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	93.0%	85.1%
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	85.1%	76.7%
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%	97.7%	100.0%
	Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy	94%	95.5%	90.3%
62 Day Waits	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	63.7%	58.0%
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	59.2%	41.7%
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	85%	82.7%	69.5%

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.

The table below [4] details the RTT performance for West Essex CCG patients in Quarter 1 of 2022/23. Performance remains challenged and failed to achieve the national standard:

RTT Waiting Times		Target	2021/22	Q1
18 Weeks	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	**92%**	**55.1%**	**55.2%**

Diagnostics

Under the NHS Constitution there is a performance standard related to patients access to diagnostic testing; the standard being that 99% of tests are undertaken less than 6 weeks from request.
The table below [5] The table details the Diagnostic performance for West Essex CCG patients in Quarter 1 of 2022/23. Performance remains challenged and failed to achieve the national standard:

Diagnostic Waiting Times		Target	2021/22	Q1
6 Weeks	Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request	**99%**	**77.1%**	**73.0%**

[4] Data shown is a 'snapshot' at end of June 2022
[5] Data shown is a 'snapshot' at end of June 2022

ENSURING QUALITY

The work of our nursing and quality team

Key focus areas of our work are:

Ensuring Quality

Maternity Commissioning & Assurance

Quarter 1 saw a continued focus on implementation of the action plan identified from the Ockenden Report which was published in March 2022. Princess Alexandra Hospital Trust (PAHT) continues to receive support from the regional midwifery team who have noted in their assurance visits a welcoming team and a strengthening of leadership and governance processes.

PAHT continue to work to enhance triage of service users on presentation to the maternity department alongside improving transitional care arrangements for babies who require additional to normal care but where admission to a neonatal unit is not necessarily required.

Working with the Local Maternity and Neonatal System (LMNS) PAHT continue to define ways in which to improve maternity services for local women and people. The service has an active Maternity Voices Partnership (MVP) who ensure the voice of service users is heard and support PAHT in the improvement of services. The organisation supports the UNICEF Baby Friendly Initiative and hopes to achieve “Gold” status later in the year.

Whilst the national shortage of midwives is currently impacting PAHT they have undertaken several recruitment drives which have been successful in increasing establishment.

Children, Young People & Families Commissioning

The ongoing success of the partnership between Essex County Council and the CCG in the commissioning of the Essex Child & Family Wellbeing Service moves into its 6th year (integrated 0-19 public health services with children’s community healthcare in West Essex). The contract, delivered by HCRG Care Group, continues to demonstrate improved outcomes for children, young people and families, working in a systematic and partnership approach. Ongoing improvement of pathways with opportunities for further joint working across the local system are being worked on in all areas of the service which have experienced a significant increase in need and therefore demand since the pandemic.

Access, patient safety, supporting vulnerable families and continually improving outcomes have been a priority whilst the service has moved in and out of business continuity measures in response to pressures experienced nationally by healthcare providers.

Working collaboratively across community and acute services, the CCG, HCRG Care Group and Princess Alexandra Hospital NHS Trust have continued to focus efforts on streamlining pathways into and out of hospital by making best use of our well-established Children's Community Nursing Team. This programme has included targeted work with practices to increase awareness of pathways into community as an alternative to acute referral/signposting, as well as upskilling staff and addressing barriers within operational process to further enable partnership working between the Children's Community Nursing Team and PAHT. This work aims to improve the experiences of children, young people and their families, further supporting them to receive care in the community, thereby avoiding hospital where safe to do so.

May 2022 saw a joint area SEND revisit to Essex to determine if sufficient progress had been made against areas of significant weakness detailed in the inspection report dated 17th November 2019. The revisit determined that there had been sufficient progress in addressing all the areas of significant weakness identified with key highlights including:

- Better partnership working between health and education organisations, as well as increased oversight of joint SEND commissioning arrangements.
- Improvements in the accurate identification of SEND for children and young people.
- Progress made in the co-production of Education Health and Care plans across health, social care and education.

It is recognised that achieving 'sufficient progress' does not mean efforts to improve SEND services will be stopped or scaled back; partnership working will continue between health and education organisations to ensure families, children and young people continue to see improvements in the services which are in place to support them.

Under these arrangements, West Essex CCG continues to take a lead role in facilitating delivery of the large-scale transformation programme for children's therapy services across Essex, Southend and Thurrock. The programme aims to develop an outcomes-based, whole system approach to the delivery of children's therapy services, ensuring the right support is available at the right time, delivered by the right people, with the right skills to achieve the best outcomes for our children and young people.

Due to a sustained increase in demand and the impact of COVID-19 on services for autism diagnosis assessments, West Essex Clinical Commissioning Group and HCRG Care Group have worked together to identify opportunities to increase resources in West Essex to address waiting times for families. The CCG invested additional funds to increase capacity

whilst longer term improvement plans are developed. Under Essex joint commissioning arrangements, the CCG has been working with other CCGs across Essex to ensure pathways for autism diagnosis align to best practice, establishing a shared dataset for monitoring and working with the Essex Family Forum to further roll out a locally developed resource for families.

This year the CCG has channelled available funds into place-based approaches to deliver early help and intervention for supporting the emotional wellbeing of children, young people and families, working with local community and voluntary sector organisations. This has included the following:

- The CCG has continued to work in collaboration with West Essex Mind and partners across Hertfordshire in the roll out of Mental Health Support Teams in schools with work in train for expansion into Epping Forest and Uttlesford.
- The CCG increased investment with YCT to expand their delivery of counselling support and play therapy, as well as launching a new programme of parenting support to help parents gain understanding of their children's difficulties and how to best help them manage underlying emotion.
- The CCG has provided financial support to PACT for Autism, a local charity providing support for families and carers of individuals within the autism spectrum and similar conditions. Funding has been put towards the provision of activities supporting child and family emotional wellbeing as well as providing dedicated support to families on the pathway for autism diagnosis.
- The CCG has worked with NOW's the time for change in improving local access to health based and therapeutic coaching for children, young people and families. This programme aims to improve access in schools from primary through to secondary, as well as collaborate with the Essex Child & Family Wellbeing Service to facilitate access for families to therapeutic intervention and support in Family Hubs across West Essex.

Southend, Essex and Thurrock Child and Adolescent Mental Health Service (SET CAMHS)

West Essex Clinical Commissioning Group (CCG) is the lead commissioner of the Southend, Essex and Thurrock Child and Adolescent Mental Health Service (SET CAMHS (Child and Adolescent Mental Health Service)) provided by Northeast London Foundation Trust (NELFT) in conjunction with Health Care Resource Group (HCRG). The service is provided on a Southend, Essex and Thurrock footprint covering 7 CCG localities, 1 Local Authority/County Council and 2 unitary bodies. The service spans 3 Integrated Care Systems areas: Hertfordshire and West Essex, Mid and South Essex and Suffolk and North-East Essex.

In October 2021 following a major re-procurement exercise, NELFT and HCRG were awarded the contract to deliver community CAMHS mental health services across Southend, Essex, and Thurrock. The contract which will run for 7 years with a potential for a further 3 years was mobilised, and services commenced on 1st April 2022. The service is now known as Southend, Essex and Thurrock Child and Adolescent Mental Health Service (SET CAMHS)

The new service is based on the nationally developed Thrive Model which thinks about the mental health and wellbeing needs of children, young people, and families through five different needs-based groupings: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help, and getting Risk Support. Community Service delivery includes:

- Single point of access (SPA)
- Crisis and Home Treatment Team
- Community Eating Disorder Service
- Children's Learning Disability service for Children with co-morbid learning disabilities and mental health problems
- Youth Offending mental health workers are seconded to the Youth Offending Teams in each of the local authority areas
- Support and joint assessment services with substance misuse services across Southend, Essex, and Thurrock

The service does not provide Tier 4 services but community teams (which include Crisis and Eating Disorder Intensive Support Services) work with wider services including acute hospitals to ensure co-ordinated and seamless care for children and young people.

The Eating Disorder service has seen a significant rise in the number of children and young people presenting for support. Additional investment was secured to enable enhancement of the service in the form of an intensive support service and a community refeeding team. The eating disorder service continues to meet its targets and receives positive feedback on its interventions.

The increased demand for CAMHS services and the national staffing and recruitment challenges have resulted in an increase in some service waiting times. These are being closely monitored and mitigation put in place where necessary. NELFT continues to work well to maintain patient safety and quality despite the increase in service demand during a significant period of change.

Patient Safety

The Patient Safety Incident Framework (PSIRF) sets out the approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Essex Partnership University Trust (EPUT) were selected as an early adopter organisation that have been instrumental in the development of the final PSIRF due to implemented in 2023. EPUT have shared their 6-month review of the Patient Safety Incident Response Framework. This includes the number of Patient Safety Incident investigations commissioning compared to the Trust Patient Safety Incident Response Plan and learning from those investigations.

Learning Themes have been identified from reviews in the last six months and have been escalated to the Executive team, highlighted areas of focus include record keeping standards, discharge and transfer processes, and involvement of family. In addition, the following learning themes from reviews over the past year include safeguarding, dual diagnosis, patient court attendance, eating disorder deaths and suspected suicide and suicide of patients with autism.

Patients and families are at the heart of the new process, they are more involved in the serious incident process. The offer to be involved can be tailored to their needs and pace – any additions to a report by a family can be added at any time as an addendum. Using different approaches for investigation has resulted in more collaborative, constructive and improvement focussed ways to learn from patient safety incidents.

Serious Incidents 2022/23 Q1

11 Serious Incidents were reported to West Essex CCG in Q1, there were no specific themes.

All Serious Incidents continue to be investigated using the 2015 Serious Incident (SI) framework. The CCG Patient safety team are working with all providers to improve immediate and long-term learning from serious incidents and reduce investigation time to ensure feedback to patients and families is not delayed.

The oversight and review of final SI reports remains with the CCG until the new National framework Patient Safety Incident Response Framework comes into place August 2023.

Patient Experience

During the first quarter the Patient Experience Team continued to speak with and support patients - their families, and their elected representatives - about a wide range of issues and concerns about the health care system.

The team had 205 queries - 4 formal complaints, 116 queries (PALs), 8 enquiries from Members of Parliament on behalf of their constituents - and 77 comments about services. The themes from all queries cover the following issues:

- funding process
- vaccinations for housebound persons
- access to services
- medications
- communication
- care pathways

Infection Prevention and Control (IPC)

Healthcare Associated Infection (HCAI) Data:

- ***Clostridioides difficile* infection (CDI)** – WECCG (West Essex CCG) have a rate below that of the East of England region, and at the end of Q1, PAHT are above the rate for acute trusts within the region.
- **MRSA (Meticillin Resistant Staphylococcus Aureus) blood stream infection -** No cases were reported by PAHT during Q1 and only 1 case was reported in WECCG. This is currently being reviewed to identify any learning.
- **MSSA (Methicillin Sensitive Staphylococcus Aureus) blood stream infection (BSI) –** During 21-22 PAHT experienced a high rate of MSSA BSI, but this reduced significantly after the establishment of a task and finish group to address IV access practices. During Q1, PAHT now have rates below region. This was also reflected in the WECCG data.
- ***E. coli* blood stream infection –** WECCG were below their threshold and below regional rates for Q1, and PAHT had exceeded their threshold and was also slightly above the regional rate.
- ***Klebsiella* spp blood stream infection – At the end of Q1,** WECCG infection rate was significantly above the regional rate.

- ***Pseudomonas aeruginosa* blood stream infection –** During Q1, WECCG were below threshold, but was slightly above the regional rate and PAHT were below their thresholds.

The ICB (Integrated Care Board) IPC team produce a monthly HCAI report and comparative data analysis that facilitates discussion with individual service providers. There is currently a process for RCA of HCAIs (Healthcare Associated Infection) and identification of learning. However, a review and overhaul of this process is included within the draft integrated HWE IPC 5 Year Strategy. The proposed strategy also prioritises key areas that will positively impact on rates of the above HCAIs locally such as programmes to strengthen IV access practice, Aseptic Non-Touch Technique (ANTT), urinary catheter management etc. A more detailed integrated plan will be produced following the strategy workshop which was carried out in August. Assurance regarding the implementation of identified learning from case reviews is also reported and monitored via the trust IPC Committee. This includes reporting of Trust audit programmes and results. Learning and challenges are disseminated more widely and discussed at the monthly system IPC network group meetings.

Outbreaks and Incidents:

The IP&C Team continued to support the CCGs across HWE to monitor the number of reported outbreaks and clusters noted in Q1. Which include COVID 19; Norovirus emerging monkeypox cases, Hepatitis A (single case), Legionella and Serratia. In each case the IPC team worked closely with The Providers in question to gain assurance that measures were in place to manage and monitor the outbreaks appropriately.

IP&C within Primary Care settings:

The IPC team has been supporting colleagues within primary care with issues relating to IPC. This has been achieved via several available routes including the implementation of an RCN (Royal College of Nursing) accredited IPC training session for the designated IPC link practitioners. Monthly webinars continue to be carried out and have been well attended with positive feedback being received from those who have joined the sessions. Filtering face piece (FFP3) training sessions have also been available for primary care staff across the system.

Primary Care

Collaborative working between the CCG's Quality and Primary Care Teams has enabled effective provision of bespoke support to practices to prepare for CQC (Care Quality Commission) Direct Monitoring calls and Inspections in addition to addressing issues identified within the CQC inspection reports.

Following a pause in routine CQC inspections, due to the pandemic, these recommenced in Quarter 1 2022/23. Two West Essex Practices received inspections in this period. One was rated as 'Good' overall and the other practice was rated as 'Inadequate' overall. The CCG is working with this practice on developing an action plan to address the issues raised by the CQC.

29 out of 30 GP (general practitioners) practices within West Essex currently meet the require CQC standards with 1 practice rated as 'Outstanding' and 28 rated as 'Good' overall.

Primary care quality assurance and quality improvement have remained integral elements within the Primary Care Commissioning Committee and Quality Committee agendas.

Support has continued to be provided to Primary Care Network (PCN) vaccination sites such as identification of learning from incidents

Learning Disability Annual Health Checks

Learning Disability Health Checks are a General Practice Enhanced Service designed to encourage practices to identify all patients aged 14 years and over with Learning Disabilities and offer them an Annual Health Check, which includes producing a Health Action Plan. At the end of Quarter 1 2022/23 West Essex practices achieved 11.5% of Annual Health checks completed.

This is an improvement on 2021/22 when 8.2% was achieved by then end of Quarter 1. The % achievement is cumulative each month of the year and it is currently envisaged that the target of 75% will be achieved by the end of the year. The CCG has supported practices with delivering the service by the following means: providing data on uptake by patients, highlighting performance trends, providing support with recall, and facilitating partnership working with statutory services and local community organisations.

Care Homes in West Essex

Quarter 1 saw a gradual decrease in covid 19 outbreaks within the care homes. By early June there were no covid cases identified in any of the 51 West Essex care homes. The decision was taken at this point to stand down the weekly meeting of the Care Provider Hub, which had predominantly focussed on covid monitoring in the sector. Covid 19 outbreaks would continue to be tracked and monitored by the Health Protection Team and the local Contact Tracing Service. Outbreak notifications would still be circulated by these agencies to ensure that any unusual or concerning infections are flagged to key partners.

After the success of the Hub meetings, there was a strong commitment amongst agency partners to continue with a regular meeting, to share intelligence and develop multifaceted

support plans for care homes where required. It was agreed that the redesigned Care Provider meeting would be held monthly and would focus on the wider issues of quality and safeguarding, as well as discussing training and development opportunities and good practice. The first meeting is due to take place in July 2022. During Quarter 1, three care homes were suspended to admissions by Essex County Council due to significant Quality and Safeguarding concerns. Ongoing support was provided to these homes by system partners to address the identified problem areas.

Caring For Our Vulnerable Residents

Safeguarding Adults and Children

The CCG is committed to safeguarding and promoting the welfare of children. The responsibilities for safeguarding are a statutory requirement supported in legislation (Children Act 1989, 2004). And the Care Act 2014 as the main legislative framework with various other supporting legislation.

The duties are further clarified within Safeguarding Children, Young People and Adults at Risk in the NHS (National Health Service): Safeguarding Accountability and Assurance Framework 201914, which sets out how the CCG fulfils their responsibilities.

The alignment to an Integrated Care Board is seen as an opportunity to enhance the integration of best practice across the system, whilst maintaining robust multiagency partnership working with the respective place based local authorities. The Hertfordshire and West Essex teams continue to work together to identify joint policies and priorities to support transition to the HWE ICB.

Nationally, there was a consultation on the draft Mental Capacity Code of Practice as well as the changes that are going to result from Liberty Protection Safeguards LPS) when these are implemented. The team have been engaged with this work and understanding the fundamental differences, (which for the first time will incorporate sixteen- and seventeen-year-olds) and (as before adults) if need arose for them to be deprived of their liberty. These new safeguards will replace Deprivation of Liberty safeguards that have been operational since 2009, outcomes of the consultation are awaited nationally.

June 2022 launched the start of the new implementation of Learning from Deaths Review (LeDeR) Policy. The team have actively been involved in supporting implementation of these learning from death reviews and communicating the changes in policy. As an

organisation we are committed to ensuring timely reviews are carried out in the area, identifying learning and sharing outcomes to changes in practice; There should in addition be involvement of family and carers involved in this learning for improvement.

During Quarter 1 safeguarding leads reminded staff about the implementation changes resulting from the Domestic Abuse Act 2021 and advised on recommended changes in practice. During this reporting period the imminent publication of the Domestic Abuse Statutory Guidance is awaited. As required by the Domestic Abuse legislation for each Local Authority area to have a Local Partnership Board there is now in West Essex locality-the Essex Domestic Abuse Local Partnership Board which is multi-agency and has been looking into the needs of the local population around domestic abuse.

Safeguarding Children

Initial Health assessments (IHA) The Statutory Guidance Promoting the Health of Looked After Children (DE/DH, 2015) place the duty on CCGs (Clinical Commissioning Groups) to cooperate with requests from local authorities to undertake health assessments for looked after children without undue delay. A registered medical practitioner is required to carry out an initial health assessment of the child's state of health within 20 working days from when the child first started to be looked after.

The CCG commissions the community paediatric service to undertake this role within the integrated contract with HCRG Care Group. Following a review of the paediatrician resource to undertake IHA's in Spring 2022 funding arrangements were revised to provide greater flexibility to increase capacity. However, due to the disproportionate number of separated migrant children placed within the area this results in significant pressure on the system to meet statutory time frames.

Within Quarter 1 2022-2023, no IHAs (Initial Health Assessments) met the 20-working day timeframe, although 25 IHAs were completed, well above the predicted commissioned capacity of 16 for this period. The change in the commissioning arrangements enable the provider to claim additional funding for those undertaken above the set threshold.

A further compounding factor is with regards to non-attendance of appointments. Notwithstanding robust processes in place by HCRG Care Group, to try to accommodate carer requests re: appointment times, 10 IHA appointments were not attended in this quarter, placing further pressure on the existing availability. This has been escalated to the Local Authority Children Social Care Children in Care team managers, and within the Essex Children in Care Partnership Board. A meeting is planned for September with local care providers to seek their engagement and commitment.

Work continues for an Essex-wide provision and for a digital platform to track the timeframe for IHAs.

Review Health Assessments (RHAs)

Review Health Assessments are commissioned directly by Essex County Council within the 0-19 services provided by HCRG Care Group. The majority are completed within expected timeframes, reasons for delay relate to late notification by the local authority, change of placement or non-engagement by a young person.

Out of area health assessments for looked after children

As recognised by Hilary Garratt CBE Deputy Chief Nursing Officer for England in January 2022, the provision across the country for the completion of IHAs and RHAs for children placed out of county is very variable. As in Essex, where all children are treated equitably, some health providers will be responsive to requests and complete timely health assessments. Others will prioritise their own originating children above others, resulting in lengthy delays and escalation.

Mitigations have included escalation between CCG Designated Nurses, virtual assessments completed by HCRG Care Group practitioners, or bringing the child back to West Essex for the assessment, although this is not always practicable. Oversight of the challenges for timely health assessments has been escalated at both regional and national levels. Until a national directive is developed, the variation will remain.

In Quarter 1, one IHA for a child placed out of area was delayed due to capacity; all RHAs were completed in timeframe.

REDUCING HEALTH INEQUALITIES

West Essex CCG is committed to taking action to meet it's statutory duties to reduce health inequalities experienced by the population that we serve. While many of our population enjoy 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.
Reducing health inequalities is a feature of CCG 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 CCG.

The CCG 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. 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 example the homeless and people from a Gypsy, Roma or Traveller background.

There are differences in people's health outcomes in different districts[6]. For example:

- Life expectancy for men in Harlow is 78.5 in comparison to 82.1 in Uttlesford
- Epping Forest has a higher prevalence of dementia in the population (1.6%) than Harlow (0.59%)
- Harlow has a higher level of prevalence of any mental health disorder among children (9.65%) than the rest of Essex (8.71%)

Working with partners to tackle health inequalities

The CCG understands that by working together with partners across the health and social care system to identify and address health inequalities we can help secure improved health outcomes for our local population. Our colleagues in **Essex County Council, Public Health Team** lead this work and have a number of statutory responsibilities.

'Population health management' is an approach that will help us to target our collective resources where evidence shows that we can have the greatest impact. Local government and health organisations, together with the community and voluntary sector, will deliver joined-up services to defined groups of the population. In this way, we will prevent, reduce, or delay need before it escalates; and prevent people with complex needs from reaching crisis points.

We know that people's health, access to services and experiences can be affected by many factors. The COVID-19 pandemic has exposed how health inequalities can affect people not just over a lifetime but in a matter of weeks. The CCG is committed as a commissioner to planning integrated services that meet the needs of everyone in our communities and we strive to continue to improve access for patients, in part by meeting our Public Sector

[6] https://data.essex.gov.uk/dataset/exwyd/essex-jsna-and-district-profile-reports-2019

Equality Duty and our requirements under the Equality Act 2010. We are also working hard to give equal priority to physical and mental health needs.

The role of Essex's Health and Wellbeing Board

The Health and wellbeing board is responsible for commissioning a Joint Strategic Needs Assessment for the local population and setting the **Joint Health and Wellbeing Strategy**.

This strategy sets out the critical issues as identified in our joint strategic needs assessment, our key countywide strategic priorities, the priorities of member organisations and system partners, our agreed outcomes and how we will measure and assess our progress.

The strategy sets out 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 HWB is to reduce the gap in life expectancy, increase years of healthy life expectancy and reduce the differences between health outcomes in our population. To reach these long-term ambitions, and as part of the development of this strategy, we have identified five key overarching priority areas:

1. Improving mental health and wellbeing
2. Physical activity and healthy weight
3. Supporting long term independence
4. Alcohol and substance misuse
5. Health inequalities & the wider determinants of Health

The strategy will be reviewed and refreshed during 2022/23 and engagement with a wide range of stakeholders will take place to gain a better understanding of the diversity and variety of health and wellbeing activity that takes place across the county and the role that local areas, networks and communities can play in helping to achieve improvements.

PATIENT AND PUBLIC ENGAGEMENT

Priorities during this period were focussed heavily around the COVID vaccination programme and combating misinformation around this and ensuring GP practices and patients were supported throughout the many changes facing primary care.

Again, stakeholders, patients, community groups, partners and colleagues all played a vital part in working with the CCG to address the health and wellbeing of the west Essex population. They are also key in working with us to develop the best ways to engage as the CCG comes to an end and the new Integrated Care Board is launched.

Health inequalities

Work to tackle health inequalities and achieve equity continues to gain momentum. This is partly because of the work to increase uptake of the COVID-19 vaccinations and boosters, which created new opportunities to connect and engage with many local communities and hard-to-reach groups.

NHS Core20Plus5

Hertfordshire and West Essex ICB submitted a bid to receive funds from NHSE Health Inequalities unit for a project called the *Core20Plus5Connectors*. This was successful and Rainbow Services in west Essex and Communities First in Hertfordshire are the delivery partners who will work in key geographical locations to recruit *Community Connectors* to help inform service design and delivery to improve health equity.

Primary Care Networks

Primary Care Networks have all identified health equity project focus areas as part of the Tackling Neighbourhood Health Inequalities initiative. These range from the promotion of cancer screening and hypertension checks to supporting patients with learning disabilities to work towards a healthier weight.

Voluntary and charity organisations come together

A new alliance representing thousands of voluntary, community, faith and social enterprise organisations across Hertfordshire and west Essex is to help the ICS in its quest to improve population health and tackle inequalities.

Working alongside the NHS, councils, the West Essex Health & Care Partnership, and other partners, the VCFSE Alliance will play a key role in the production of ICS strategies and pathways and help ensure services are commissioned in the most effective way, making best use of the VCFSE offer.

Wider determinants of health

Working closely with Essex County Council, local district councils, Healthwatch Essex and the voluntary sector, we have launched a range of activities to address inequalities issues across the wider determinants of health. Areas of focus include healthy behaviours, education, socio-economic support, clinical access, housing and transport. Medium term priorities have been set and projects include Epping Forest DC's multi-agency project led by Epping Forest District Council to tackle health inequalities on the Ninefields Estate in Waltham Abbey, a *Let's Cook, West Essex* programme and using new ways to promote cancer screening – which have proved successful in increasing uptake.

Levelling Up

The HWE ICB West Essex team, together with Harlow District Council, Essex County Council, Essex Police and others, have formed a steering group to develop short and long-term direction for the *Levelling Up* agenda in Harlow.

There at currently some 86 schemes or activities that, directly or indirectly, relate to Harlow and the missions of *Levelling Up*. A key priority is to map out what they all are and link them together to create mutual awareness and understanding and maximise their chances of success in improving the quality of life for local people.

A workshop was held at Harlow Civic Centre on 21 July 2022 to do this. Attendees included representatives of public sector, voluntary and charity organisations as well as people from the local community. They considered how they can all play a part in achieving not only the *Levelling Up* missions but the NHS's Core 20 Plus objectives too.

Information from the event will be invaluable in helping to shape and plan practical and effective solutions for the town's many challenges in terms of inequalities. One of the first projects to benefit will be the population health management place development programme currently underway in Harlow (see below). It will also help the cost-of-living support work (also see below).

Cost of living impact

Organisations and groups from across west Essex have come together to provide help and support to those most impacted by the recent increases in the cost-of-living.

Representatives from Citizens Advice, the district councils, NHS, and voluntary sector have held two summit meetings, arranged by the HWE ICB West Essex team as part of the West Essex Health & Care Partnership's 'socio-economic' workstream. It's sparked joint action on priorities such as income maximisation and debt management support, as well as better intelligence and information sharing between service providers.

The summits have also strengthened support for community hubs. These are not only playing a key part in meeting the growing demand for emergency food provision, and help with energy costs, but are seen as essential in improving access to, and take up of, health and other public services generally. The intention is to operate the hubs in both fixed and mobile form and include 'pop ups' in GP practices and hospitals, for example. The two Harlow PCNs are currently arranging access for Citizens Advice staff.

Population Health Management Place Based Development

West Essex Health & Care Partnership is taking part in a National Place Based Development Programme provided by NHSE. The purpose is to build capability across place-based teams through practical hands-on data-led action learning to embed Population Health Management as a way of working, underpinned by enabling governance and decision-making structures. This programme takes the form of a 20-week programme finishing in the summer, consisting of partners across health, care, and voluntary sectors. This opportunity has been used as a vehicle for delivering existing workstreams, noting the health equity and Levelling Up agendas with a particular focus on Harlow.

Progress so far includes the identification of a cohort of people whose outcomes can be improved through partnership, collaboration and 'connectedness' with existing services, in this case people on waiting lists who are living in the most deprived deciles within Harlow. The collective focus of the partnership is to deliver interventions (health & care) which will improve outcomes for this cohort and ultimately reduce the gap in healthy life expectancy and be able to measure the shorter-term impact whilst delivering the longer-term outcome. In embedding these capabilities through a series of facilitated modular Action Learning Sets it will enable these skills to be applied at a greater scale and spread beyond west Essex.

Events

The CCG has organised and taken part in many virtual and some face-to-face events throughout the year.

The easing of COVID-19 restrictions enabled the CCG to engage face to face with older residents on winter vaccination, COVID and general health in Epping – something we were unable to do the previous year.

Virtual meetings have continued and remain an invaluable way of connecting with, and growing, relationships within communities across the patch. This includes various faith groups, harder to reach communities and younger people.

The CCG has developed strong relationships with the younger population through face to face and virtual meetings. The communications team maintained a strong presence at freshers' fairs and wellbeing events at colleges in Epping and Harlow, sharing messages and gaining insight into young people's views on topics including mental health and vaccinations. This feedback was vital to help direct communications going forward. Since these events, the CCG has been invited to work more closely with colleges and students.

The first west Essex cancer conference took place with the support of a local college in September 2021, bringing together cancer patients, students, clinicians, and partners. The event was recorded and continues to be a resource to support patients being diagnosed with cancer.

The team has supported partners at wellbeing and health-focused events for targeted populations, and also attended the popular RideLondon event in Epping and the Epping Town Show. These events provided an excellent opportunity to speak directly to the public about the issues affecting them day-to-day.

Citizens' Panel
The Citizens Panel continues to grow. The CCG has been engaging with core members on priorities and strategy going forward, key considerations around access to services and communications and will be key in helping to shape engagement within the One Health and Care Partnership (from 1 July the West Essex Health and Care Partnership) and the Integrated Care Board (ICB) going forward.

Work began in late winter/spring to encourage members of the Panel to also join wider, Hertfordshire and west Essex engagement workshops to discuss how we would engage with the public and patients as an ICB and to form a working group to collaborate on the strategy.

Patient Participation Groups (PPG)
PPGs are key to the work the CCG is doing to improve access to GP practices in west Essex.

COVID-19 meant primary care colleagues had to adapt the ways they were working. This impacted on patient access to practices. The CCG is embarking on a new programme of work to develop stronger and productive PPGs for practices, that can help address issues and work through solutions going forward. This work, with the national Patients'

Association, includes training for practices and patients on how best to form a productive PPG. Alongside this is a separate piece of work to encourage practices to go above and beyond in their quest for a productive PPG and achieve bronze, silver and gold levels of engagement with their patients.

This work also includes wider engagement with PPGs, the Citizens Panel and community groups on shaping engagement within the ICB following the transition of the CCG. This work is being coordinated in conjunction with engagement colleagues across the Hertfordshire CCGs to ensure a consistent process and sharing of information, as well as gathering feedback.

Keeping people informed
In 2021, the CCG launched a stakeholder briefing highlighting the key messages around the vaccination programme. This briefing has been welcomed by stakeholders and provides an important way to share information to enable stakeholders to keep their contacts and networks informed.

In addition to this in December 2021, the CCG added a GP access briefing to update stakeholders on progress around improvements to patient access and experience around GP practices.

Social Media
The CCG continues to make full use of its LinkedIn, Facebook, and Twitter accounts, which have been vital in communicating messages around the vaccination programme, clinics, and changes to guidance.

Engaging with primary care colleagues
Closer relationships have been built with primary care colleagues, as we all work to support patients through the pandemic, improve their experiences and ensure practices have what they need to provide the best service possible to their population.

Engagement with GPs, nurses, practice managers and reception and administrative staff continues through several channels:

COVID-19 briefing
This briefing is circulated fortnightly, with information including up to date guidance, webinars, opportunities, and good work across the CCG area.

GP Hub

The password-protected GP Hub website has further developed and includes a categorised resources hub that provides practices with operational information, communications materials to further engage with their patients and guidance.

Practice Manager Meetings
The Practice Manager meetings are a key way to highlight the most important topics the CCG wants to share, but is also a vital way to gather questions, concerns and comments from practices based on their experiences.

These meetings are ongoing on a fortnightly basis and are an important way for the communications and engagement team to share updates, further develop and refine communications practice and offer support to practices when they want it.

PREPARING FOR EMERGENCIES

The CCG 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.

Emergency Preparedness, Resilience and Response (EPRR) is a core function of the NHS and is a statutory requirement of the Civil Contingencies Act (CCA) 2004. Responding to emergencies is also a key function within the NHS Act (2006) as amended by the Health and Social Care Act (2012). The role of WECCG relates to potentially disruptive threats and the need to take command of the local NHS system, as required, during emergency situations

Our Incident Response Plan sets out the process by which we will respond to, manage, and recover from such an incident.

During this period the CCG remained fully compliant with all nine areas of **NHS E/I's Core Standards for Emergency Preparedness, Resilience and Response.**

Incident Response

The response to the coronavirus pandemic has remained the priority. Although the COVID-19 response reduced to level 3, the CCG remained in command and control maintaining situational awareness and oversight.

There were also two concurrent incidents within the period of 01/04/2022 to 30/06/2022, both incidents required a response from the CCG:

- MonkeyPox outbreak, ongoing
- Lassa Fever outbreak, stood down

During this period, the Accountable Emergency Officer (AEO) and EPRR Leads attended two EPRR exercises with its key stakeholders and ensure that as a region we are working collaboratively to manage a level 2/3 incident. Both exercises were used to validate and test the new HWE ICB incident response plan to support the new ICB arrangements.

SUSTAINABLE DEVELOPMENT

The NHS has made a national commitment to taking on the challenge of tackling climate change and reaching net zero carbon has been maintained, as outlined in the 'Delivering a 'Net Zero' National Health Service'.

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) are met.

To fulfil our responsibilities for the role we play, the CCG has developed a **Green Plan** in collaboration with ICS partners. Our sustainability mission statement is: The vision for a sustainable health and care system by reducing carbon emissions, protecting natural resources, preparing communities for extreme weather events and promoting healthy lifestyles and environments.
The Plan addresses all areas of the net zero NHS ambitions while also addressing the need to:

- improve health and patient care and reduce health inequalities
- build a more resilient healthcare system that understands and responds to the threats of climate change.

Our Green Plan provides direction and a framework for collaboration across the ICS footprint to deliver sustainable outcomes. Over the next three years the following ICS priority workstreams will be set up:

- Estates and Facilities.
- Travel and transport
- Sustainable procurement
- Adaptation
- Sustainable Models of Care

In addition to the ICS and local priorities, we will also work with the East of England (EOE) region on regional priorities. The current priorities for the EOE regional Greener NHS team are travel and transport, medicines, waste and PPE.

Our Successes

The organisation successfully moved largely to remote working because of the Covid-19 pandemic.. A number of Covid-19 protection arrangements have continued to a number of sustainable positives, which support lowering the organisation's carbon footprint including:

- The use of Microsoft Teams video and telephone conferencing, reducing the need for face-to-face contact leading to reduced business travel and commuting cutting carbon emissions and improving air quality.
- Video and telephone conferencing for patients: reducing the need for face-to-face contact leading to reduced patient travel: cutting carbon emissions and improving air quality.
- Previously occasional cycling and walking for business and commuting purposes: maintaining social distancing. Sustainable/active travel option: reducing carbon emissions and improving air quality; promoting better health and wellbeing.
- Reducing occupation levels in office areas by encouraging working from home: maintaining social distancing parameters. Reduced business travel and commuting cutting carbon emissions and improving air quality. Reducing impact of seasonal hot and / or cold weather / heat waves: lowering need for supplemental mechanical heating, ventilation and cooling – cutting carbon from power consumption.
- Major reduction in circulation of printed matter – papers, reports and so on: minimises virus transfer risk. Reduction in use of natural resources and associated carbon emissions.

CCG staff members continue to enjoy the benefits of the government's 'cycle to work' scheme, although of course the bicycles can be used outside of work activities too. This allows staff to purchase a bike and cycle safety equipment as a tax-free benefit and as a salary sacrifice scheme. The scheme contributes supports the organisation's reduction in carbon emissions whilst promoting physical activity as part of a health and wellbeing strategy.

The CCG also continues to maintain a number of policies and plans in place to ensure that the organisation can react to changing circumstances, including those related to climate change. These include:

- Business Continuity Plan
- Emergency Planning, Resilience and Response Policy
- Incident Response Plan
- Risk Management Policy

Total Energy Cost (All Energy Supplies)[7]

West Essex CCG spent £27,716 in Q1 2022-23. The total CCG spend on energy in 2021-22 was £103,541.

REVIEW OF FINANCIAL PERFORMANCE

Financial Overview

On 1st July 2022, West Essex CCG ceased to exist, with its functions and that of two other neighbouring CCGs transferred to the Hertfordshire and West Essex Integrated Care Board (HWEICB). The CCG is required to prepare an Annual Report and set of Accounts for the 3-month period 1st April 2022 to 30th June 2022.

West Essex CCG's Accounts for this period are included within this Annual Report. The accounts have been prepared under a Direction issued by NHS England under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

CCGs have a statutory duty to keep their expenditure within the resources available. There are six separate duties with this regard, although there is some overlap between them, and some are not relevant to the CCG in 2022/23. The duties, their relevance in 2022/23 and the performance of West Essex CCG in 2022/23 are set out in the following table.

Further details are provided in of the accounts from page 115 of this report.

[7] Please note that West Essex CCG shares estates with other organisations and pays a percentage of the overall cost for utilities as part of the lease agreement. It is not possible to identify consumption by the organisation so the figures in KWH and kg CO2e are not shown.

Duty	What this means	West Essex CCG's Achievement
Expenditure does not exceed sums allotted to the CCG plus other income received	To keep the amount spent on commissioning and delivering services to or below the amount allocated	✓ Achieved Underspent £1.4m
Capital resource use does not exceed the amount specified in Directions	To not spend more on buying property, plant and equipment then allocated	Not Applicable
Revenue Resource use does not exceed the amount specified in Directions	To not spend more on commissioning and delivering services than allocated	✓ Achieved Underspent £1.4m
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	To not spend more on buying property, plant and equipment then allocated for a specific purpose	Not Applicable
Revenue administration resource use does not exceed the amount specified in Directions	To ensure that CCG efficiently discharges its responsibilities and keeps the spend to or below the amount allocated	✓ Achieved Running costs achieved breakeven in Q1 2022/23
Cash Limits are not exceeded in any one year	To keep the cash in the bank within acceptable limits	✓ Achieved

Funding Allocated to the CCG

The original intention had been for ICBs to be created on 1st April 2022 and NHS England had originally agreed allocations for ICBs rather than CCGs. The 2022/23 annual allocation was therefore notified as a total for the ICB.

In this allocation round NHS England more than halved the previously provided Covid funding to Systems (£49m for Hertfordshire and West Essex Integrated Care System [HWEICS]), ceased the Hospital Discharge Programme and its funding (£25m for HWEICS), and reduced System top-up funding using a convergence to fair share factor (£17m or 0.7%

of baseline funding for HWEICS). These funding reductions were in addition to a national efficiency requirement of 1.1%.

NHS England did allocate £2.3billion, on a fair share basis, to support elective recovery and HWEICB has initially received £45m to support additional elective activity. Where systems deliver additional activity above the annual target, they will earn additional funding at 75% of tariff. Where activity is below the annual target, funding will be reduced at 75% of tariff capped at the total received.

The Running Costs Allowance for 2022/23 has remained at the 2021/22 level with a small adjustment reflecting the impact of the increased employer National Insurance Contributions. With the allocation remaining static, CCGs and ICBs are required to absorb the cost of any pay award to staff and other inflationary cost pressures.

With the delay in introduction of ICBs, allocations for the first quarter of the year had to be made to CCGs. However, the intention remained that ICBs would be held responsible for the System as a whole, including that of the CCGs they replaced. To achieve this CCGs have been allocated with exactly the funding they need to achieve a breakeven position. The balance of the year's funding will be allocated to the ICB.

During the audit of the 30 June 2022 financial statements, it was identified that a number of accruals, which had been recorded as at 31 March 2022 and 30 June 2022, had not resulted in the expected expenditure for the CCG taking place. This resulted in an underspend of £1.403m in the current year and a prior period adjustment (PPA) of £12.734m in the 2021/22 financial year. The external auditors considered this as a significant deficiency in control. The accruals related primarily to Memoranda of Understanding with NHS England, where the CCG had accrued for the potential return of allocated resources not spent by the end of the financial year, and situations where the CCG had accrued for budgeted expenditure which did not occur.

This means that West Essex CCG is reporting and underspend position of £1.403m with the cumulative underspend over the life of the CCG (£24.137m) will be carried forward. NHS England will then make decisions on how much of this carry forward will be transferred to HWEICB.

The total allocation received by the CCG during the Q1 2022/23 was £175.030m. West Essex CCG was the lead CCG for the Hertfordshire and West Essex Integrated Care System and therefore received and distributed both the Service Development Funding (SDF) and the prospective system top-up, growth and COVID-19 allocations for the System. This is shown in the table below:

Allocation received	Total
	£'000
Programme	100,075
Devolved Commissioning	11,889
Running Costs	1,417
Service Development Funding (SDF)	10,726
Prospective System Top-up, growth and COVID-19 funding	50,923
TOTAL	175,030

The CCG met the statutory requirement to keep spend within the resources allocated

Details of how the CCG spent its allocation during April to June 2022 is shown in the chart below and the categorisation of spend is consistent with the categories utilised for reporting to the Finance and Performance Committee.

NHS England holds the vast majority of the capital assets on behalf of CCGs and West Essex CCG did not need to bid for capital resources. Although the CCG did purchase IT and other equipment, this expenditure did not need to be capitalised. The costs are shown as part of the revenue spend of the CCG, within the most appropriate expenditure category.

The CCG is provided with a cash limit based on our planned expenditure. This cash is used to pay for services commissioned from NHS and non-NHS Providers, for Primary Care contracts and other payments, for prescribing and other healthcare costs, and for the costs of running the CCG. The CCG draws down a proportion of the limit each month and the CCG drew down less cash than the limit and therefore met its statutory duty.

As well as staying within the cash limit, as a public sector organisation, we are expected to pay our obligations promptly. This is known as the Better Payment Practice Code and requires the CCG to pay 95% of valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Performance against this code is measured by value and volume of invoices paid and is shown in Note 4 of the Financial Statements.

The CCG has therefore met all of their financial duties for Quarter 1 of 2022/23.

Audit Arrangements

External audit services are provided by BDO LLP (KPMG LLP in Financial Year 2021/22). The total fee for Q1 2022/23 was £79,450 excluding VAT (£82,500 for Financial Year 2021/22)

Internal Audit services are provided by West Midlands Ambulance Service.

The total fee for Q1 2022/23 was £6,820 excluding VAT (£27,000 for Financial Year 2021/22).

Please note:

The figures above are for periods of different duration, namely Quarter 1 2022/23 and the Financial Year 2021/22, but may cover similar levels of work, so they cannot be extrapolated or directly compared.

REVIEW OF STATUTORY DUTIES

West Essex CCG 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 function

ACCOUNTABILITY REPORT

Dr Jane Halpin
Accountable Officer

Date signed: 24th May 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

MEMBERS' REPORT

The Governing Body (West Essex CCG Board) is made up of a group of individuals, who are appointed to the CCG with the main function of ensuring that the organisation has made appropriate governance arrangements, and for formulating policy and directing its affairs.

On 30 June 2022 Dr Rob Gerlis was the Chair of the CCG and Jane Halpin was the Accountable Officer. There are 16 members of the CCG Board.

Information about our Board members and their responsibilities can be found on our website: **https://westessexccg.nhs.uk/our-work/meet-the-board**

MEMBER PRACTICES

During the year 2022/23, the membership body of the CCG was formed of 30 member practices, grouped below under their respective Primary Care Network:

Locality	Practice Name
North Uttlesford	Crocus Medical Practice
	Gold Street Surgery
	Newport Surgery
	Thaxted Surgery
South Uttlesford	Elsenham Surgery
	Stansted Surgery
	Angel Lane Surgery
	John Tasker House Surgery
	Eden Surgery
Harlow North	Old Harlow Health Centre
	Church Langley Medical Practice
	Nuffield House Surgery
	Sydenham Surgery
	Addison House Surgery
Harlow South	Lister Medical Practice
	The Hamilton Practice
	Ross Practice
Epping Forest North	Ongar Health Centre
	The Limes Medical Centre
	High Street Surgery Epping
	Abridge Surgery
	Maynard Court Surgery
	Market Square Surgery
Loughton, Buckhurst Hill and Chigwell	Loughton Health Centre
	The Loughton Surgery
	The Forest Practice
	Palmerston Road Surgery
	Kings Medical Centre
	The River Surgery
	Chigwell Medical Centre

Composition of Board

The Chair of the CCG is Dr Rob Gerlis. The Chief Executive is Dr Jane Halpin.

From 1sy April 2022 to 30th June 2022, the Board was composed of the following members:

Role	Name
Chair	Dr Rob Gerlis
Deputy Clinical Chair	Dr Angus Henderson
GP Representative - Uttlesford	Dr Jen West

GP Representative – Epping Forest	Dr Shawarna Lasker
GP Representative – Epping Forest	Dr Ian Perry
Clinical Lead – Urgent Care	Dr Amik Aneja
Secondary Care Consultnant	Dr Duncan Forsyth
Lay Member - Audit	Stephen King
Lay Member – Patient and Public Involvement	Bobbie Graham
Lay Member – Primary Care	David McConnell
Chief Executive (Accountable Officer)	Dr Jane Halpin
Managing Director	Peter Wightman
Director of Clinical and Professional Services	Dr Rachel Joyce
Chief Finance Officer	Alan Pond
Director of Nursing and Quality	Jane Kinniburgh
Director of Primary Care Transformation	Avni Shah

Committee(s), including Audit Committee

The members of the Audit Committee throughout the year and up to the signing of the Annual Report and Accounts and unless otherwise stated:

- Lay Member (Audit), Chair of Audit Committee.
- Deputy Clinical Chair
- Lay Member (Primary Care)

The Remuneration Report starting on page 80 provides details of the membership of the Remuneration Committee.

The Governance Statement, from page 63 provides details of the attendance of the Board and its Committee members at their respective meetings, namely:

- Board
- Audit Committee
- Primary Care Commissioning Committee
- Remuneration Committee

Register of Interests

The Board maintains an up-to-date Register of Interests, which formally records the declarations of interests made by its employees and members and is available on the Clinical Commissioning Group's website. Any interest that arises during the course of a meeting is declared immediately and recorded in the minutes of the meeting. This ensures that the Board acts in the best interests of the organisation and avoids situations where there may be a potential conflict of interest. To view the Register of Interests please visit our website: **www.westessexccg.nhs.uk**

Personal data related incidents

The organisation has not reported any Information Governance Serious Untoward Incidents to the Information Commissioner's Office in Q1 2022/23

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS West Essex Clinical Commissioning Group 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.

STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board NHSE, NHSE has appointed Joint Accountable Officer to be the Accountable Officer of West Essex CCG

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

The propriety and regularity of the public finances for which the Accountable Officer is answerable,

For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),

For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).

The relevant responsibilities of accounting officers under Managing Public Money,

Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),

Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

Observe the Accounts Direction issued by NHS E, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

Make judgements and estimates on a reasonable basis;

State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,

Prepare the accounts on a going concern basis; and

Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

I also confirm that:

as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Dr Jane Halpin
Accountable Officer

Date signed: 24th May 2024

GOVERNANCE STATEMENT

Introduction and context

NHS West Essex Clinical Commissioning Group (CCG) is a body corporate established by NHS E on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG 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 local population.

Between 1 April 2022 and 30 June 2022, the clinical commissioning group is not subject to any directions from NHS E issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group'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 my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group 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.

The CCG's Constitution sets out the arrangements made for the group to meet its responsibilities for commissioning care for the people which it is responsible for. It describes the governing principles, rules and procedures that the group has established to ensure probity and accountability in the day to day running of the CCG; to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to its goals.
The Constitution has been supported by the CCG's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation and policies including managing conflicts of interest. The Corporate Governance Manual sets out those decisions that are reserved for the membership as a whole and decisions that are the responsibility of its Board.

The group has observed generally accepted principles of good governance in the way that it has conducted its business, in line with it's Business Code of Conduct which brings together existing standards and guidance from the NHS and other CCG adopted standards and guidance.
The generally accepted principles of good governance applied by the CCG in conducting its business include:-

- The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of it's business;
- The Good Governance Standard for Public Services;
- The standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles';
- The seven key principles of the *NHS Constitution*;
- The Equality Act 2010.

The group has demonstrated its accountability to its members, localities, local people, stakeholders and to NHS E/I in a number of ways, including by:

- Publishing its Constitution;
- Appointing independent lay members and a non-GP clinician to its Board;
- Holding meetings of its Board in public (except where the Board considers that it would not be in the public interest in relation to all or part of a meeting);
- Publishing an annual operating plan;
- Complying with local authority, health overview and scrutiny requirements;
- Producing annual accounts for this financial year which have been externally audited;
- Holding a virtual planned Annual General Meeting on 23rd September 2022 to publish and present the annual report and audited accounts for the year ending 2021/22
- Having a published and clear complaints process;
- Complying with the Freedom of Information Act 2000;
- Providing information to NHS E/I & Improvement as required;

• Working closely with Internal Audit and Counter Fraud Services to ensure assurance and risk processes within work programmes are aligned to the statutory responsibilities of the CCG.

In addition to these statutory requirements the group has demonstrated its accountability by:

• Publishing its principle commissioning and operational policies;

• Held member practice, membership meetings and regular GP shutdown meetings; Harlow, Epping and Uttlesford Membership meetings continue to take place but are now held virtually. They were held monthly but are now bi-monthly to enable PCNs to meet in between.

• Delivered an extensive programme of bespoke training, development and wellbeing initiatives for our whole primary care workforce including GPs, nurses, AHPs, additional roles working within primary care networks and primary care colleagues on career breaks to improve primary care retention and recruitment.

• Whilst it has not been possible to hold public engagement events due to Covid-19 the CCG has published regular updates throughout the year to stakeholders and partners, including patient group representatives. We have also participated in health and wellbeing boards and held a number of virtual briefings with local council leaders/cabinet members.

The Board

The Board is responsible for setting the strategic priorities of the CCG. This includes ensuring the optimal use of resources to improve health and health services. This remit includes commissioning of elective hospital care, rehabilitation, urgent and emergency care (including out of hours services), community health services, services for children and younger persons, maternity services, mental health and learning disability services.

The Board, acting on behalf of the CCG membership, is responsible for ensuring that the CCG has appropriate governance frameworks, resources, capability and capacity in place to enable the CCG to exercise its functions effectively, efficiently and economically to meet its delegated responsibilities and in accordance with accepted good governance principles.

The Board is responsible for holding the executive to account for the delivery of the CCG strategy. The Board was advised on all service and commissioning decisions by the Executive Health and Care Commissioning Committee.

The membership of the Board can be found within the Corporate Governance Report and attendance of the Board meetings is detailed on page 63.

Governance Structure

The Board has created the statutorily-required Audit Committee and Remuneration Committee. Additionally the Board has established, a Quality Committee, and an and a Primary Care Commissioning Committee[8]

Board

The Board (Governing Body) met regularly last year in both public and private sessions. During the year the Board worked to develop transition to an Integrated Care System (ICS) and Health and Care Partnerships (HCPs) for Hertfordshire and West Essex. This is in line with the **white paper** and the NHS Long Term Plan sets out evidence demonstrating the effectiveness of Integrated Care working.

The Board reviewed its roles and structures to move towards integrated working.

An ICS acts as a strategic planner and commissioner for the health and care needs of a whole population and aligns the system in terms of strategy, commissioning and delivery. It commissions care from providers that focus care needs for specific population cohorts. HCPs coordinate care delivery at local level between multiple providers, reducing barriers between organisations and enabling a shift in focus from traditional disease or pathway based approach to a holistic and individual value based approach. It is about partners working together to deliver commissioned care pathways and how it is delivered to best meet the needs of their populations.

Audit Committee

The Audit 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.

[8] The Board, Renumeration Committee and Primary Care Commissioning Committee met in Common with Herts Valleys CCG and East and North Hertfordshire CCG in 2022/23

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 summary reports to Board.

GOVERNANCE REPORT

Primary Care Commissioning Committee

The role of the Primary Care Commissioning Committee is to carry out the functions relating to the commissioning of primary medical services provided under General Practice Contract arrangements, for example, General Medical Services and Alternative Provider Medical Services contracts. This is with the exception of those functions relating to individual GP performance management, which have been reserved to NHS E/I.

The remit of the committee has covered premises, supporting transformation and resilience in general practice, technological developments, workforce, education and training, new care models and mergers, monitoring quality and improving standards.

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. 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 patient representation to provide an invaluable patient perspective.

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 Clinical Commissioning Group. A Very Senior Manager typically has Executive Director level responsibility and reports to the Chief Executive. No individual is involved in determining their own remuneration.

Board Attendance

Members' attendance records are detailed in the following table.

	Board In Common*
Number of meetings held during Q1 2022/23	**2**
Name:	**Title/Locality:**
Dr Rob Gerlis	Chair	1
Dr Angus Henderson	Deputy Clinical Chair	1
Dr Jen West	GP Representative - Uttlesford	0
Dr Shawarna Lasker	GP Representative – Epping Forest	0
Dr Ian Perry	GP Representative – Epping Forest	0
Dr Amik Aneja	Clinical Lead – Urgent Care	0
Stephen King	Lay Member - Governance	2
Bobbie Graham	Lay Member – Patient and Public Involvement	2
David McConnell	Lay Member – Primary Care	2
Dr Jane Halpin	Chief Executive (Accountable Officer)	1
Peter Wightman	Managing Director	2
Dr Rachel Joyce	Director of Clinical and Professional Services	2
Jane Kinniburgh	Director of Nursing and Quality	0
Alan Pond	Chief Financial Officer	2

* West Essex CCG Board has met in common with East and North Hertfordshire CCG and Herts Valleys CCG.

Audit Committee

Number of meetings held during Q1 2022/23	**2**
Title:	**Attendance:**
Lay Member, Governance*	2/2
Lay Member, Public and Patient Engagement	0/2
Lay Member, Primary Care	2/2

* Chair of Audit Committee

Primary Care Commissioning Committee

Number of meetings held during Q1 2022-23	1
Title/Locality	
Lay Member - Primary Care (Chair)	1/1
Lay Member (Vice Chair)	1/1
Joint Chief Executive Officer H&WE ICS & CCGs	0/1
Managing Director	1/1
Chief Finance Officer	1/1
Acting Primary Care Lead & Chief Pharmacist	1/1
Director of Primary Care Transformation H&WE ICS & CCGs	1/1
Director of Nursing & Quality	1/1
Independent GP Member	1/1
Independent GP Member	0/1

* Chair of Primary Care Commissioning Committee

Quality Committee

Number of meetings held during 2021-22	1
Title/Locality:	**Attendance:**
Special Advisor to the Board for Clinical Quality *	1/1
Secondary Care Consultant	0/1
Chief Medical Officer OHCP	1/1
Director of Nursing & Quality	1/1
GP Board Member - Uttlesford	0/1
GP Board Member – Epping Forest	1/1
GP Board Member - Harlow	0/1
Primary Care Lead	1/1
Performance Lead	0/1

* Chair of Quality Committee

Remuneration Committee

Number of meetings held during Q1 2022-23	0

Title/Locality:	Attendance:
CCG Chair	0
CCG Lay Member, Patient and Public Engagement*	0
CCG Lay Member	0
Special Advisor to the Board for Clinical Quality	0
CCG Lay Member, Primary Care	0
CCG Clinical Vice Chair	0

* Chair of Remuneration 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 CCG 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 CCG 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. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk Management Arrangements and Effectiveness

Deterrents for Risks Arising

The deterrents for risks arising are referenced within the Audit Committee section of this statement. They include Counter Fraud activity which plays a key part in deterring risks to the organisation's financial viability and probity. An annual Counter Fraud Plan is agreed by the Audit Committee which focuses on the deterrence, prevention, detection and investigation of fraud. The CCG's Standing Orders, Standing Financial Instructions and policies and procedures place an obligation on all employees and lay members to act in accordance with best practice in order to prevent fraud, bribery and corruption.

If there is evidence of fraud, it is referred to our Local Counter Fraud Specialist (LCFS) and following the conclusion of an investigation, available sanctions will be considered in accordance with previous NHS Counter Fraud Authority Guidance. This may include criminal prosecution, civil proceedings and disciplinary action, as well as referral to a professional or

regulatory body. Awareness of the need to detect and deter risks is available to all employees through posters on display, leaflets and surveys together with educational related information sessions.
Our information risk policies provide all staff with information regarding compliance with legal requirements and how to avoid breaches of any law, statutory, regulatory or contractual obligations and security requirements in relation to the prevention of misuse of information.
The management of our current risks is in accordance with our risk management framework and as applied under the Risk Assessment in Relation to Governance, Risk Management and Internal Control

The CCG has in place:-

- a risk register on which the latest updates are reported
- clear ownership of risks with escalation arrangements in place to the Board
- a recording process for all risks and incidents
- appropriate and consistent validation of risks through use of the risk methodology and review by the committees and Board
- learning from incidents through root cause analysis and shared learning
- triangulation of complaints and incidents
- the accurate reflection of known strategic risks to the organisation through the Board Assurance Framework
- mandatory training on risk management.
- The CCG has developed an “open, just and non-punitive” culture where all staff are encouraged to report adverse incidents, near misses and hazards in the knowledge that incidents or errors are not normally investigated through the disciplinary procedure.
- A number of policies and procedures are in place to enable managers and staff to resolve concerns or issues that may arise. The Raising Concerns (Whistleblowing) Policy also provided a framework for employees to raise concerns in line with the Public Interest Disclosure Act 1998, without the perception of being disloyal to colleagues, managers or the organisation. Our disciplinary procedure promotes an approach where action will only be taken when it is felt that staff deliberately attempt to disguise errors and / or dangerous practice, or when the incident involves significant negligence or significant poor standards of care.
- The CCG is committed to identifying the underlying or root causes of incidents, claims and complaints and the principal objective is to identify “system failures”, rather than focusing on individual malfunctions.

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

The Risk Management Policy, previously approved and adopted by the Board, provides a risk management framework for a streamlined, systematic and proactive approach to all clinical and non-clinical operational and strategic risks.
The aim of the risk management framework is to:-

- Ensure that all individuals, committees and the Board are aware of their roles and responsibilities.
- Support all staff and the Board through provision of risk management training.
- Create a learning culture that encourages the sharing of knowledge to risk assessment and risk management.
- Enable a positive attitude to risk management.
- Develop and promote policies and procedures that support all in identifying and managing risk.
- Encompass the management of risks inherent in activities that seek to deliver project and business objectives.

Our Board Assurance Framework provides the risks that are identified as overarching, or provide a high level of risk that could adversely impact on the CCG reaching its planned goals or strategic objectives. The more detailed business or operational risk elements are recorded on the Operational Risk Register.
The Executive Committee review the Board Assurance Framework and Risk Register regularly, to ensure progress is made on mitigating actions and recommends or approves where risks are to be closed.
The Audit Committee reviews both the Board Assurance Framework and Risk Register for the effectiveness of the process at each meeting.
The Board is routinely presented with the Board Assurance Framework on the risks to the strategic objectives together with the red risks on the business or operational risks for scrutiny, challenge and assurance.
The application of the risk management framework enables the prevention of risk through:-

- Commitment to identifying the underlying or root causes of incidents, claims and complaints
- Promoting an open, just and non-punitive culture
- Driving an ongoing information and education programme which empowers and supports staff in the risk management process
- Updating and maintaining the knowledge of Board members

• All staff being familiar with the terms of the Anti-fraud, Bribery and Corruption Policy through promotion with the help of Counter Fraud services.

Capacity to Handle Risk

The risk management framework has previously been set out in this statement. Within the risk management accountability and reporting structure, the Accountable Officer has overall responsibility for risk management and assurance processes including their implementation. The Accountable Officer holds Executive Directors to account in their role as risk owners. The Board is responsible for reviewing the effectiveness of internal controls and receives a red risk report at each Board meeting. Risk management issues are channelled to the Board from the Executive Committee, with the Audit Committee providing assurance to the Board on the risk management system and controls in place, as it is the Audit Committee that is responsible for ensuring that the CCG establishes and maintains effective systems of integrated governance, risk management and internal controls across the whole of the organisation's activities.

The Accountable Officer is the Executive Director with overall responsibility for corporate governance and risk management and is also responsible for all facets of financial risks. The Director of Nursing and Quality is responsible for clinical governance and clinical risk management, to provide expert professional advice throughout the organisation and be the focal point for clinical risk issues within the Quality Committee.
The Executive Directors have been assigned responsibility for operational management of the CCG on a day to day basis and, as such, the Board has been assured that risk management issues are integral to the decision making process.

Risk Assessment in Relation to Governance, Risk Management and Internal Control

At the end of the year our risk profile showed the following:

WECCG risk assessment		
Profile of risks to achieving our strategic objectives at 26th May 2022 (the Board Assurance Framework)		
Red (High)	**Amber (Significant)**	**Yellow or Green (Low)**
0	**5**	**1**
1 strategic risk achieved the target score.		
Profile of operational corporate risks at 26th May 2022		
Red (High)	**Amber (Significant)**	**Yellow or Green (Low)**
6	**10**	**1**
The remaining red assessed corporate operational risks are identified as:		

Risk description		Risk level with arrows indicating progress trend (out of a potential score of 25 at year end)
<u>NHS Constitutional Standards PAH.</u> A&E 4 Hours 95% RTT 92% 62 Day Cancer 85% Diagnostics 99%	<u>Feb 2022 Performance</u> A&E: 65.1% RTT: 50.3% 62d Cancer: 41.4% Diagnostics: 79.9%	**20** 
Transfer of the GP Extended Access Service from the IUC Contract to PCNs - cost pressures risk		**20** 
IF there is a lack of tier 4 MH provision for children and young people THEN children will be inappropriately admitted into paediatric settings RESULTING IN pressures in acute trusts across the system		**25** 
IF the current quality and safety concerns relating to PAH, highlighted through the CQC's latest inspections and the ongoing quality oversight of the CCGs, are not adequately addressed - including ED section 31 notice, paediatrics, maternity services, core medical services and overall staffing rates		**25** 

and skill mix, THEN there is a risk that our patients will not receive safe and effective care, as well as a risk to the wider system regarding operational pressures. RESULTING IN possible patient harm	
Eating Disorders Medical Monitoring: system partners across Essex have identified the need to increase the workforce and protocol in relation to high-risk patients that are treated in the community with an ED for the whole region.	**16** 
These risks will be carried forward into 2022/23. Working within the risk management framework, the respective committees of Quality, Finance and Performance, Executive Health and Care Commissioning and Executive will lead the controls and mitigating actions required with the responsible Executive Director lead. The Audit Committee will provide scrutiny and challenge to the risk management of these risks and provide an assurance opinion to the Board. The Board will ensure that any additional measures are fully explored in order to manage or reduce the identified risks. Risks were transferred to appear as equivalent risks on the Integrated Care Board corporate risk register from 1st July 2022	

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The control mechanisms are described within the **Risk Management Framework**.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS E/I has published a template audit framework.

In March 2022 West Midlands Ambulance Services University NHS Foundation Trust undertook an annual independent internal audit of NHS West Essex CCG's conflicts of interest as part of the Governance, Assurance Framework and Conflicts of Interest Audit, and provided the following findings – the audit as a whole received reasonable assurance of the controls in place and the level of compliance with those controls.

The audit focused on the following conflict of interest areas:

- Registers of Interests, Gifts & Hospitality and Procurement Decisions are in place, updated regularly and available on the website for the public to view;
- Declarations of interests cover all employees and GP members at the CCG;
- The CCG's Managing Conflicts of Interest Policy covers all requirements outlined within the Statutory Guidance; and
- Declarations are made by bidders/potential contractors during tender processes.

With respect to Conflicts of Interest, the CCG's processes remained aligned to the Statutory Guidance issued by NHS E/I in June 2017, but further work is required to ensure that all members of staff are identified and captured in the CCG's declaration of interest collation process and that all staff respond promptly to requests for declarations of interest.

Data Quality

The CCG uses regular validation checks on all data that is received, published and distributed and is confident about the quality of information used in decision making by our membership and board. During this period the CCG, has worked closely with the ICS and other ICPs to learn and share best practice models.

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 IG Framework is supported by a Data Security & Protection Toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have developed information governance processes and procedures in line with the Data Security & Protection Toolkit (DSPT). We have ensured all staff undertake annual IG training and have implemented a staff IG resource guide to ensure members of staff are aware of their information governance roles and responsibilities, and how to access information or assistance.

There are processes in place for incident reporting and investigation of serious incidents. No serious incidents requiring investigation involving personal data were reported to the Information Commissioner in Q1 2022/23

The CCG has nominated information asset owners who have completed the data flow mapping and information asset registers to ensure compliance with the General Data Protection Regulations. This was done with support from the IG Team to ensure consistency of approach.

The CCG publish a DSPT assessment before 30 June 2022 and met all mandatory assertions.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, this CCG confirms that a framework and environment is in place to provide quality assurance of business critical models, this model is reviewed and forms part of the Audit Committees annual cycle of assurance checks. Given the developments in algorithmic or similar platforms, assurance models such as this remain under constant review.

Third party assurances
Where third parties are assigned through services commissioned by West Essex CCG, provider compliance is regulated through clauses such as General Condition 12 (Assignment and Sub-Contracting) of the NHS Standard Terms and regular performance monitoring.

Control Issues

The audit of CCG's annual accounts revealed accruals for obligations that had not materialise by the balance sheet date, resulting in an underspend of £1.403m in the current year and a prior period adjustment (PPA) £12.734m in 2021/22 financial year. The external auditors considered this as significant deficiency in control. The accruals related primarily to Memoranda of Understanding with NHS England, where the CCG had accrued for the potential return of allocated resources not spent by the end of the financial year, and situations where the CCG had accrued for budgeted expenditure which did not occur.

Review of economy, efficiency & effectiveness of the use of resources
Ensuring the effective and efficient use of resources is a key duty of the CCG.
The CCG's Finance and Performance Committee reviews and agrees the organisation's financial plans and budgets at the beginning of the year and is responsible for receiving and reviewing the detailed monthly finance and performance reports in respect of the CCG's operational performance together with its performance against transformation and efficiency targets.

At each meeting the Board receives a report on key financial and performance issues including related risks, with the FACT sheets being presented as an appendix to the Chief Officer / Managing Directors Report. Additionally, more recently, the Deputy Director of Finance, Contracts and Performance has included a finance update.

The continuous requirement to deliver year on year efficiency within available resources is developed in line with best practice and benchmarking of key performance metrics whilst demonstrating that the health needs of the local population are being considered and appropriately commissioned.
Key financial risks are incorporated with the organisation's risk register which is subject to review by the Executive and Audit Committees, with risks rated significant being reported to the Board.

Internal audit plans are approved by the Executive Committee and endorsed by the Audit Committee and will provide a focus on areas relating key controls required to ensure the effective use of resources.

The External Auditor provides assurance through their opinion on whether the CCG's financial statements give a true and fair view of the financial position at the end of each year and of the regularity of expenditure and income. The external Auditors issued a modified opinion on the financial statements of the CCG. The modification relates to a limitation of scope on opening accruals balances. Their opinion is not modified in respect of any other matters.

The CCG has in place appropriate procurement procedures to ensure that value for money is achieved when tendering for goods and services.

Delegation of functions
The CCG has no delegated functions, however we do hold NHS E/I&I delegated functions.

Counter fraud arrangements

Counter fraud arrangements are in place for the CCG in line with the NHS Counter Fraud Authority Standards for NHS Commissioners 2020/21: Fraud, Bribery and Corruption[9].

To assist in this NHS Counter Fraud Authority, issue an annual self-review assessing how the organisation meets these standards. It incorporates a requirement that the CCG employs or contracts a qualified person or persons to undertake the full range of anti-fraud work, and that it produces a risk-based work plan that details how it will approach anti-fraud and corruption work. The standards also require an annual report showing how the Standards have been met, and any areas in which corrective actions are needed to address a failure to do so. There is a significant focus on the achievement of outcomes rather than simply reporting on tasks completed.

The CCG commission local counter fraud specialist services from WMAS who deliver an annual plan that ensures compliance with the requirements of NHS Counter Fraud. Consequently, the CCG has an assigned Accredited Local Counter Fraud Specialist (LCFS) contracted to undertake counter fraud work proportionate to identified risks through both the pro-active delivery of an annual work plan and through the re-active work responding to potential fraud. The Audit Committee receives an annual report from the LCFS highlighting how the service has ensured compliance against the Counter Fraud Functional Standard return which is supported by completion of the self-review tool submitted by the LCFS with the support and sign off of the Chief Finance Officer, as the member of the executive Board responsible for tackling fraud, bribery and corruption and the audit committee chair. The CCG is committed to robustly investigating all reports of fraud, bribery and corruption and will seek to recover lost NHS funds where proportionate and necessary.

[9] **NHS Counter Fraud Standards for Providers 2020-21 v1.3 (cfa.nhs.uk)**

Committee effectiveness

Board members have undertaken mandatory training throughout the year, which included risk management, health and safety, bullying and harassment, information governance, equality and diversity and equality impact assessments. Annual mandatory training enables the members to regularly keep their knowledge and skills up-to-date. In addition, each member is allocated sufficient time to discharge their respective duties and responsibilities effectively.

The Audit 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, encompassing all the assurance needs of the Board and Accountable Officer. Within this, the Committee has a particular arrangement with the work of Internal Audit and External Audit and Financial Reporting. The Audit Committee undertook a self-assessment of their effectiveness in May 2022 with a positive outcome covering good practice, objectivity and independence, skill mix to perform it function, effective communication, Internal Auditors and External Auditors and members.

Capacity to Handle Risk

The Board delegates to the Chief Executive 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 about the agreed level of risk appetite. The Chief Executive 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 CCG 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 Clinical Commissioning Group is an active member of the Health and Wellbeing Board and regularly participates in Essex 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 Assurance Framework and highest-scoring risks are published for Board Meetings. They are reviewed three times a year, providing a further opportunity for public engagement with stakeholders in risks that impact them.
All 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 in risk management. Risk management training is also mandatory for all managers and staff. As of 30 June 2022, the risk management training compliance for the CCG was 87.91%. Work to increase training uptake was undertaken.

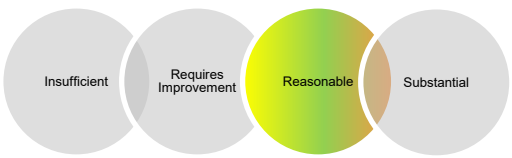
Risk Assessment

Risk assessment is the overall process of risk identification, risk analysis and risk evaluation, starting with the CCG 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 CCG from achieving its strategic objectives.

All levels of staff 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.

HEAD OF INTERNAL AUDIT OPINION

Following completion of the planned audit work for the period for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that: For the 3 months ended 30 June 2022, our Head of Internal Audit Opinion for NHS West Essex Clinical Commissioning Group is as follows:



Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied

consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

The latest reports issued by Internal Audit can be found below:

Area of Audit	Level of Assurance Given
Data Security and protection Toolkit pt1	Reasonable
Training and Appraisal	Reasonable
Patient and Carer Engagement	Advisory Report
Primary Care Governance	Substantial
Cyber Security	Requires Improvement
Primary Care Prescribing Performance Management	Substantial
Key Financial Systems	Substantial
Risk Management, Assurance Framework, Conflicts of Interest and Gifts and Hospitality	Reasonable
Payroll and Expenses	Reasonable

There have not been any “no assurance” opinion reports in this period. One has received “requires improvement”: Cyber Security. Detailed actions have since been undertaken and reported to the Audit and Risk Committee. The CCG changed IT provider in April 2022, and extra controls and restrictions on firewalls and monitoring systems have been put in place to ensure any potential suspicious activities are blocked and additional Cyber Security Technicians have been employed by the new provider to further increase the proactive security monitoring capability and defences.

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 Clinical Commissioning Group 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

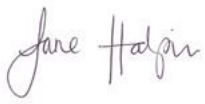
manage risks to the Clinical Commissioning Group achieving its principal objectives have been reviewed.

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

- Board
- Audit 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 that the "significant deficiency" identified by external auditors reflected the ICB incorrectly recognising costs for specifically funded activities when the funding was received**,** rather than when the costs were incurred.



Dr Jane Halpin
Accountable Officer

Date signed: 24th May 2024

PART TWO: REMUNERATION AND STAFF REPORT

REMUNERATION REPORT

The information on pages 80 and 81 is not subject to audit, except for 'payments to past senior managers'.

REMUNERATION COMMITTEE

The members of the Remuneration Committee for the year were as follows. Members attendance is noted on page 64.

- CCG Chair – Dr Rob Gerlis
- Lay Member Patient and Public Engagement (Committee Chair)
- Lay Member Primary Care
- Lay Member Governance
- Special Advisor to the Board for Clinical Quality
- Clinical Vice Chair of CCG

REMUNERATION OF VERY SENIOR MANAGERS

The Accountable Officer of the CCG is paid a salary in excess of £150,000 per annum for the joint post of Accountable Officer of Hertfordshire and West Essex CCGs and ICS and is a shared arrangement between East and North Hertfordshire, Herts Valleys and West Essex CCGs and the ICS. This has been approved by NHS E/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 Clinical Commissioning Group's Remuneration Committee used the remuneration guidance provided by NHS E/I 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. 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.

POLICY ON SENIOR MANAGERS' CONTRACTS (not subject to audit)

The CCG uses the NHS England published remuneration guidance for CCG Chief Officers and Chief Finance Officers in determining the remuneration for these roles. For other Very Senior Manager (VSM) roles, the previous NHS VSM framework is used as a guide. The CCG benchmarks with local CCGs to ensure that remuneration is in line with the local Economy. Remuneration for all senior roles is agreed via the Remuneration and Terms of Service Committee. For all other staff, the Agenda for Change framework is applied

PAYMENTS TO PAST SENIOR MANAGERS (subject to audit)

There have been no payments to past senior managers.

It has not been possible for the Pensions Agency to provide pension figures for CCG staff for the period April to June 2022 and it has not been possible to complete the salaries and allowances tables for this period.

OFF-PAYROLL ENGAGEMENTS

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

For all off-payroll engagements as of 30 June 2022, for more than **£245** per day

Number of existing engagements as of 30 June 2022	**8**
Of which… the number that have existed:	
for less than one year at time of reporting	2
for between one and two years at time of reporting	1
for between 2 and 3 years at time of reporting	4
for between 3 and 4 years at time of reporting	1
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 30 June 2022, for more than £245 per day

No of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	0
Of which…	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
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 April 2022 and 30 June 2022

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	4
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	20

The 4 off payroll engagements relate to GP Board members working under a contract for services

Salary and Allowances 2022/23 (subject to audit)

Renumeration for members of the Board Apr - Jun 2022
Table 1: Single total figure (subject to audit)

Note	NAME	TITLE	2022-23						Dates served	
			Salary (bands of £5,000) £000	Expense payments (Taxable) to the nearest £100 £	Performance pay and bonuses (bands of £5000) £000	Long-term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	Total (bands of £5000) £000	Commenced	Ceased
	Executive Directors									
4	Dr Rob Gerlis	Chair and GP Member	20-25	0	0	0	0	20-25	01-Apr-13	30-Jun-22
	Dr Angus Henderson	Clinical Vice Chair/GP Member	10-15	0	0	0	2.5-5	15-20	27-Jul-15	
1,2	Dr Jane Halpin (15.21%)	Accountable Officer	5-10	0	0	0	0	5-10	01-Jun-20	
2	Dr Christine Moss	Clinical Director, one health and care partnership	10-15	0	0	0	0	10-15	01-Oct-20	
1	Alan Pond (15.21%)	Chief Finance Officer	5-10	0	0	0	0	5-10	01-Aug-20	
2	Toni Coles	Director of Integrated Care Partnership Development for the West Essex area	25-30	0	0	0	0	25-30	01-Aug-20	
1	Avni Shah (15.21%)	Director of Primary Care Transformation	0-5	0	0	0	0-2.5	5-10	01-Dec-20	
1	Frances Shattock (15.21%)	Director of Performance & Delivery	0-5	0	0	0	7.5-10	5-10	01-Mar-21	
1,2	Jane Kinniburgh (15.21%)	Director of Nursing & Quality	0-5	0	0	0	0	0-5	01-Aug-20	
	Peter Wightman	Managing Director	30-35	0	0	0	5-7.5	35-40	01-Jul-20	30-Jun-22
1	Rachel Joyce (15.21%)	Director of Clinical & Professional Services	5-10	0	0	0	0-2.5	5-10	01-Oct-20	
1	Elizabeth Disney (15.21%)	Director of Operations (from 6 June 2022)	0-5	0	0	0	0-2.5	0-5		
2	Ian Tompkins	Director Corporate Services	25-30	0	0	0	0	25-30	18-Feb-19	
3	Dr Amik Aneja	GP Member	5-10	0	0	0	0	5-10	27-Jul-15	30-Jun-22
4	Dr Janet West	GP Member	0-5	0	0	0	0	0-5	27-Jul-15	30-Jun-22
3	Dr Ian Perry	GP Member	0-5	0	0	0	0	0-5	01-Aug-18	30-Jun-22
3	Dr Shawarna Lasker	GP Member	0-5	0	0	0	0	0-5	25-Nov-19	30-Jun-22
	Lay Members									
5	Stephen King	Lay member, Governance and Deputy Chair	0-5	0	0	0	0	0-5	01-Apr-13	30-Jun-22
5	David McConnell	Lay members, Primary Care commissioning Committee	0-5	0	0	0	0	0-5	01-Jan-18	30-Jun-22
5	Bobbie Graham	Lay member, PPE	0-5	0	0	0	0	0-5	01-Jan-18	30-Jun-22
	Peter Boylan	Special Advisor to the board for clinical quality	0-5	0	0	0	0	0-5	15-Jul-16	30-Jun-22

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 of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

1 - Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the member remuneration has been apportioned across the three CCG's and the ICS, only that relating to West Essex CCG has been disclosed based on the West Essex contribution of 15.21% of their total remuneration. For transparency the member's total remuneration across Hertfordshire and West Essex CCGs and the ICS is disclosed in the table below.
2 - Members who chose not to be covered by the Civil Service pension arrangements during the reporting year.
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 "Practioner Pension Scheme". The CCG 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.
4 - GP member chose not to be covered by the Practitioner pension arrangements during the reporting period.
5 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Only GP members who are members of the Board have been included in this table.

Integrated Care System (ICS) Joint Executive Team: The following table shows the senior managers total Remuneration where there has been a sharing arrangement between CCG's and the ICS.

NAME	TITLE	2022-23						Dates served	
		Salary (bands of £5,000) £000	Expense payments (Taxable) to the nearest £100 £00	Performance pay and bonuses (bands of £5000) £000	Long -term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	Total (bands of £5000) £000	Commenced	Ceased
Paul Burstow	Independent Chair Herts and West Essex Integrated Care System (ICS)	15-20	0	0	0	0	15-20	01-Dec-18	
Dr Jane Halpin	Accountable Officer (from 1 June 2020)	40-45	0	0	0	0	40-45	01-Jun-20	
Jane Kinniburgh	Director of Nursing (until 31 July 2020) ICS Director of Nursing & Quality (from 1 August 2020)	30-35	0	0	0	0	30-35	17-Mar-14	
Frances Shattock	Director of Performance & Delivery (from 1 March 2020)	30-35	0	0	0	7.5-10	35-40	01-Mar-21	
Alan Pond	Chief Finance Officer (from 1 August 2020)	30-35	0	0	0	0	30-35	01-Aug-20	
Elizabeth Disney	Director of Operations (from 6 June 2022)	5-10				2.5-5	10-15	06-Jun-23	
Rachel Joyce	Medical Director E&N Herts and ICS (until 30 Sept 2020), ICS Director of clinical and Professional services from (1 October 2020)	35-40	0	0	0	7.5-10	40-45	01-Apr-20	
Avni Shah	Director of Primary Care Transformation (from1 Dec 2020)	30-35	0	0	0	12.5-15	40-45	01-Dec-20	

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, no non-consolidated performance-related pay, benefits-in-kind, or severance payments were made. 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 West Essex CCG in the financial year 2022-23 was £130K to £135K (2021-22, £130k to £135K). This was 2.76 times (2021-22, 2.77 times) the median remuneration of the workforce, which was £47,937 (2020-21, £47,784).

YEAR	25th Percentile total remuneration ratio	Median total remuneration ratio	75th Percentile total remuneration ratio
2022-23	**132,500:33,111**	**132,500:47,937**	**132,500:65,310**
	4.00	**2.76**	**2.03**
2021-22	132,500:33,210	132,500:47,784	132,500:63,893
	3.99	2.77	2.07

There has been no change from the previous financial year in respect of the salary of the highest paid Director

There has been no material change from the previous year in respect of average employees salary and allowances, (2022-23 £50,711: 2021-22 £49,771). The increase of 1.85% is due to additional senior management appointments.

In 2022-23 no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £1,375 to highest paid director (2020-21 £2,102 to highest paid director). Remuneration for the lowest paid employee relates to a time commitment below the normal contractural hours, and therefore the annualised FTE calculation reflects the differant terms.

As a number of Director posts included in the fair pay disclosure above were shared across three CCGs and the ICS, for transparency if the disclosure had been based on the total salary for those directors, disclosure would have been as follows:

YEAR	25th Percentile total remuneration ratio	Median total remuneration ratio	75th Percentile total remuneration ratio
2022-23	**172,500:33,111**	**172,500:47,937**	**172,500:65,310**
	5.20	**3.60**	**2.64**
2021-22	172,500:33,210	172,500:47,784	172,500:63,893
	5.19	3.60	2.70

There has been no change from the previous financial year in respect of the salary of the highest paid Director

The highest paid Director salary relates to a post which was working across the Integrated Care System. The CCG followed national guidance in relation to this payment, support and approval was obtained via NHS England and Improvement and the national remuneration committee considering senior manager pay. Benchmarking has also been carried out for similar size organisations to ensure that salaries are competitive and in line with that of similar systems.

Table 2 Pension benefits April - June 2022 (Subject to Audit)

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2023 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2022 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2023 £000	Employers contribution to partnership pension £000
Executive Directors									
Peter Wightman	Managing Director	0-2.5	5-7.5	40-45	80-85	777	3	833	0
Dr Angus Henderson	Clinical Vice Chair/GP Member	0-2.5	0	25-30	30-35	336	7	358	0
Frances Shattock (15.21%)	Director of Performance & Delivery (from 1 March 2021)	0-2.5	0	0-5	0	4	0	9	0
Alan Pond (15.21%)	Chief Finance Officer	0	0	10-15	15-20	198	2	207	0
Rachel Joyce (15.21%)	Director of Clinical & Professional Services (from 1 October 2020)	0-2.5	0-2.5	5-10	15-20	166	2	183	0
Avni Shah (15.21%)	Director of Primary care Transformation (from 1 December 2020)	0-2.5	0-2.5	5-10	10-15	91	1	102	0
Elizabeth Disney (15.21%)	Director of Operations (from 6 June)	0-2.5	0-2.5	0-5	0-5	14	0	20	0

Notes

The real increase in pension, lump sum and cash equivlanet transfer values have been approtioned to reflect the period ending June 2022.
The total accrued pension, lump sum and cash equivalent transfer value are as at 31 March 2023.

Note 1: Where members have been appointed to Hertfordshire and West Essex ICS Joint Executive Team, the member remuneration has been apportioned across the three CCGs and the ICS, the West Essex CCG proportion (15.21%) of members pension benefits is disclosed above, from the date of their appointment. For transparency the table below shows members total pension benefits for the period across the CCGs and ICS.

Note 2: Certain Members do not receive pensionable remuneration therefore there will be no entries in respect to pensions for certain Members.

Note 3: No CETV is shown for pensioners or senior managers over Normal Pension age 60 in the 1995 Scheme, age 65 in the 2008 Section, or State Pension age or age 65, whatever is later, in the 2015 Scheme .

Note 4: There is no lump sum payment for 2015 scheme members

Note 5 - 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 the 1995/2008 Scheme were automatically moved to the 2015 scheme on 1 April 2022.

Hertfordshire & West Essex Integrated Care system (ICS): The following table discloses the Total pension entitlements of directors and senior managers where there is a sharing arrangement between CCG's and ICS

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2023 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2022 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2023 £000	Employers contribution to partnership pension £000
Executive Directors									
Frances Shattock	Director of Performance & Delivery (from 1 March 2021)	0-2.5	0	0-5	0	29	3	60	0
Alan Pond	Chief Finance Officer (from 1 August 2020)	0	0	75-80	120-125	1301	15	1,361	0
Rachel Joyce	Director of Clinical & Professional Services (from 1 October 2020)	0-2.5	0-2.5	50-55	120-125	1093	14	1,203	0
Avni Shah	Director of Primary care Transformation (from 1 December 2020)	0-2.5	0-2.5	40-45	75-80	595	10	672	0
Elizabeth Disney	Director of Operations (from 6 June)	0-2.5	0-2.5	10-15	5-10	89	1	130	0

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Salary and Allowances 2021/22 (Prior year)

Note	NAME	TITLE	2021-22						Dates served	
			Salary (bands of £5,000) £000	Expense payments (Taxable) to the nearest £100 £	Performance pay and bonuses (bands of £5000) £000	Long -term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	Total (bands of £5000) £000	Commenced	Ceased
	Executive Directors									
	Dr Rob Gerlis	Chair and GP Member	80-85	0	0	0	0	80-85	01-Apr-13	
	Dr Angus Henderson	Clinical Vice Chair/GP Member	55-60	0	0	0	142.5-145	200-205	27-Jul-15	
1	Dr Jane Halpin (15.21%)	Accountable Officer	25-30	0	0	0	0	25-30	01-Jun-20	
2	Beverley Flowers (15.21%	Interim Accountable Officer	10-15	0	0	0	2.5-5	10-15	01-Nov-22	
	Dr Christine Moss	Clinical Director, one health and care partnership	50-55	0	0	0	10-12.5	65-70	01-Oct-20	
1	Alan Pond (15.21%)	Chief Finance Officer	25-30	0	0	0	7.5-10	30-35	01-Aug-20	
3	Toni Coles	Director of Integrated Care Partnership Development for the West Essex area	105-110	0	0	0	0	105-110	01-Aug-20	
1	Avni Shah (15.21%)	Director of Primary Care Transformation	25-30	0	0	0	10-12.5	30-35	01-Dec-20	
1	Frances Shattock (15.21%	Director of Performance & Delivery	15-20	0	0	0	2.5-5	25-30	01-Mar-21	
1	Jane Kinniburgh (15.21%	Director of Nursing & Quality	15-20	0	0	0	0	15-20	01-Aug-20	
	Peter Wightman	Managing Director	130-135	0	0	0	10-12.5	140-145	01-Jul-20	
1	Rachel Joyce (15.21%)	Director of Clinical & Professional Services	20-25	0	0	0	5-7.5	25-30	01-Oct-20	
	Ian Tompkins	Director Corporate Services	105-110	0	0	0	0	105-110	18-Feb-19	
	Dr Amik Aneja	GP Member	35-40	0	0	0	0	35-40	27-Jul-15	
	Dr Janet West	GP Member	10-15	0	0	0	0	10-15	27-Jul-15	
	Dr Duncan Forsyth	Secondary Care Consultant	5-10	0	0	0	0	5-10	01-Apr-13	
	Dr Ian Perry	GP Member	15-20	0	0	0	0	15-20	01-Aug-18	
	Dr Shawarna Lasker	GP Member	15-20	0	0	0	0	15-20	25-Nov-19	
	Lay Members									
	Stephen King	Lay member, Governance and Deputy Chair	10-15	0	0	0	0	10-15	01-Apr-13	
	David McConnell	Lay members, Primary Care commissioning Committee	15-20	0	0	0	0	15-20	01-Jan-18	
	Bobbie Graham	Lay member, PPE	10-15	0	0	0	0	10-15	01-Jan-18	
	Peter Boylan	Special Advisor to the board for clinical quality	5-10	0	0	0	0	5-10	15-Jul-16	

Notes

1 - Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the member remuneration has been apportioned across the three CCG's and the ICS, only that relating to West Essex CCG has been disclosed based on the West Essex contribution of 15.21% of their total remuneration. For transparency the member's total remuneration across Hertfordshire and West Essex CCGs and the ICS is disclosed in the table below.

2 - Beverley flowers was appointed as interim Accountable Officer 1 November 2022

3 - Toni Coles chose not to be covered by the Civil Service pension arrangements during the reporting year.

Only GP members who are members of the Board have been included in this table.

Integrated Care System (ICS) Joint Executive Team: The following table shows the senior managers total Remuneration where there has been a sharing arrangement between CCG's and the ICS.

NAME	TITLE	2021-22						Dates served	
		Salary (bands of £5,000) £000	Expense payments (Taxable) to the nearest £100 £00	Performance pay and bonuses (bands of £5000) £000	Long -term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	Total (bands of £5000) £000	Commenced	Ceased
Paul Burstow	Independent Chair Herts and West Essex Integrated Care System (ICS)	55-60	0	0	0	0	55-60	01-Dec-18	
Dr Jane Halpin	Accountable Officer (from 1 June 2020)	170-175	0	0	0	0	170-175	01-Jun-20	
Jane Kinniburgh	Director of Nursing (until 31 July 2020) ICS Director of Nursing & Quality (from 1 August 2020)	125-130	0	0	0	0	125-130	17-Mar-14	
Frances Shattock	Director of Performance & Delivery (from 1 March 2020)	125-130	0	0	0	27.5-30	150-155	01-Mar-21	
Alan Pond	Chief Finance Officer (from 1 August 2020)	135-140	0	0	0	60-62.5	195-200	01-Aug-20	
Rachel Joyce	Medical Director E&N Herts and ICS (until 30 Sept 2020), ICS Director of clinical and Professional services from (1 October 2020)	140-145	0	0	0	42.5-45	185-190	01-Apr-20	
Beverley Flowers	ICS Accountable Officer (until 31 May 2020), ICS Director of Integration and Transformation from (1 June 2020)	145-150	0	0	0	40-42.5	185-190	01-Apr-20	
Avni Shah	Director of Primary Care Transformation (from1 Dec 2020)	125-130	0	0	0	75-77.5	200-205	01-Dec-20	

Notes
1 - Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the member remuneration has been apportioned across the three CCG's and the ICS, only that relating to West Essex CCG has been disclosed based on the West Essex contribution of 15.21% of their total remuneration. For transparency the member's total remuneration across Hertfordshire and West Essex CCGs and the ICS is disclosed in the table below.
2 - Beverley flowers was appointed as interim Accountable Officer 1 November 2022
3 - Toni Coles chose not to be covered by the Civil Service pension arrangements during the reporting year.

Only GP members who are members of the Board have been included in this table.

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 inform movements in the gap between the workforce and the highest paid director.
Total remuneration disclosed consists of salary and allowances, no non-consolidated performance-related pay, benefits-in-kind, or severance payments were made. 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 West Essex CCG in the financial year 2021-22 was £130K to £135K (2020-21, £130k to £135K). This was 3.59 times (2020-21, 3.71 times) the median remuneration of the workforce, which was £47,784 (2020-21, £46,294).

YEAR	25th Percentile total remuneration ratio	Median total remuneration ratio	75th Percentile total remuneration ratio
2021-22	**132,500:33,210**	**132,500:47,784**	**132,500:60,866**
	3.99	**3.10**	**2.19**
2020-21	132,500:32,145	132,500:46,294	132,500:63,792
	4.12	2.86	2.08

West Essex CCG Salary and pension entitlements of directors and senior managers

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2021 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March £000	Employers contribution to partnership pension £000
Executive Directors									
Dr Christine Moss	Clinical Director, one health and care partnership	0-2.5	0-2.5	15-20	40-45	0	0	0	0
Peter Wightman	Managing Director	2.5-5	0	40-45	55-60	722	33	777	0
Dr Ian Perry	GP Member	0	0	15-20	40-45	233	6	242	0
Dr Angus Henderson	Clinical Vice Chair/GP Member	5-7.5	10-12.5	20-25	30-35	234	96	336	0
Frances Shattock (15.21%	Director of Performance & Delivery (from 1 March 2021)	0-2.5	0	0-5	0	0	1	4	0
Alan Pond (15.21%)	Chief Finance Officer (from 1 August 2020)	0-2.5	0-2.5	10-15	10-15	162	9	175	0
Rachel Joyce (15.21%)	Director of Clinical & Professional Services (from 1 October 2020)	0-2.5	0-2.5	5-10	15-20	154	8	166	0
Avni Shah (15.21%)	Director of Primary care Transformation (from 1 December 2020)	0-2.5	0-2.5	5-10	5-10	79	8	91	0
Beverley Flowers (15.21%)	Acting Accountable Officer (from 1 November 2021)	0-2.5	0-2.5	5-10	15-20	139	3	149	0

Notes

Note 1: Where members have been appointed to Hertfordshire and West Essex ICS Joint Executive Team, the member remuneration has been apportioned across the three CCGs and the ICS, the West Essex CCG proportion (15.21%) of members pension benefits is disclosed above, from the date of their appointment. For transparency the table below shows members total pension benefits for the period across the CCGs and ICS.

Note 2: Certain Members do not receive pensionable remuneration therefore there will be no entries in respect to pensions for certain Members.

Note 3: No CETV is shown for pensioners or senior managers over Normal Pension age 60 in the 1995 Scheme, age 65 in the 2008 Section, or State Pension age or age 65, whatever is later, in the 2015 Scheme .

Hertfordshire & West Essex Integrated Care system (ICS): The following table discloses the Total pension entitlements of directors and senior managers where there is a sharing arrangement between CCG's and ICS

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2021 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March £000	Employers contribution to partnership pension £000
Executive Directors									
Frances Shattock	Director of Performance & Delivery (from 1 March 2021)	0-2.5	0	0-5	0	2	9	29	0
Alan Pond	Chief Finance Officer (from 1 August 2020)	2.5-5	0-2.5	65-70	95-100	1068	57	1,151	0
Rachel Joyce	Director of Clinical & Professional Services (from 1 October 2020)	2.5-5	0-2.5	50-55	110-115	1013	54	1,093	0
Avni Shah	Director of Primary care Transformation (from 1 December 2020)	2.5-5	5-7.5	35-40	70-75	519	55	595	0
Beverley Flowers	Acting Accountable Officer (from 1 November 2021)	2.5-5	0-2.5	50-55	95-100	913	45	982	0

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

McCloud judgement

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

EXPENDITURE ON CONSULTANCY The total spend on consultants in 2022/23 is shown within the accounts from page 115

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 2021/22	Full-time equivalent employee number
0	0

Table 8: Percentage of time spent on facility time

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

Table 9: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£0
Total pay bill	£0
Percentage of the total pay bill spent on facility time	0%

Table 10: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	0%

About our CCG staff

As at 31 January 2022, West Essex CCG employed a total of 215 staff (172.57 full time equivalents). These figures include all Board members and 7 staff on external secondment to partnership organisations.

The table below details how many senior managers are employed by the CCG by banding (as at 31 March 2022).

Agenda for Change Band	Headcount	FTE
8a	36	31.52
8b	23	21.93
8c	11	10.8
8d	10	9.98
9	4	4.00
Very Senior Manager (VSM)	9	7.14
Medical & Dental (M&D)[10]	12	2.76

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.

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

Throughout this period, West CCG's engagement approach was fully cognisant of this duty and it will continue to promote equality of opportunity for the population of West Essex in the context of all its commissioning engagement activities in the future.

The CCG met statutory responsibilities around data publication and will meet the NHS requirements in using the NHS Equality Delivery System (EDS2) 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 CCG is required to implement WRES in respect of its own workforce. It is recognised that the small size of many CCGs 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 being implemented within the CCG.
The CCG's profile for staff-declared ethnicity appears in the table below (at 31 March 2022).

Ethnic Origin	Headcount	%
A White - British	148	69%
B White - Irish	3	1%
C White - Any other White background	5	2%
CA White English	3	1%
CY White Other European	1	0%
D Mixed - White & Black Caribbean	1	0%
F Mixed - White & Asian	2	1%
G Mixed - Any other mixed background	2	1%
GF Mixed - Other/Unspecified	1	0%
H Asian or Asian British - Indian	10	5%
J Asian or Asian British - Pakistani	2	1%
K Asian or Asian British - Bangladeshi	2	1%
L Asian or Asian British - Any other Asian background	2	1%
LB Asian Punjabi	1	0%
LE Asian Sri Lankan	1	0%
LH Asian British	1	0%
M Black or Black British - Caribbean	3	1%
N Black or Black British - African	12	6%
P Black or Black British - Any other Black background	1	0%
S Any Other Ethnic Group	1	0%
SB Japanese	1	0%

SE Other Specified	1	0%
Unspecified	3	1%
Z Not Stated	8	4%
Grand Total	215	100%

Equality and Diversity Action Planning and the NHS Equality Delivery System (EDS2)

The CCG has an equality and diversity action plan which supports the CCG to meet the statutory and NHS requirements around equality and diversity. It is overseen by an Equality, Diversity and Inclusion Steering Group. This group is also coordinating the CCGs completion of EDS2, the NHS equality and delivery system.

The group is chaired by our Lay Member for Patient and Public Involvement who leads on equality, diversity and inclusion on our Board. The aim of the group is to refresh the Equality Delivery System for the NHS within the organisation, which is based around 4 goals:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce, and
4. Inclusive leadership

Each goal has a designated lead who will identify the current processes that are working well and envisioning the processes that would work well in the future.

Equality and diversity support is delivered to the CCG, via a shared service resource alongside Herts Valleys and East and North Herts CCGs. This model enables best practice and expertise to be shared amongst all organisations.

Disability

The CCG is working on the principles of **Disability Confident** which recognises our commitment to recruiting and developing disabled employees. Disability Confident award replaces the 'Positive About Disabled People' (PADP) award, this will be renewed for the ICB once established.

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 starts in early September 2022.

The CCG 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 CCG 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 2022, 67.73% of staff have declared they have no disability, with 3.18% declaring a disability and the remaining 29.09% undeclared. Staff are regularly reminded to check and update their personal information including declarations.

Gender Profile

Gender Profile – overall workforce (at 31 March 2022)

Gender	%
Female	77
Male	23

% gender by pay band (at 31 March 2022)

Agenda for Change (AfC)	Male (%)	Female (%)
Band 3	0.00%	100%
Band 4	8%	92%
Band 5	17%	83%
Band 6	23%	77%
Band 7	14%	86%
Band 8A	22%	78%
Band 8B	9%	91%
Band 8C	36%	64%
Band 8D	30%	70%
Band 9	25%	75%
Medical & Dental	54%	46%
Very Senior Managers (VSM)	50%	50%

Gender breakdown (as at 31 March 2022)

Board members, VSM and Medical and Dental staff			
Male		**Female**	
Headcount	%	Headcount	%
13	42	18	58
Bands 8a and above			
Male		**Female**	
Headcount	%	Headcount	%
18	21	66	79
All other bands (band 7 and below)			
Male		**Female**	
Headcount	%	Headcount	%
13	15	75	85

Gender pay gap reporting regulations

All public sector organisations in England employing 250 or more staff are required to publish gender pay gap information annually, both on their website and on the designated government website at **www.gov.uk/genderpaygap**. West Essex is one of the few CCGs nationally which is required to publish this information, as most CCGs employ fewer than 250 members of staff.

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the difference in the average pay (both mean and median) between all men and women in our workforce. Calculations are based on the hourly rate of ordinary salary paid to each employee on a snapshot date in the financial year. This includes staff employed under Agenda for Change terms and conditions, clinical advisers and very senior managers.

West Essex CCG employs more women than men, with women making up approximately 77% of the workforce.

The mean gender pay gap is the difference between the average hourly earnings of men and women and gives us an overall indication of the size of our gender pay gap, if any.

On 31 March 2022 (the latest available data) the mean gender pay gap was 30.69% which is an increase on the 2020 figure of 25.65%.

The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle salary. We believe this is a more representative measure of the pay gap because it is not affected by outliers – a few individuals at the top or bottom of the range. On 31 March 2021 (the latest available data) the median gender pay gap was 39.41%. This means that typically women are paid 39.41% less in the CCG than men.

All salaries in the CCG will be reviewed as part of the progression to the ICS in order to ensure equity and fairness, which will have a positive impact on the gender pay gap.

Religion and beliefs

The declared religion or belief of CCG staff at 31 March 2022 (the latest available data) appears in the table below:

Religious Belief	Headcount	%
Atheism	21	10%
Buddhism	4	2%
Christianity	82	38%
Hinduism	8	4%
I do not wish to disclose my religion/belief	60	28%
Islam	6	3%
Judaism	2	1%
Other	5	2%
Unspecified	27	13%
Grand Total	**215**	**100%**

Sexual Orientation

The declared sexual orientation of CGG staff at 31 March 2022 (the latest available data) appears in the table below:

Sexual Orientation	Headcount	%
Bisexual	2	1%
Gay or Lesbian	5	2%
Heterosexual or Straight	139	65%
Not stated (person asked but declined to provide a response)	41	19%

Undecided	1	0%
Unspecified	27	13%
Grand Total	**215**	**100%**

Sickness Absence Data

Sickness absence data relating to the year 2021/22 (the latest available data) extracted from ESR:

Total days lost:	283 days (equivalent calendar days)
Total absence (FTE)	283 days out of a total of 57158 available FTE days
Average absence per employee:	1.81 days (average of total days lost by CCG employee headcount)
Of total days lost, long term absence episodes:	2
Long term days total:	79 days (included in total days lost)

The CCG's sickness absence rate for the last financial year was 0.50%

This figure is based on the total full time equivalent days available to work during the last financial year 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.

COVID-19 related absence was recorded separately to general sickness absence in accordance with government guidelines. In addition, where sickness absence has been extended due to COVID-19, consideration has been given to the impact of this on sickness levels, for example where an operation has been delayed and has resulted in the staff member's absence being longer than the norm.

Staff turnover

Headcount
6.46%

EMPLOYEE BENEFITS (SUBJECT TO AUDIT) –

Average number of people employed

2022-23 (3 months to 30 June)		
Permanently employed	Other	Total
Number	Number	Number
166.50	33.05	199.55

For information relating to staff costs please refer to the annual accounts from page 115

Please note, in this time period, the electronic staff record (ESR) system was not able to fully report on all activity within the ICB as the ESR merger did not take place until 1 July 2022. There were minimal changes to the staffing profile and did not significantly effect on the numbers presented here

HR shared service model

The human resources provision continues to be delivered via a shared service, hosted by Herts Valleys CCG. The service provides support to West Essex and East and North Hertfordshire CCGs.

As part of a shared service, the CCG benefits from economies of scale, an enhanced knowledge base and a wider pool of HR and organisational skills and expertise, as well as access to a dedicated Director of Workforce, who is representing the CCG in aspects of the STP workforce agenda across both Hertfordshire and West Essex.

CCG managers have access to the HRXtra service – a telephone and online resource providing advice and guidance on people and employee relations issues. HRXtra have also provided a suite of management awareness sessions on people management topics such as having wellbeing conversations and compassionate leadership.

Whistleblowing

The CCG has in place a 'Raising Concerns at Work – Whistleblowing' 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 CCG has nominated a lay member- - to oversee the effectiveness of this process.

The CCG promoted Freedom to Speak Up Champions to help keep the CCG safe and supported. Including the Lay Member; Speak Up Guardian, there are five trained champions based at the CCG, from different directorates, levels and backgrounds. To further support CCG the champions have also been trained as Mental Health First Aiders.

Training and values

The compliance rate for mandatory training as at 30 June 2022 was 82.67%%. Non-compliance is addressed via system alerts to relevant staff and their managers, OLM workshops and regular mandatory training reporting to Directors. The OLM system is fully operational and managers can view a dashboard of their teams' compliance in real time on My ESR.

The HR and ODL Shared Service continue to offer appraisal training to managers and employees to support the process of undertaking meaningful appraisals.

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 CCG values are:

- Patients come first
- Providing the best possible care for all
- Honesty and respect

The values will be used within appraisals to assess if staff are modelling the right behaviours and linked into the recruitment process as part of value-based interviews.

Apprenticeship Levy

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

The Apprentice Levy was nationally introduced in April 2017 to help deliver new apprenticeships and to support quality training by putting employers at the heart of the system. As part of the program, the government is committed to developing vocational skills, and to increasing the quantity and quality of apprenticeships.

Employers with annual pay bills in excess of £3 million are required to pay 0.5 % of their pay-bill into the scheme. 3 members of staff are now taking part in the Apprenticeship programme. The CCG will continue to encourage staff to take up further opportunities.

Health and safety

The CCG 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 CCG 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 CCG also accepts such responsibility for other persons who may be affected by its activities.

The CCG ensured compliance with The Health and Safety (Display Screen Equipment) Regulations 1992 by continuing to issue guidance to staff to reduce the risk of developing related health problems, particularly while working from home. The CCG carried out regular health and safety and wellbeing risk assessments with staff to enable effective working from home.

The CCG has a policy review programme, and policies are reviewed partnership with management, staff-side and staff representatives across the 3 Hertfordshire and west Essex CCGs.

Employee consultation and communications

Joint Partnership Forum

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

The forum has worked to address key issues that were raised in previous years' national staff surveys. Other actions taken to support the workforce included:

- Provide a forum to air staff views on key issues.
- Advise West Essex CCG senior leadership team and make recommendations on strategies and actions that impact on staff.
- Support the embedding of values and the behaviours framework.
- Provide support for a range of key projects.
- Provide a testing forum for a range of policies and strategies of relevance to staff.
- Promote staff engagement.
- Work in close liaison with health and wellbeing champions

Staff Survey

The 2021 NHS National Staff Survey (the latest available data) has demonstrated that there has been significant improvement in the following areas:

Most improved scores	Trust 2021	Trust 2020
q14b. Not experienced harassment, bullying or abuse from managers	95%	88%
q4c. Satisfied with level of pay	65%	59%
q14c. Not experienced harassment, bullying or abuse from other colleagues	90%	85%
q3b. Feel trusted to do my job	91%	88%
q3a. Always know what work responsibilities are	80%	77%

The CCG have co-created action plans through 'The Big 5' campaign, which has taken place across 5 months (May to September) with 5 themes with one Executive lead sponsoring each month. Staff have collaborated through various fora including focus groups and engagement through the staff partnership group.

The full reports can be viewed here: Benchmark & directorate reports 2021 – NHS Staff Survey Results

Staff health and wellbeing

The CCG 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 CCG understands that a healthy and happy workforce is crucial to delivering improvements in patient care.

The CCG continues to provide an Employee Assistance Programme (EAP), provided by Vita Health group accessed through a free and confidential helpline.

The CCG have staff who are trained 'Mental Health First Aiders', who support staff with a listening ear and signpost them to appropriate local services. The CCG also has access to occupational health services, to support staff with health concerns.

The CCG continues to promote flexible working provision on job adverts and has run training sessions for managers to ensure opportunities for flexible work are offered equitably across the CCG.

Other initiatives to help staff keep fit and healthy include the cycle-to-work scheme which allows staff to buy a bike at a reduced cost and pay for it monthly through tax efficient salary deductions.

The focus on staff wellbeing continues to ensure early interventions with regards to sickness absence. Actions currently underway and planned to address these issues are as follows:

- Here for You programme has been launched for NHS staff. This is a service that is managed by our local psychologists
- Team building activities to support job role and partnership working
- HR masterclasses being promoted and delivered to line managers to ensure absence and performance issues are addressed at an early stage
- Compassionate leadership approach through coaching conversations with staff
- Health and wellbeing conversation training for all managers to promote a positive culture for health and wellbeing

- Staff have access to the HR ODL intranet that has a wealth of information on health and wellbeing
- Menopause awareness webinars
- Financial wellbeing; individual pensions and financial awareness sessions
- Access to carer information and resources

Equality of opportunity for staff HR to update

Our organisation's **commitment** to challenging inequalities in the workplace and improving opportunities for all of our staff. Staff are encouraged to discuss equality issues within team meetings and bring forward comments and suggestions. Our BAME staff 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 CCG can be improved and co-produce our Race equality action plan. Our organisation promotes diversity and inclusion training and has held a number of popular lunch and learn bitesize workshops which staff across Herts and West Essex CCGs have attended

PART THREE: PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

West Essex CCG 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 this period.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD IN RESPECT OF NHS WEST ESSEX CLINICAL COMMISSIONING GROUP

Qualified opinion on financial statements

We have audited the financial statements of NHS West Essex Clinical Commissioning Group (the CCG) for the period ended 30 June 2022, 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, except for the effects and possible effects of the matters described in the Basis for qualified opinion section, the financial statements:

- give a true and fair view of the financial position of NHS West Essex CCG as at 30 June 2022 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 qualified opinion on financial statements

We were unable to gain sufficient appropriate evidence in connection with £17.588 million of opening balances presented as 2021/22 comparatives as 'Trade and other payables' in the Statement of Financial Position. These balances are disclosed within Note 10 to the financial statements in the lines 'Non-NHS and Other WGA accruals' and 'Other payables and accruals' at £14.785 million and £2.803 million respectively. The ICB has not provided evidence in relation to this balance due to the passage of time and resources that would be involved in doing so. We were unable to satisfy ourselves by alternative means concerning the balance, by using other audit procedures. Consequently we were unable to determine whether any adjustment to this amount was necessary, or whether there was any consequential adjustment to corresponding expenditure.

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 CCG 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 qualified opinion.

Emphasis of matter - basis of preparation of financial statements

As explained in Note 1.1 to the financial statements the Health and Social Care Act 2022 allowed for the establishment of Integrated Care Boards (ICBs) across England. ICBs took on the commissioning functions of CCGs from 1 July 2022. On this date the CCG ceased to exist, and its functions, assets and liabilities transferred to NHS Hertfordshire and West Essex ICB.

Given that services previously provided by the CCG will continue to be provided by another public sector entity the financial statements have been prepared on a going concern basis. Our opinion is not modified in respect of this matter.

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 continuation of the CCG's services by other entities after the demise of the CCG, 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.

As described in the Basis for qualified opinion on financial statements section of our report, our audit opinion is qualified in respect of a limitation of scope. This impacts the reported net operating expenditure. The limitation of scope also impacts the assurance we have over the CCG's disclosed financial performance in the Financial Overview section of the Annual Report.

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 described in that report as subject to audit.

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 CCG for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

We have completed our work on the CCG's arrangements. We have identified the following significant weakness in the CCG's arrangements for the period ended 30 June 2022:

Significant weakness in arrangements	Recommendation
Our audit procedures identified a material misstatement in relation to trade and other payables, specifically the subset relating to Non-NHS and Other WGA accruals and Other payables and accruals. Many of these errors represented situations where the CCG had accrued on the basis of a budgeted commitment or a memorandum of understanding, but for which no goods or services had been received and thus no obligating event had occurred. These represent overstatements of accruals and of corresponding expenditure streams. While management have stated that in many of these situations, the CCG still expected future expenditure to be incurred, the absence of such an obligating event during the period in question means that these are not valid accruals. This in turn results a mismatch between expenditure incurred by the CCG for a specific period and the corresponding revenue allocation, to an extent that undermines the utility of the financial statements from an informed decision-making perspective. Given the materiality of this issue, in our view this is evidence of a significant weakness in the CCG's governance arrangements.	The CCG demised on 30 June 2022. Therefore, this recommendation is being reported to its successor body, NHS Hertfordshire and West Essex Integrated Care Board. We recommend that the ICB review its guidance to management accountants to help embed understanding of the accounting principles relating to accruals, and that pre audit quality review processes at period ends are strengthened to identify incorrect accruals prior to the draft financial statements being presented. Management have confirmed that current processes and practices around budget profiling, such as the large volume of monthly accruals journals and the quality of supporting evidence documented in support of accruals journals, will be reviewed and strengthened. We recommend that management embed improvements to these processes into guidance to management accountants.

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 CCG, or an officer of the CCG, 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 CCG 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 CCG'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 CCG has been informed of an intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the CCG 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 CCG'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 CCG's head of internal audit, the CCG's local counter fraud specialist and those charged with governance, including obtaining and reviewing supporting documentation in respect of the CCG'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 CCG's controls relating to Managing Public Money requirements;
- discussing among the engagement team 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;

- considering the possible fraud risk arising from the limitation of scope set out in the Basis for Qualified Opinion on Financial Statements section above and satisfying ourselves by reviewing the errors identified in our testing and considering the requirements of the Clinical Commissioning Groups financial management regime, that it did not represent fraud;
- obtaining an understanding of the CCG's framework of authority as well as other legal and regulatory frameworks that the CCG 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 CCG. 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 CCG 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 Governing Body;
- 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; and 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 to 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.

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 CCG 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 CCG'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 January 2023.

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 NHS West Essex Clinical Commissioning Group for the period ended 30 June 2022 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 respect of NHS West Essex CCG, 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 CCG 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.

Ciaran McLaughlin
Key Audit Partner

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

30 May 2024
BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the 3 months ended 30 June 2022

	Note	2022-23 (3 months to 30 June) £'000		2021-22 restated £'000
Income from sale of goods and services	2	**0**		0
Other operating income	2	**(821)**		(6,146)
Total operating income		**(821)**		(6,146)
Staff costs	4	**2,976**	*	11,945
Purchase of goods and services	5	**171,144**	*	795,432
Depreciation and impairment charges	5	**68**		111
Provision expense	5	**186**		659
Other Operating Expenditure	5	**75**		287
Total operating expenditure		**174,449**	*	808,434
Net Operating Expenditure		**173,628**	*	802,288
Net expenditure for the Period		**173,628**	*	802,288
Total Net Expenditure for the period ended 30 June 2022		**173,628**	*	802,288

*** Refer to note 1.17**

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000		31 March 2022 restated £'000
Non-current assets:				
Property, plant and equipment		**3**		3
Right-of-use assets		**181**		0
Total non-current assets		**184**		3
Current assets:				
Trade and other receivables	8	**2,870**		4,390
Cash and cash equivalents	9	**(1,097)**		(3,921)
Total current assets		**1,773**		469
Total assets		**1,957**		472
Current liabilities				
Trade and other payables	10	**(30,677)**	*	(42,657)
Lease liabilities	7	**(187)**		0
Provisions		**(1,098)**		(1,035)
Total current liabilities		**(31,962)**	*	(43,692)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(30,005)**	*	(43,220)
Non-current liabilities				
Provisions		**(35)**		(34)
Total non-current liabilities		**(35)**		(34)
Assets less Liabilities		**(30,040)**	*	(43,254)
Financed by Taxpayers' Equity				
General fund		**(30,040)**	*	(43,254)
Total taxpayers' equity:		**(30,040)**	*	(43,254)

*** Refer to note 1.17**

The notes on pages 120 to 136 form part of this statement

The financial statements on pages 116 to 119 were approved by the Board on 24th May 2024 and signed on its behalf by:

Jane Halpin
Chief Accountable Officer
24th May 2024

Statement of Changes In Taxpayers Equity for the period ended 30 June 2022

	General fund £'000		Total reserves £'000
Changes in taxpayers' equity for 2022-23 (3 months to 30 June)			
Balance at 01 April 2022	**(43,254)**		**(43,254)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23 (3 months to 30 June)			
Net operating expenditure for the financial year	**(173,628)**		**(173,628)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(173,628)**		**(173,628)**
Net funding	**186,842**		**186,842**
Balance at 30 June 2022	**(30,040)**		**(30,040)**

Changes in taxpayers' equity for 2021-22	General fund £'000		Total reserves £'000 restated
Balance at 01 April 2021	(46,542)		(46,542)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	(46,542)		(46,542)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22			
Net operating costs for the financial year	(802,288)	*	(802,288)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(802,288)	*	(802,288)
Net funding	805,576		805,576
Balance at 31 March 2022	(43,254)	*	(43,254)

*** Refer to note 1.17**

The notes on pages 120 to 136 form part of this statement

Statement of Cash Flows for the 3 months ended 30 June 2022

	Note	2022-23 (3 months to 30 June) £'000		2021-22 £'000 restated
Cash Flows from Operating Activities				
Net operating expenditure for the financial year		**(173,628)**	*	(802,288)
Depreciation and amortisation	5	**68**		111
(Increase)/decrease in trade & other receivables	8	**1,521**		32
Increase/(decrease) in trade & other payables	10	**(11,980)**	*	(7,487)
Provisions utilised		**(123)**		(311)
Increase/(decrease) in provisions		**186**		660
Net Cash Inflow (Outflow) from Operating Activities		**(183,956)**		(809,283)
Cash Flows from Investing Activities				
Net Cash Inflow (Outflow) before Financing		**(183,956)**		(809,283)
Cash Flows from Financing Activities				
Grant in Aid Funding Received		**186,842**		805,576
Repayment of lease liabilities		**(62)**		0
Net Cash Inflow (Outflow) from Financing Activities		**186,780**		805,576
Net Increase (Decrease) in Cash & Cash Equivalents	9	**2,824**		(3,707)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(3,921)**		(214)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(1,097)**		(3,921)

*** Refer to note 1.17**

The notes on pages 120 to 136 form part of this statement

Notes to the financial statements

There has been a change to the reporting period for NHS West Essex CCG ('the CCG') in 2022 - 2023 due to the dissolution of the CCG on 30 June 2022. These accounts have therefore been prepared for the three Months to 30 June 2022 and as such the amounts presented in the financial statements are not comparable to the prior Year.

1 **Accounting Policies**

NHS England has directed that the financial statements of CCGs (CCGs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be 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.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the CCG is a going concern and the financial statements are prepared on the going concern basis.

Following the approval of the Health and Care Bill on 28 April 2022 NHS West Essex CCG (the CCG) was dissolved on 30 June 2022. Whilst the CCG as an entity ceased to exist on that date, the activities undertaken by the CCG will continue to be undertaken by Herts and West Essex Integrated Care Board. In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG should be prepared on a going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention.

1.3 **Joint arrangements**

Arrangements over which the CCG has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the CCG is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. Further information on Joint Arrangements is available in note 14.

1.4 **Operating Segments**

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

1.5 **Revenue**

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

• As per paragraph 121 of the Standard the CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The CCG is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

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

Payment terms are standard reflecting cross government principles. Significant terms include payment of invoices within 30 Days of receipt.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees.

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. 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 CCG commits itself to the retirement, The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Notes to the financial statements cont.

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 **Leases**

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

1.8.1 **The CCG as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise

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

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

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

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

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

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

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

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

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.8.2 **Services Received**

The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’.

1.9 **Cash & Cash Equivalents**

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

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

1.10 **Clinical Negligence Costs**

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

1.11 **Non-clinical Risk Pooling**

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

1.12 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the CCG 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 **Value Added Tax**

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

Notes to the financial statements cont.

1.14 **Critical accounting judgements in applying accounting policies**

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

Since 2015/16 the CCG has operated a Better Care Fund (BCF) together with Essex County Council under a section 75 agreement. This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. This conclusion has been reached as both parties retained the financial risks associated with each of the schemes as existed before the fund was set up.

1.15 **Key sources of estimation uncertainty**

In the application of the CCG's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.
The CCG is of the opinion that there are no key sources of estimation uncertainty that will materially affect these financial statements.
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
For the provision regarding Retrospective Continuing Healthcare claims (CHC) responsible commissioner debtors. As these cases span a number of prior years the CCG has been prudent in assuming there will be no recovery for these amounts.

Retrospective CHC, where a provision has been made based on the number of claims received. The provision is based on the probability that a liability to the CCG will crystalise during the next 12 Months for the 30 cases identified. The CCG has based this provision on an expected value of the maximum liability

The provision regarding GP Pensions is based on the probability that a liability to the CCG will crystalise during the next 12 Months, the CCG has based this provision on an expected value of the maximum liability.

The provision regarding building dilapidations is based on the probability that a liability to the CCG will crystalise during the next 12 Months, the CCG has based this provision on an expected value of the maximum liability.

1.16 **Adoption of new standards**

On 1 April 2022, the CCG adopted IFRS 16 ‘Leases’. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.
Under IFRS 16 the group will recognise a right-of-use asset representing the group’s right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.
In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The CCG has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.
IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.
The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value (less than £5,000).
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.
The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.
As of 1 April 2022, the group recognised £249k or right-of-use assets and lease liabilities of £249k. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an no impact to tax payers’ equity.

1.17 **Prior period adjustment**

During the audit of the 30 June 2022 financial statements it was identified that a number of accruals, which had been recorded as at 31 March 2022, had not resulted in the expected expenditure for the CCG taking place. This has resulted in a restatement of the accruals balance totalling £12.734m, as at 31 March 2022. The accruals related primarily to Memoranda of Understanding with NHS England, where the CCG had accrued for the potential return of allocated resources not spent by the end of the financial year, and situations where the CCG had accrued for budgeted expenditure which did not occur. Restated figures are as follows:

	Original 21/22 accounts	Movement	Revised 21/22 comparator
	£'000	£'000	£'000
SOFP and note 10 Trade and other payables	55,391	(12,734)	42,657
SoCNE Total net expenditure	815,022	(12,734)	802,288
Note 5 Total purchase of goods & services	808,152	(12,720)	795,432
Note 4 Staff costs	11,957	(14)	11,943
SOCITE	55,988	(12,734)	43,254
Note 16 Expenditure not to exceed income	821,167	(12,734)	808,433
Note 16 Revenue resource use does not exceed the amount specified in Direction	815,021	(12,734)	802,288

2 Other Operating Revenue

	2022-23 (3 months to 30 June) Total	2021-22 Total
	£'000	£'000
Other non contract revenue	**821**	6,146
Total Operating Income	**821**	6,146

3 Revenue

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.

Hertfordshire and West Essex Integrated Care System (ICS), formally known as Hertfordshire and West Essex Sustainability and Transformation Partnership (STP) do not have a legal status and are therefore not a statutory body. This means that they and their team need to be hosted by a statutory body, and from 1 April 2018 West Essex CCG became the host of the ICS (STP). £361k of the income above relates to the ICS (£5.783m in 2021-22).

4. Employee benefits and staff numbers

4.1.1 Employee benefits	Total Permanent Employees £'000	Other £'000		2022-23 (3 months to 30 June) Total £'000
Employee Benefits				
Salaries and wages	**2,220**	**75**		**2,295**
Social security costs	**280**	**0**		**280**
Employer Contributions to NHS Pension scheme	**393**	**0**		**393**
Other pension costs	**0**	**0**		**0**
Apprenticeship Levy	**8**	**0**		**8**
Gross employee benefits expenditure	**2901**	**75**		**2976**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**		**0**
Total - Net admin employee benefits including capitalised costs	**2901**	**75**		**2976**

4.1.1 Employee benefits	Total Permanent Employees £'000	Other £'000		2021-22 Total £'000
Employee Benefits				Restated
Salaries and wages	8,976	273	*	9,249
Social security costs	1,066	0		1,066
Employer Contributions to NHS Pension scheme	1,598	0		1,598
Other pension costs	1	0		1
Apprenticeship Levy	31	0		31
Gross employee benefits expenditure	11672	273	*	11945
Less recoveries in respect of employee benefits (note 4.1.2)	0	0		0
Total - Net admin employee benefits including capitalised costs	11672	273	*	11,945

*** Refer to note 1.17**

4.1.2 Recoveries in respect of employee benefits

The CCG had no recoveries in respect of employee benefits (nil in 2021-22)

4.2 Average number of people employed

	2022-23 (3 months to 30 June) Permanently employed Number	Other Number	Total Number	2021-22 Permanently employed Number	Other Number	Total Number
	166.50	**33.05**	**199.55**	159.39	19.37	178.76
Of the above:						
Number of whole time equivalent people engaged on capital projects	0	0	0	0	0	0

4.3 Exit packages agreed in the financial year

There were no exit packages paid the period (nil in 2021-22)
There were no departures where special severance payments were made (nil in 2021-22)

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	Notes	2022-23 (3 months to 30 June) Total £'000		2021-22 Total £'000 Restated
Purchase of goods and services				
Services from other CCGs and NHS England		**165**	*	377
Services from foundation trusts	(i)	**34,951**		138,307
Services from other NHS trusts		**93,420**		467,686
Services from Other WGA bodies		**0**		1
Purchase of healthcare from non-NHS bodies		**18,101**	*	79,344
Purchase of social care		**232**		884
Prescribing costs		**11,874**	*	44,314
GPMS/APMS and PCTMS		**11,361**	*	56,021
Supplies and services – clinical		**9**		43
Supplies and services – general		**298**	*	3,338
Consultancy services		**(122)**	*	545
Establishment		**291**	*	1,556
Transport		**149**		1
Premises		**221**	*	1,422
Audit fees	(ii)	**79**		90
Other non statutory audit expenditure				
· Other services	(iii)	**13**		0
Other professional fees		**22**		166
Legal fees		**25**		165
Education, training and conferences		**55**	*	1,172
Total Purchase of goods and services		**171,144**	*	795,432
Depreciation and impairment charges				
Depreciation		**68**		111
Total Depreciation and impairment charges		**68**		111
Provision expense				
Provisions		**186**		659
Total Provision expense		**186**		659
Other Operating Expenditure				
Chair and Non Executive Members		**75**		287
Expected credit loss on receivables		**(0)**		0
Total Other Operating Expenditure		**75**		287
Total operating expenditure		**171,472**	*	796,490

(i) Services from Foundation Trusts includes the sum of £7k for Internal Audit Fees (£21k in 2021-22)

(ii) Expenditure relates to external audit fee of £79k plus VAT of £16k. The liability for loss contained in this contract is limited to a maximum aggregate of £1m, claims must be made within 4 years.

(iii) The CCG was required to obtain external assurance over reported compliance with the requirements of the Mental Health Investment Standard. This work was carried out by BDO LLP, the fee was £13k plus VAT of £3k.

*** Refer to note 1.17**

6.1 Better Payment Practice Code

Measure of compliance	**2022-23 (3 months to 30 June) Number**	**2022-23 (3 months to 30 June) £'000**	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**3,271**	**41,696**	11,734	131,934
Total Non-NHS Trade Invoices paid within target	**3,222**	**41,238**	11,483	129,802
Percentage of Non-NHS Trade invoices paid within target	**98.50%**	**98.90%**	97.86%	98.38%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**396**	**137,801**	1,369	633,993
Total NHS Trade Invoices Paid within target	**391**	**137,570**	1,297	629,635
Percentage of NHS Trade Invoices paid within target	**98.74%**	**99.83%**	94.74%	99.31%

7 Leases

7a.1 Right-of-use assets

2022-23 (3 months to 30 June)	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2022	**0**	**0**
IFRS 16 Transition Adjustment	**249**	**249**
Cost/Valuation at 30 June 2022	**249**	**249**
Depreciation 01 April 2022	**0**	**0**
Charged during the year	**68**	**68**
Depreciation at 30 June 2022	**68**	**68**
Net Book Value at 30 June 2022	**181**	**181**

Revaluation Reserve Balance for right-of-use assets

There has been no revaluation of right-of-use assets.

7a.2 Lease liabilities

2022-23 (3 months to 30 June)	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Lease liabilities at 01 April 2022	**0**	0
IFRS 16 Transition Adjustment	**(249)**	0
Repayment of lease liabilities (including interest)	**62**	0
Lease liabilities at 30 June 2022	**(187)**	0

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

	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Within one year	**(187)**	0
Balance at 30 June 2022	**(187)**	0
Included in:		
Current lease liabilities	**(187)**	0
Balance at 30 June 2022	**(187)**	0

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

2022-23 (3 months to 30 June)	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Depreciation expense on right-of-use assets	**68**	0
Interest expense on lease liabilities	**0**	0

7a.5 Amounts recognised in Statement of Cash Flows

	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Total cash outflow on leases under IFRS 16	**62**	0

The Lease detailed above relates to CCG Headquarters building, the building is owned and maintained by NHS Property Services Ltd

8 Trade and other receivables	**Current 2022-23 (3 months to 30 June) £'000**	Current 2021-22 £'000
NHS receivables: Revenue	**1,233**	2,905
NHS prepayments	**123**	0
NHS accrued income	**333**	546
Non-NHS and Other WGA receivables: Revenue	**134**	231
Non-NHS and Other WGA prepayments	**820**	615
Non-NHS and Other WGA accrued income	**44**	0
Expected credit loss allowance-receivables	**(2)**	(3)
VAT	**180**	93
Other receivables and accruals	**5**	3
Total Trade & other receivables	**2,870**	4,391
Included above:		
Prepaid pensions contributions	0	

8.1 Receivables past their due date but not impaired

	2022-23 (3 months to 30 June) DHSC Group Bodies £'000	**2022-23 (3 months to 30 June) Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	**621**	**13**	127	30
By three to six months	**0**	**2**	0	5
By more than six months	**0**	**24**	0	19
Total	**621**	**39**	127	54

8.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	**Total £'000**
Balance at 30 June 2022	**(3)**	**(3)**
Total	**-**	**(3)**

There has been no material change in loss allowance.

9 Cash and cash equivalents

	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Balance at 1 April	**(3,921)**	(214)
Net change in year	**2,824**	(3,707)
Balance at 30 June	**(1,097)**	(3,921)
Made up of:		
Cash with the Government Banking Service	**(1,098)**	(3,922)
Cash in hand	**1**	1
Cash and cash equivalents as in statement of financial position	**(1,097)**	(3,921)

The CCG holds no Patients' money (nil in 2021-22)

The negative balance in Government Banking Service is due to a timing issue relating to committed BACs payments of £1,868k due to clear between 1st and 5th July 2022.
Cash was drawn down from the Department of Health on 1st July 2022 which offset this. The actual Cash at Bank figure as at 30 June 2022 was £850k.

10 Trade and other payables	**Current 2022-23 (3 months to 30 June) £'000**		Current 2021-22 £'000 restated
NHS payables: Revenue	**803**		4,957
NHS accruals	**3,768**		1,778
Non-NHS and Other WGA payables: Revenue	**4,321**	*	11,069
Non-NHS and Other WGA accruals	**16,567**	*	18,944
Social security costs	**163**		149
Tax	**139**		151
Other payables and accruals	**4,916**	*	5,609
Total Trade & Other Payables	**30,677**	*	42,657

There are no non Non-Current payables

Other payables include £446k outstanding pension contributions at 30 June 2022, also included here are payables relating to Autism Spectrum Disorder Assesments, ageing well and eating disorder support projects and staff support projects.

*** Refer to note 1.17**

11 Financial instruments

11.1 Financial risk management

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

Because NHS West Essex CCG 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 CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities.

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

11.1.4 Liquidity risk

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

11.1.5 Financial Instruments

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

11 Financial instruments cont'd

11.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 (3 months to 30 June) £'000	**Total 2022-23 (3 months to 30 £'000**
Trade and other receivables with NHSE bodies	**1,120**	**1,120**
Trade and other receivables with other DHSC group bodies	**490**	**490**
Trade and other receivables with external bodies	**139**	**139**
Cash and cash equivalents	**(1,097)**	**(1,097)**
Total at 30 June 2022	**652**	**652**

	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	3,038	3,038
Trade and other receivables with other DHSC group bodies	435	435
Trade and other receivables with external bodies	212	212
Cash and cash equivalents	(3,922)	(3,922)
Total at 31 March 2022	(237)	(237)

11.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 (3 months to 30 June) £'000	**Total 2022-23 (3 months to 30 £'000**
Trade and other payables with NHSE bodies	**1,317**	**1,317**
Trade and other payables with other DHSC group bodies	**3,459**	**3,459**
Trade and other payables with external bodies	**25,785**	**25,785**
Total at 30 June 2022	**30,561**	**30,561**

	Financial Liabilities measured at amortised cost 2021-22 £'000 restated		Total 2021-22 £'000 restated
Trade and other payables with NHSE bodies	3,796		3,796
Trade and other payables with other DHSC group bodies	3,164		3,164
Trade and other payables with external bodies	35,397	*	35,397
Total at 31 March 2022	42,357	*	42,357

*** Refer to note 1.17**

12 Operating segments

The CCG and consolidated group consider they have only one segment:- commissioning of healthcare services

		2022-23 £'000
Gross expenditure		**174,449**
Income		**(821)**
Net Expenditure		**173,628**
Total Assets		**1,957**
Total liabilities		**(31,996)**
Net Liabilities		**(30,039)**

		2021-22 restated £'000
Gross expenditure	*	808,434
Income		(6,146)
Net Expenditure	*	802,288
Total Assets		472
Total liabilities	*	(43,726)
Net Liabilities	*	(43,254)

*** Refer to note 1.17**

13 Joint arrangements - interests in joint operations

The clinical commissioning group was not party to any joint operations during the three months to 30 June 2022 and for 2021-22.

Better Care Fund

Since 2015-16 the CCG has operated a Better Care Fund (BCF) together with Essex County Council under a section 75 agreement. This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. This conclusion has been reached as both parties retained the financial risks associated with each of the schemes as existed before the the fund was set up. The CCG's expenditure on BCF in 2022-23 was £5.904m (£22.463m in 2021-22). The arrangements for each scheme within the Better Care Fund have been reviewed to determine the appropriate accounting treatment by the CCG and Essex County Council. Control of the commissioning arrangements has been key to determining the nature of each scheme within the fund.

Where Essex County Council has been identified as Lead Commissioner or Principal the accounting treatment has been for the transaction with the County Council to be recorded within Non NHS Healthcare £2.288m (£8.724m in 2021-22). Where the CCG has control over the commissioning of the service the transactions with the individual provider(s) are recorded in the relevant expenditure categories £3.616m (£13.738m in 2021-22).

14 Related party transactions

2022-23
The Transactions listed below are in relation to interests declared by the governing Body members (excluding transactions with practices, Department of Health bodies and other Government Departments)

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Stellar Healthcare	156	(9)	0	0
Uttlesford Health Ltd	86	(9)	0	(9)
Stroke Association	12	0	0	0

The transactions listed below are in relation to those practices where one of the GP's of that practice is or has been a member of NHS West Essex CCG's Governing Body during 2022-23

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
The Ross practice (Dr R Gerlis, CCG chair)	51	0	44	0
Moss CE & partners (DR C Moss, medical Director)	3	0	3	0
Newport surgery (Dr Jen West)	110	0	52	0
Old Harlow health centre (Dr Amik Aneja)	129	0	36	0
Stansted surgery (Dr Angus Henderson)	125	0	49	0
Maynard Court (Dr Ian Perry)	46	0	39	0
Kings Medical Centre (Dr Shawarna Lasker)	144	0	43	0

The CCG also had transactions with the following GP Practices

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Abridge surgery	13	0	9	0
Addison house surgery	84	0	81	0
Angel Lane surgery	35	0	32	0
Chigwell medical centre	34	0	33	0
Church Langley medical centre	36	0	35	0
Crocus practice (Previously Rectory practice)	79	0	73	0
Elsenham surgery	24	0	23	0
Forest practice	62	0	50	0
Hamilton practice	43	0	42	0
Eden surgery Hatfield Heath	44	0	38	0
High Road Loughton	46	0	41	0
High Street surgery	23	0	17	0
John Tasker house	59	0	49	0
The Limes medical centre	142	0	128	0
Lister house	175	0	67	0
Loughton health centre	30	0	28	0
Market Square surgery	152	0	52	0
Nuffield House	50	0	44	0
Ongar health centre	85	0	62	0
Sydenham House	10	0	9	0
Taylor & Briggs surgery	10	0	8	0
Thaxted surgery	95	0	90	0
Gold Street surgery	68	0	56	0

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions (over £5m) with entities for which the Department is regarded as the parent organisation. These entities are:

The Princess Alexandra Hospital NHS Trust
Barts Health NHS Trust
Essex Partnership University NHS Foundation Trust
Cambridge University Hospital NHS Foundation Trust
East of England Ambulance Service NHS Trust
Mid & South Essex NHS Foundation Trust
Barking, Havering & Redbridge University Hospitals NHS Trust
East & North Herts NHS Trust
Hertfordshire Community NHS Trust
West Hertfordshire Hospitals NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
North East London NHS Foundation Trust

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Essex County Council, Harlow District Council, Epping Forest District Council and Herts county Council HM Treasury considers government departments and their agencies, and Department of Health and Social Care Ministers, their close families and entities controlled or influenced by them, as being parties related to DHSC group bodies, there have been no transactions with any of these bodies or entities during 2022/23.

15 Events after the end of the reporting period

On 28 April 2022 the Health and Care Bill was approved by Parliament. The Health and Care Bill approved the formation of Integrated Care Boards (ICBs) and for them to take over the functions of CCGs. As a result NHS West Essex CCG was dissolved on 30 June 2022 and Herts and West Essex ICB was formed from the following day. In line with the provisions of the Group Accounting Manual, the assets and liabilities of the CCG was transfer to the newly formed ICB at book value.

16 Financial performance targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).
The NHS West Essex Clinical Commissioning Group performance against those duties was as follows:

	2022-23 (3 months to 30 June)	**2022-23 (3 months to 30 June)**	**2022-23 (3 months to 30 June)**	2021-22	2021-22 restated	2021-22
	Target	**Performance**	**Duty achieved?**	Target	Performance	Duty achieved?
Expenditure not to exceed income	**175,851**	**174,449**	**Yes**	831,169 *	808,433	Yes
Revenue resource use does not exceed the amount specified in Directions	**175,030**	**173,628**	**Yes**	825,023 *	802,288	Yes
Revenue administration resource use does not exceed the amount specified in Directions	**1,582**	**1,417**	**Yes**	6,274	6,182	Yes

*** Refer to note 1.17**