NHS
West Essex
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS

2021/22

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Dr Jane Halpin,
Accountable Officer

PERFORMANCE REPORT

PERFORMANCE REPORT: OVERVIEW OF PERFORMANCE

This section contains a summary of our performance as an organisation during 2021/22 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 in public 9 times during 2021/22. 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 2022/23.

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.

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

TYPES OF COMISSIONING

West Essex CCG buys services from organisations which provide patient care, including GPs, NHS hospitals, mental health and community trusts, voluntary organisations and independent organisations. We also fund the cost of medicines and treatments prescribed by GPs and nurse prescribers.

In 2021/22, we commissioned services in the following ways:

- as ***lead commissioner***, where we procure services on behalf of other CCGs. For example, we are the lead commissioner for the Princess Alexandra Hospital NHS Trust.

- as the ***co-ordinating commissioner***, where our CCG has the biggest share of activity and holds the contract, allowing other commissioners to be associates to the contract. Examples of this include Essex Partnership University NHS Foundation Trust, Ramsay Rivers Hospital and British Oxygen Company

- as an ***associate commissioner***, where another commissioner has the biggest share of activity and holds the contract, examples of this include contracts with Barts Health NHS Trust and East of England Ambulance Service NHS Trust

- as a ***joint commissioner***, where funding is pooled with partners and services are commissioned using that combined budget. Examples include mental health and learning disability services, where funding is pooled with Essex County Council (ECC) and other Essex based CCGs to commission care, mainly from Essex Partnership University NHS Foundation Trust and from ECC's adult social services. We also jointly commission services from community and voluntary sector organisations with Essex County Council.

- as a ***delegated commissioner***, where we assume full day-to-day responsibility for commissioning general practice services, although the legal responsibility remains with the national organisation NHS England and Improvement (NHS E/I). NHS E/I also commissions specialised services and services provided by dentists, pharmacists and optometrists. The CCG has a duty to assist and support NHS E/I to carry out these functions and secure continuous improvement in the quality of primary medical services.

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.

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 spent more than £5m in 2021/22 – 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 in 2021/22 can be found from page 89.

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 SUMMARY AND ANALYSIS OF KEY PERFORMANCE

At the time this report is published, in the summer of 2022, almost two and a half years have passed since the COVID pandemic changed all our lives and the delivery of healthcare across the world. I would like to once again put on record my heartfelt thanks and appreciation to all the dedicated staff who work in health and social care, both in our system and beyond, as well as the hardworking volunteers and partners who have given up their time to support the NHS this year and help us recover and restore our services.

The year 2021/22 in Hertfordshire and west Essex has been one of careful balances and compromises. We have continued to manage the direct and indirect impact the COVID pandemic is placing on our staff and the care they provide, while putting additional effort and resource into catching up following the necessary pause in routine, non-urgent care which happened at the peak of the first wave.

Like other areas of the country, this catch up will take some time, but we have made good progress in Hertfordshire and west Essex thanks to the combined efforts of colleagues from across primary care, hospitals and our community and mental health teams. You will read more in this report about some of the initiatives that have been introduced to ensure people receive the care they need as quickly as possible, in the place that is best suited and feel supported while they wait for their treatment to begin.

The continuing impact of the pandemic has inevitably affected the performance of our health system against some of the key national standards. As is usual in our annual report, you will be able to read more about how our hospitals have performed and the particular challenges facing them in each target area. Further details can be found from page 41.

Transition to an Integrated Care Board (ICB)

This year the three clinical commissioning groups in Hertfordshire and west Essex – West Essex CCG, Herts Valleys CCG and East and North Hertfordshire CCG have also been carefully preparing for the transition to becoming an Integrated Care Board (ICB) and the establishment of our Integrated Care System on a statutory footing. 2021/22 is our final full year of operation with the new ICB assuming responsibilities from the CCGs on 1 July 2022, following a nationally agreed three-month delay to the implementation date.

We have been delivering on the governance requirements of the 'Readiness to operate' statement including preparing and consulting upon our constitution and the make up of our Board. It is our intention that the voices of people and communities are heard at every level

in our new organisation. Following my confirmation as chief executive designate for the ICB and that of our independent chair we have appointed to a number of our executive roles and our non-executive directors.

We have also dedicated significant time and resource to supporting our staff through change. Through our HR and organisational development teams we have introduced a programme of listening events, enabling staff to ask questions and ensure that the excellent work that is happening in our CCGs is not lost during the transition. We have also worked hard to keep the channels of dialogue and communication open with our staff, through fortnightly chief executive briefings and weekly written updates. I would like to acknowledge the support I have received from my executive team colleagues to make this happen so successfully.

Caring for our staff

As well as supporting our directly employed staff to navigate their way through the changes to organisational structures, a key priority has been to support all health and care staff to look after their health and wellbeing as the pressure of the pandemic continues to affect their working lives.

The system continues to prioritise and protect those that are most vulnerable within our workforce. A co-ordinated approach to risk assessments for our Black, Asian and ethnic minority workforce was put in place in the spring based on the effects of COVID on those populations. The Hertfordshire and West Essex Health and Care People Plan was developed this year, aligned to the four key pillars of the national NHS People Plan. A detailed analysis of recruitment and retention of nursing, health care support worker and care support worker roles is being undertaken to ensure that we have the skills we need locally and can attract the best candidates to care for people in new and innovative ways.

Delivering services differently

There are many examples of innovation taking place in our services locally. Our system's deployment of technology in health care has accelerated over the course of the pandemic. Our 'Consultant Connect' app is bringing specialist advice and guidance into primary care in real time with GPs able to connect with a consultant in less than a minute. The app is helping to reduce the number of people referred to our hospitals' busy Emergency Departments meaning that patients get swift, expert reassurance straight away, helping to avoid stress and worry and consultants can spend more time seeing the patients who really need a face-to-face appointment.

A new 'Shared Care Record' has also started rolling out in Hertfordshire and west Essex to increase the information available to support joined-up direct care. The aim of the Shared Care Record is to allow health and care professionals access to a real-time summary of information from within a patient record. This information is used safely and securely to support patients as they move between different parts of the NHS and social care. GP practices are in the first phase of roll-out along with Princess Alexandra Hospital and our provider of NHS111 services and the two community providers that work across the county. Usage of the shared system is rapidly increasing with more than 1,000 clinicians accessing a record in February 2022. Over the next 12-18 months, more providers will be connected in stages including mental health providers, acute trusts, and local authorities within the ICS. We will also be able to connect to similar systems in neighbouring areas, for example hospital trusts in London.

Our hospitals have also continued with ways of working that have proved successful earlier in the pandemic, for example, carrying out virtual or telephone consultations for some outpatient clinics. Face to face appointments are carefully scheduled to allow for safe social distancing and to meet the requirements of strict infection control and COVID prevention procedures which remain in place across all our healthcare facilities.
This year has also brought welcomed new treatments for COVID-19 with hundreds of people most at risk of becoming seriously ill from the virus benefiting from their use.

The antibody and antiviral treatments are being offered to high-risk patients who have tested positive for the virus, to reduce the chances of them needing hospital care. Our hospital trusts began to treat patients in September 2021, and since December this has been expanded to those in the community. Eligible patients have received a letter from the NHS explaining who they should contact if they test positive for Covid-19, so that they can rapidly access the treatment they need.

In some cases this means taking an antiviral medicine at home, while for other patients they are asked to come into hospital for an infusion of monoclonal antibodies – which have been proven to lessen the chances of them being admitted to hospital due to COVID-19.

This is an important milestone in helping people who are particularly at risk of being seriously ill with COVID-19 and it's encouraging that despite all of the current pressures in the health system, our clinical and operational teams have been able to set up this new service very quickly. It's possible that more patient groups will be eligible for treatments of this sort in future.

Protecting and supporting vulnerable communities

Tackling health inequalities has been a key focus for this year. The COVID pandemic has exposed how health inequalities can affect people not just over a lifetime but in a matter of weeks. This calls for community-wide action and we have been working with the voluntary and community sector and local authorities to support our most vulnerable residents through what has been a difficult period.

The ICS led a bid for NHS Charities (Captain Tom) funding which has paid for community groups reaching out to Black, Asian and minority ethnic communities and providing technology and training to the 'digitally excluded'. Thanks to the support of the voluntary sector we now have volunteers calling people on hospital waiting hospital lists to check on their wellbeing and volunteers supporting over 65s leaving hospital, to make sure they have the practical help and support they need to allow them to go home.

There are now more than 100 social prescribing link workers embedded in GP practices across the ICS, affiliated with HertsHelp and Frontline, who are helping people to tap into the amazing range of support available in our communities.

Additional funding has also been provided to support other recovery initiatives across the voluntary and community sector. This includes the 250 COVID Information Champions expanding their role to 'Community Champions' for the longer term. These champions have been a vital cascade of important information and have actively targeted thousands of residents with weekly key messages, using social media, emails, leaflets and face to face sessions. Resources and messages continue to be available in different languages and formats for sharing to help target all communities. Volunteers have also been delivering pulse oximeters, to enable people to monitor their own blood oxygen levels at home if they test positive for COVID.

COVID vaccinations

In December 2021, we marked the first anniversary of the COVID vaccination rollout. The scale of delivering an immunisation programme as vast as this on this unprecedented scale should not be underestimated and it is thanks to the dedication of many hundreds of NHS staff and volunteers that more than 3 million vaccinations have been given in Hertfordshire and west Essex alone. This has saved lives, protected residents from severe illness, and spared many thousands of families from the distress and disruption that COVID can bring.

The co-ordination of the vaccination programme has required quick thinking, flexibility and determination in order to rapidly respond to the demands that new variants and changes in

Joint Committee on Vaccination and Immunisation[1] (JCVI) guidance have made on the delivery model. This year our vaccinations teams in the CCGs, community trusts, GP practices and hospitals have offered vaccinations to all adults and children over the age of 12 and are currently protecting those 5-11 year olds who are vulnerable because of their health condition or the condition of someone they live with. The model has adapted from booked appointments for eligible cohorts to walk-in sessions for everyone and the logistics of this have been managed smoothly by staff. The reaction of our teams to the overnight expansion of the COVID booster programme is to be commended and has no doubt protected many people from serious effects of the Omicron variant. Our residents have responded remarkably to the vaccination programme and I would thank every individual for coming forward to protect themselves.

We're now vaccinating a wider range of people in more venues than ever before. From schoolchildren to great-grandparents, in schools, football stadiums, shopping centres, council offices, GP surgeries and pharmacies – the campaign rolls on. But it is our more targeted outreach work that I would like to draw attention to here.

Our area's vaccination teams have focused on bringing vaccination opportunities directly into the heart of vulnerable communities. They have visited homeless shelters, women's refuges and have 'popped up' at community halls and shopping centres to reach people who may not usually engage with health services. Run in partnership with community leaders, including the Afro GP Herts and Beds group, vaccination sessions have been held in churches, a Hindu temple and mosques. Faith leaders have also visited Gypsy and Traveller communities to encourage them to get their vaccine and talk to them about other pastoral matters.

Slower-paced 'relax and vax' clinics for teenagers worried about getting the vaccine have also been offered during the recent half term holiday.

The teams have built strong relationships within the local community among people who were initially extremely reluctant to engage with the vaccine programme. By arranging local pop-up clinics with interpreters, providing translated materials and communicating through trusted community and business leaders, there's been a positive response to vaccine uptake. Many people have also registered with a local GP for the first time.

This outreach work may be small in scale but is making a big impact for people not able to access their vaccine in the usual places – of which there are more than 50 operating across Herts and west Essex.

This year we have also dedicated efforts to supporting those who are pregnant to have their vaccination following a change to the guidance. Expert online panels were convened

[1] This is the committee that advises UK health departments on immunisation

to answer public questions on fertility, pregnancy and breastfeeding and our Local Maternity and Neonatal Network has tirelessly promoted the benefits of having the vaccination to the parents they engage with.

Pressures and challenges facing our system

Primary, hospital and community services have remained under sustained pressure this year as the delivery of routine, elective services accelerates and the staffing shortages caused by COVID infection and isolation continues to impact across the board. This winter our system, like others across the country, has experienced increased activity in emergency departments, through our NHS 111 service and in primary care. Our mitigations, which I will go on to describe in more detail shortly, have enabled us to weather much of the storm, however for the first time our system has been planning a number of 'in extremis' measures for our urgent and emergency care services that we would hope never to need to implement.

As is usually the case during winter, our hospitals have been planning how they might rapidly increase their critical care capacity if required to do so. This surge planning is supported by the CCGs who also ensure that hospitals are able to work together to manage ambulances arriving at emergency departments when a particular acute trust is under immense pressure. We work closely with the region's ambulance service to drive up performance. You can read more about this in the detailed performance information from page 41.

This year, the NHS 111 service began booking people into timed appointment slots at emergency departments and urgent care centres, in order to try and better manage demand. The public have been asked to 'Think NHS111 First' before making their own way to an emergency department. Primary care and hospital services have seen an increase in severe respiratory illness in children and babies this year.

While respiratory infections are common in children, last winter saw many fewer infections in younger people due to the impact of COVID-19 restrictions, which limited people's opportunities to socialise. Many children and babies will not have been exposed to viruses to develop their immunity and may be at higher risk of severe illness which has driven some of the increased use of NHS urgent care services by parents of young children this year.

Managing waiting lists for routine care

At the time this report is published, the current planning guidance – which sets out national NHS priorities for local systems to deliver - has set an ambitious goal that in order to reduce waiting times for patients, around 30% more planned routine activity will take place by

2024/25 than was being delivered pre-pandemic.

The ICS has played a key role in helping patients to have their treatment as soon as possible by using shared data to oversee clinical prioritisation of patients waiting for treatment. Particular attention is being paid to those who are our longest waiters with CCGs' quality teams meeting regularly with our hospital trusts to ensure that risks of clinical harm and kept to a minimum and are managed. Additional capital funding has been made available to our system to develop surgical hubs to increase bed capacity and to further separate planned from emergency activity to minimise disruption to routine surgery lists.

Ensuring people have tests and receive a diagnosis in a timely way is a key support to this programme of work and also to improving care for diseases like cancer. Our performance on diagnosing cancer has been impacted by the pandemic and we are working hard to improve care along the whole pathway. Encouraging people to come forward for cancer screening is an important part of our health promotion and prevention work, with examples of how promotion to patients can improve uptake being seen in West Essex CCG's cervical screening campaign.

To help as many patients have the diagnostic tests they need as quickly as possible, we have increased opening hours into the evening and at weekends and used mobile scanning units and spare capacity in other centres to help see more patients.

The ICS has worked with our hospital providers to introduce patient initiated follow ups (PIFU). This gives patients greater control over their hospital follow-up care and to initiate their own appointments with a specialist as and when they need them, rather than them taking place at set times after a procedure when they might not be needed. Patients may want to make a follow up appointment if they have a flare up of their symptoms or change in their circumstances. This helps avoid unnecessary routine appointments and frees up consultants to see more patients and help drive waiting lists down.

Mental health recovery

With the demand for mental health services increasing since the start of the pandemic, services in Essex are seeing people present with conditions which are more acute and complex than before, with a proportionate effect on the length of time people then need to spend receiving treatment, whether this is in the community or in a mental health inpatient facility.

Mental health service providers across the local health and care system have worked together to better understand this demand and to invest in additional capacity. As a result, waiting times for mental health services in Essex are generally in line with or better than

current national averages, including almost all referrals for 'talking therapies' starting their treatment within six weeks.

The ICS submitted a bid to NHS E/I and Improvement to enhance adult community mental health services over the next three years. We will build on the work we've already done to ensure there is no 'wrong front door 'to access care, to provide a full range of appropriate services for those severe mental health needs and develop integrated and personalised care and support plans.

Key investments and developments include:

- More investment in and expansion of early intervention services
- Introducing Mental Health Support Teams in schools
- A new 24-hour crisis support service
- Identifying people at risk of an eating disorder earlier and increasing capacity to treat them
- An extra £7million to reduce waiting times in primary and community mental health services

Areas where we continue to focus our efforts to improve include routine referrals for adult services and the Early Memory Diagnosis and Support Service, both of which have has significant staffing challenges because of COVID absences.

In child and adolescent mental health services (CAMHS) we have seen a 40% increase in referrals to the community eating disorder service and there are also pressures on routine referrals, where some young people are waiting longer than 28 days to be seen.

Waiting times for Autism Spectrum Disorder (ASD) diagnosis for children and young people are high across the country. We have made additional investment of £3million which is expected to significantly reduce the numbers by October this year. A new pathway is also being developed supported by more money to maintain shorter waiting times in future.

Improving access to primary care

Getting help from a GP remains high on the public's list of priorities and work is continuing to support general practice to deliver safe, effective and good quality care. GP practices are facing unprecedented demands for their services and are continuing to adjust how clinicians' time can be best used to support patients – particularly those who need to see a healthcare professional the most.

Practices have remained open throughout the pandemic, offering patients telephone and online appointments, with face to face consultations available for those who need them.

This was in line with national requirements to keep patients safe, whilst COVID infection rates were high and before the vaccination programme was widespread. Practices have continued to manage their patients' care alongside delivering the COVID vaccination programme.

During the pandemic, the use of online GP systems such as 'eConsult' increased, as they offer a convenient way to contact a practice without waiting on the phone. These systems are a great way for people who are online to approach a GP surgery to get advice or arrange to speak to a clinician. However, it is worth remembering that each consultation takes time to review and there are lots of other ways for patients to get advice.

In early 2022, the three CCGs and NHS E/I and Improvement funded 238,000 extra appointments until the end of March across the 135 GP practices in our area. These appointments were offered in usual practice operating hours, in extended hours services as well as in the respiratory hubs which are set up to safely care for patients with COVID. All GP practices have also received a supportive visit from the CCG to help resolve problems and share best practices. Work is also underway to improve GP practice phone access across the ICS, as out of date telephone systems is often a cause of frustration for patients and practice staff alike.

Conclusion

I would like to end by noting my thanks to the entire NHS and social care workforce who have delivered what is needed in the context of continued pressure and public expectation. As we look forward into the next year, where the structural changes we have planning for some years will come to fruition, I know our staff will remain focused on improving the health and wellbeing of our residents and will seize the tremendous opportunities that will come from closer integration of our health and care system.

THE CCG'S WORK IN 2021/22

The projects on the following pages are some examples of the work we have undertaken to improve patient care over the past twelve 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.

This population size is recommended so that Primary Care Networks remain small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale that come through better collaboration.

While GP practices have been finding different ways of working together over many years, the NHS Long Term Plan and the new five-year framework for the GP contract, published in January 2019, put a more formal structure around this way of working.

Primary care networks (PCNs) will eventually be required to deliver a set of seven national service specifications. Three started in 2020/21: structured medication reviews, enhanced health in care homes, and supporting early cancer diagnosis. During 2021/22 two further services were introduced; PCNs are required to improve cardiovascular disease case-finding and to tackle neighbourhood health inequalities, codesigning an intervention with the population. There are further planned additions of two new PCN services during 2022/23- anticipatory care (with community services) and personalised care.

Each PCN will also have its own list of priorities for their population, and they may deliver care in a slightly different way.

Although primary care networks will be delivering services, primary care networks 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 and Restoration

In line with the emergency response to COVID-19 pandemic, NHS E/I declared incident level 4 for health which includes general practice and all health providers within the NHS to respond accordingly.

The CCG, working with all partners in the Hertfordshire and west Essex health and care system has worked throughout the pandemic to respond to the needs of the pandemic; maximising patient safety and service provision ensuring continued delivery of priority of care. This included stepping down a number of clinical services and redeploying staff to all areas of where the need has been greatest at any point in time.

Throughout the pandemic, even at the peak of infection rates the most important care and services have always remained available, for example ensuring that patients with signs and symptoms of serious illness, with learning disabilities and those with complex or unstable long-term conditions can access the care that they require. Recovery of cervical screening in primary care after the first wave was a priority and very quick progress was made back towards near pre-pandemic rates. In relation to urgent and two week wait cancer referrals, referral data confirms that general practice has continued to assess and refer patients with suspected cancer in line with the two week wait pathway, although it should be noted that waiting times targets within our local hospitals have been impacted by the pandemic.

The underlying principles to restoration in primary care include:

- Delivering access to safe, high quality and effective services
- Capturing and building on the innovation and transformation
- Step change to delivering population health through co-design/co-producing with patients and stakeholders primary care with a view to reducing inequalities and reshaping to a community led recovery with the community/volunteering as an asset
- Embedding and accelerating digital change including rapid evaluation, co-design tools with involvement of health and care staff and patients and public whilst preventing digital exclusion
- Putting the whole primary care workforce at the centre stage through recovery, recruitment, retention supported by the estates and digital infrastructure
- Continuous engagement, involvement and communicating with patients and stakeholders
- Build financially sustainable systems; maximising the efficient use of resources to deliver affordable, high quality, outcomes focussed care

The restoration of priority routine services has remained a key objective during the year, however these efforts have been punctuated by fluctuations in the pandemic and demands of the vaccination programme; in December 2021 NHS E/I once again, of necessity, instructed GP practices to focus their efforts on the vaccination programme, in order to accelerate coverage and ensure the highest levels of protection across local population.

The need to care for those unwell with Covid-19 whilst simultaneously delivering a vaccination programme on an unprecedented scale and continuing to deliver as much routine patient care as possible has been a huge challenge for the health and social care system; our primary care services have been nothing short of amazing, testimony to the outstanding individuals that work in our GP practices, both clinicians and the management and clerical staff.

During 2021/22 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. Total triage has continued to be important in reducing avoidable footfall in practices and protect patients and staff from the risks of infection. 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 pandemic has catalysed digital transformation in primary care services. The requirement to deliver patient care differently limiting face-to-face contact due to the risk of COVID has seen a huge expansion in the use of telephone consultations and offering consultations via video has become commonplace. Loss of clinical workforce through self-isolation requirements has been a major challenge in terms of maintaining service delivery for patients, to support home working and remote patient consultations we have rolled out significant amounts of additional IT equipment and virtual desktop interfaces and also ensure the necessary licenses are in place for patient health questionnaires and video consultation technology. We worked closely with our GP practices to review and enact (when faced with loss of workforce) their business continuity plans, including the ability to receive mutual aid from a 'buddy' practice to ensure patient care and safety was maintained.

This has significantly reduced footfall physically within practices who were all supported to introduce robust infection prevention and control measures. Practices found ways to maintain services for patients whilst keeping them safe and reducing the risk of spreading infection.

Face-to-face appointments have remained available for patients throughout the pandemic whenever clinically required. Recent information suggests that local GP practices are providing (on average) at least 50% of all appointments face-to-face and many are offering a choice of appointment type. Many of our local practices have found that a large cohort (in some cases the majority) of their patients actually prefer a remote consultation to a face-to-face appointment and request this.

We have supported general practice at all stages in the pandemic with the review of service provision arrangements and ensure that access for patients has kept pace with the status of the pandemic, however whilst there have been significant changes to wider societal restrictions (and the NHS E/II Standard Operating Procedure was withdrawn on 19th July 2021) there remains a national instruction for practices to continue to offer a blended approach of face-to-face and remote appointments with digital triage where possible and the national Infection, Prevention and Control guidance for healthcare settings has remained in place largely unchanged. We know that this apparent discrepancy has created confusion for patients and in a small number of instances has led to practice staff being subjected to abusive behaviour. We have worked very hard to ensure that we provide accurate and timely information to ensure that patients are always well-informed and know what to expect from their GP practice. We thank the vast majority of people, for their patience and understanding, always treating staff in their GP practice with kindness and respect.

Use of the Electronic Prescription Service (EPS) has been implemented across national health services over the last few years. However, during the covid pandemic, patients were encouraged to nominate a pharmacy so that they could have their medication delivered from their local pharmacy to their home or available to collect as appropriate.

In December 2021 NHS E/I launched a programme to improve access to GP services underpinned by additional funding. The Hertfordshire and West Essex ICS recognised that the pandemic has affected all practices and therefore established a programme of practice visits. The majority of these visits have now been completed and they have proved hugely valuable in understanding some of the practice specific challenges in terms of patients being able to make contact and obtain an appointment that meets their needs – such as physical premises space and telephony systems. Critically we have, in many instances, been able to identify potential improvement action that can be taken to address such barriers and our Primary Care Teams are in the process of working with our practices on these initiatives.

The overall demand on primary care services has risen substantially as patients present with concerns that they haven't addressed during the pandemic, long-term conditions requiring monitoring and stabilization, help whilst waiting on hospital waiting lists for surgical procedures and of course presenting for Covid vaccination.

This increased demand is also reflected in GP appointment data collected by NHS Digital[2], the total number of appointments attended across Hertfordshire and West Essex in November 2021 rose to 656,553 an increase of 102,178 compared to November 2019 representing an overall 18% increase. The West Essex increase was 24,560 (22%)

[2] Appointments in General Practice - NHS Digital

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. The total number of appointments available are detailed below by CCG per month but also gives the committee the expected appointments over the coming winter to support patients in the community.

Appointment data[3] published by NHS Digital during the year indicates that nearly half of all appointments were provided on the day that they were requested and that 85% of appointments were offered within 14 days. 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.

The Hertfordshire and West Essex ICS 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.

Winter Access Fund Programme

On 14 October 2021 NHS E/I launched "*Our plan for improving access for patients and supporting general practice*" making available £250 million to support primary care and same day urgent care during the challenging winter period. The allocation available for the Hertfordshire and West Essex ICS was £6.16m for the five months November 2021 to March 2022. £0.81m of this was allocated to West Essex CCG.

The two main uses of the fund are to:

Drive improved access to urgent, same day primary care ideally from patients own general practice service, by increasing capacity in GP practice or PCN level or in combination.

Increase resilience of NHS urgent care system during winter by expanding same day urgent care capacity.

In line with the guiding principles for restoration in primary care and the plans underway to improve access, the ICS plan submitted to NHS E/I following engagement with the LMC,

[3] **NHS Digital GP Appointment data**

primary care and clinical leads included: additional on the day capacity; accelerating training for the Community Pharmacy Consultation Service; supporting communications and engagement; advanced telephony and piloting in-hours triage.

In addition, all West Essex CCG GP practices were supported through tailored practice visits which were completed by March 2022. The aim of the practice visits was to have practice owned access plan which will include actions for practices to improve or sign post them to the appropriate resource such as:

- support on recruitment for all staff through Primary Care Careers
- short term estates support
- maximising the use of online consultations and opportunities to integrate within the practice model
- access to training especially telephone consultation for admin staff
- reinvigorating PPGs.
- Nationally a further £5m for improving security arrangements in General Practice
- is also being rolled-out.
- Community Pharmacist Consultation Service

The NHS Community Pharmacist Consultation Service (CPCS) was launched by NHS E/I and NHS Improvement on the 29 October 2019, to facilitate patients having a same day appointment with their community pharmacist for minor illness or an urgent supply of a regular medicine, improving access to services and providing more convenient treatment closer to patients' homes.

The service continues to help to alleviate pressure on GP appointments and emergency departments, in addition to harnessing the skills and medicines knowledge of pharmacists. Should the patient need to be escalated or referred to an alternative service, the pharmacist can arrange this.

The Local Pharmaceutical Committee has been working with CCGs to encourage all practices to sign up to this service.

All practices in West Essex have now been trained and are implementing the referral process with their reception staff.

Digital / IT

Following the disruptive impact of the pandemic in 2020, this last year has been one of more gradual change. As the nation has begun to recover, Primary Care has been opening up and returning to a new normal. The main focus of activity has been around the various

vaccination efforts and our role has been to support and help practices and PCNs to begin to deliver face to face patient care again.

This has not meant a reduction in the efforts to provide remote care and the infrastructure to enable this. The deployment of laptops, VPN access, webcams etc. has continued during the year as practices and PCNs build upon the emergency foundations constructed during 2020.

We have been piloting new functionality to allow practice staff to work remotely from the main practice building to ensure practices can operate in a more agile way. This virtual solution gives people the opportunity to work is self-isolating or outside of hours to support a better work life balance.

We continue to work with the broader primary care and community providers and are supporting the Community Pharmacy Clinical Services programme to signpost patients to community pharmacies when appropriate. In addition, Patient Proxy Access has been implemented in Care Homes; this has been restricted to access for medications, enabling Care homes to order repeat medications electronically from the patient's GP Surgery.

With the "Digital First Primary Care" Programme we are conducting research into how patients do and want to engage with primary care so we can ensure that services are delivered in meaningful ways in the future. Part of this will also look at digital inclusion to make sure that everyone can engage with their practice in a way that suits them.

Toward the end of the year work has started on trialling the use of Virtual Smart Cards (VSCs). VSC's in conjunction with the Virtual Desktop Interface solution allow access to clinically systems from any remote device at short notice without the user having a physical smartcard in their presence. With increasing winter pressures this solution could, in the future, enable smarter and faster working across a wide spectrum of our customers.

Workforce Development

Hertfordshire and West Essex (HWE) ICS receives funding, predominantly from NHS E/I and Improvement (NHS E/I/I) and Health Education England (HEE), to support ICS level Primary Care Workforce recruitment and retention across the ICS. In 2021/22 this will amount to £3.7m. Some of this funding supports specific small initiatives; however, there are a number of major funding streams:

NHS E/I/I Training Hub Infrastructure:	£296k
HEE Training Hub Infrastructure:	£314k
GP/GPN New to Practice Fellowship Scheme:	£1,357k

Primary Care Flexible Staff Pool:	£120k
Local GP Retention Fund:	£300k
Supporting Mentors Scheme:	£200k
International GP Recruitment	£650k
GPN/AHP CPD[4]	£172k
GPN/CARE Programme[5]:	£158k

In May 2021, a paper was presented to the CCG Primary Care Commissioning Committees to seek approval for a proposed workplan for 2021/22 and the associated utilisation of Primary Care Workforce Funding. This workplan has underpinned the initiatives that have been delivered by the ICS Training Hub and three placed-based Local Training Hubs during 2021/22. However, throughout the year projects have been added to the workplan either as a result of need, for example a range of wellbeing initiatives, or as project specific funding has been made available.

Other local initiatives presented below:

West Essex CCG Scheme	21-22 Expenditure and Commitments (£'000)
PCN Leadership Payment	226
GP tutors	101
Training Costs	100
Primary Care Support	29
Nurse Tutors	21
GP resilience Fund (Local)	21

[4] Continuing professional development for General Practice Nurses and Allied Health Professionals
[5] https://gmprimarycarecareers.org.uk/care-programme/

Bluestream Academy	15
EPCC	10
PM Tutor	9
GP Forward View - Workforce	**531**

Workforce Numbers

The highest-level metric for primary care workforce that we track and report is overall workforce numbers. Target workforce numbers for 2021/22 were agreed with NHS E/I through the Operating Plan. The targets are shown in the table below together with reported figures for Q1-Q4.

2021/22						
Workforce Group	Baseline (Q4 20/21)	Q1 21/22 Target/ (Actual)	Q2 21/22 Target/ (Actual)	Q3 21/22 Target/ (Actual)	Q4 21/22 Target/ (Actual)	Year end change Target/ (Actual)
GPs (excluding Registrars)	693	698 (701)	702 (698)	706 (707 – M8)	710 (710)	17 (17)
Registered Nursing Staff	312	321 (306)	330 (303)	339 (310 – M8)	348 (312)	36 (0)

Other staff providing Direct Patient Care (ARRS)	273	341 (280)	374 (286)	407 (415)	440 (415*)	134 (142)
Other Practice Staff (Admin)	1642	1634 (1629)	1627 (1648)	1619 (1687 – M8)	1612 (1721*)	-23 (45)

*Please note the NHS Digital NWRS data[6] is dependent upon accurate and timely reporting by practices, there is work underway to improve reporting across the system

Health Education England Procurement – ICS Training Hub

Primary Care ICS level Training Hubs are integral to delivering the Health Education England mandate and business plan in supporting the delivery of excellent healthcare and health improvement to patients and the public.

In supporting, leading, and assisting the delivery of the NHS Long Term Plan and the We are the NHS: People Plan 2020/21, there needs to be a continued strengthening of the education and training infrastructure to support new role and multi-professional team development, systematically and at scale in primary care.

Procurement for ICS training hubs was launched by HEE on 18th October for a 3-year contract with a potential to extend for a further 2 years. The value per annum for HWE was proposed to be £310,000. HWE ICS put in a bid as the training hub is essential to the future delivery model of primary care workforce across HWE working in partnership across system and place. The ICS was successful in the procurement and has been awarded the contract. This funding together with NHS E/I/I funding will allow us to build on the learning to date and restructure the primary care managerial workforce functions at system level to improve delivery and remove overlap.

Workplan Highlights

6 https://app.powerbi.com/view?r=eyJrIjoiYTM4ZTA3NGItMTM2Mi00NzAwLWEyY2QtNDgyZDkxOTk3MmFlIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

Following a mini procurement process, the ICS contracted with the National Association of Sessional GPs (NASGP) for the provision of a Flexible GP Pool for two years. This was launched on 1st October. By the end of the fourth month, 75 practices had registered and 24 clinicians were accessing the funded offer. 353 sessions had been booked through the platform. NASGP also provide the same service across the rest of Essex and have been tying in with Primary Care Careers (PCC), an organisation that provides recruitment support to practices and PCNs. West Essex CCG have used PCC for a number of years and in 2020/21 the training hubs funded PCC recruitment support for PCNs. In the current year, this service has been extended to all GP practices.

In addition, the training hubs have continued to offer a wide range of initiatives to support recruitment and retention across all workforce groups and have also been striving to remove inequity of provision, for example when CPD funding has been provided by HEE and NHS E/I for some workforce groups, we have looked to extend a similar offer to all.

All training and development opportunities are published on the training hub website alongside a range of resources for the primary care workforce[7]

Covid-19 Response and Wellbeing

From the outset of the Covid-19 response, the training hubs have acted as a conduit for returning clinicians who responded to national calls to action from March 2020, including initial conversations and signposting to local operational teams. More recently, the ICS Training Hub in partnership with HCT as lead provider for Vaccination Centres launched a portal to register interests of professionals who have retired or would like to volunteer to support delivery of local schemes such as vaccination across HWE.

In early 2020/21, we undertook a primary care wellbeing survey which elicited 190 responses and provided information about the support that HWE primary care colleagues identify that they need at the time and going forward. The results identified that a wellbeing survey, training needs analysis and training Mental Health First Aiders would be valued. Other ideas elicited included celebrating achievements and recognition, time for teams to reconnect, wellbeing initiatives and training.

Following on from this we worked with colleagues across the ICS to deliver training opportunities for Mental Health First Aid and Compassionate Conversations. We have also made resilience training available locally in addition to signposting national offers such as Here for You Too. These opportunities have been made available to all practices via the GP newsletters and the training hub website.

[7] https://www.hwetraininghub.org.uk/

In the survey, we had also asked how we could genuinely thank staff and identify other areas to support primary care colleagues. Part of the response to this was for each CCG to host an annual event to celebrate the success of primary care in 21/22. The next steps beyond those initially identified included linking to the NHS Leadership Academy in the East of England to explore new leadership, lifelong learning and talent management opportunities for general practice.

Primary Care Estates

The last year was a busy year for the CCGs premises teams and whilst the pandemic may have temporarily slowed things down, new premises completed, some are on site and business cases have been approved for new premises with more to follow.

Many of the completed schemes are those funded under NHS E/I's Estate Transformation and Technology Fund (ETTF). General themes were increased clinical and treatment rooms, increased training rooms and facilities, areas for triage and digital working, aimed at increasing clinical access for patients and providing better environments for staff and all. Whilst the capital and fees are funded by NHS E/I and private funding, the CCGs agreed to fund the ongoing revenue of every project. The projects include:

Crocus Medical Practice have relocated to Saffron Walden Community Hospital, with a fully funded ETTF scheme to completely reconfigure an unused wing at the hospital delivered by NHS Property Services. The project was an excellent example of all system partners working together to create an excellent facility for the local population.

Projects not funded by ETTF have also completed such as:

- High Street Surgery at Cheshunt, where the private landlord funded the capital to
- Keats House was reconfigured by Landlords Harlow Health Centres Trust to provide further clinical space for both Hamilton Practice and The Ross Practice.
- The recently built Lister House Medical Centre in Harlow community area has now been fully fitted out by the Landlords, with Harlow South PCN now taking much needed clinical space.

Many practices gained CCG approval to Project Initiation Documents (PIDs), Outline Business Cases (OBC) and Full Business Case (FBC). As with the ETTF projects, whilst the capital is privately funded, the CCGs have agreed to meet the ongoing increased revenue costs. The CCGs have also reimbursee all eligible professional fees to practices in accordance with the Premises Cost Directions. The projects include:

- Numerous schemes are intended with PIDS submitted for extensions at Chigwell Medical Centre for Practice us and Florence Nightingale Medical Centre, for both Practice and PCN requirements, both clinical and admin.
- An OBC is underway for a replacement new build at Felsted, branch of John Tasker House, with the CCG supporting the extra revenue cost. Capital will be provided by a third party developer.
- Maynard Court have been funded by NHS E/I to complete an OBC for a new build property, with land being made available by Essex County Council as part of a wider regeneration scheme.
- An options appraisal is now complete for Old Harlow Health Centre with an OBC being prepared for a large extension to their current premises to meet local population growth.

Many other projects are being worked up across all three CCGs. A major piece of work that created PCN Workbooks for every PCN and locality are advancing well and from these further premises' plans will emerge,

In addition to the work around new premises development, the premises teams across all three CCGs have 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

- Small fund and grant schemes have been supported via NHS E/I national funding under the Winter Access Fund as well as CCG funds

- NHS E/I embarked on a national data collection on primary care assets and the team have been busy providing and validating the data

- The premises team have provided much support to CCG colleagues and practices on practice mergers, closures and GMS contract related matters

Covid Response

Vaccination Programme

Since the implementation of the Covid Vaccination Programme in December 2020, over 3 million vaccinations have been given across the HWE ICS, with more than a million people having received a second dose and almost 90% of the population receiving a booster dose.

A large portion of the uptake may be attributed to the efforts of the vaccination delivery providers in the weeks leading up to the end of the year. The promise that every adult in the UK would be able to book their booster dose before the end of the year, meant that capacity had to be doubled to meet the demand.

The vaccination programme continues to be delivered by Mass Vaccination Sites, through Primary Care Networks and Community Pharmacists across the ICS.

Primary Care Networks were invited to vaccinate Children aged 12 to 15 year old and the uptake increased for this cohort since they commenced delivery. Significant progress has been made in the age group of 16 to 17 year old cohort, as have the 3rd doses provided to patients who are Immunosuppressed and patient with Learning Disabilities.

A separate Health Inequalities workstream was set up during 2021-22; the main focus initially was to increase the uptake of covid vaccinations to our hard-to-reach groups. Pop-up clinics were delivered in numerous locations to capture those groups in collaboration with local community leaders.

COVID Immunisation Programme 5–11 year olds

On 22 December 2021, Joint Committee on Vaccination and Immunisation (JCVI) advised that children aged 5 to 11 years in a clinical risk group, or who are a household contact of someone who is immunosuppressed, should be offered vaccination with an interval of 8 weeks between the first and second doses. The minimum interval between any vaccine dose and recent COVID-19 infection should be 4weeks. Across Hertfordshire and west Essex, there are approximately 1,500 children and vaccinations for this cohort to be completed by end of January 2022. During February 2022 the JCVI extended a recommendation for non-urgent vaccination to all children over 5.

Seasonal Flu Vaccination

Despite some challenging vaccine supply issues and significant focus placed on the COVID vaccination programme, uptake for the adult cohorts has progressed well, with 82.6% of patients aged 65 and over and 51% of patients aged 50-64 years having received their vaccination. Community Pharmacies are heavily supporting the programme and delivering more vaccines than ever this year.

Challenges remain with the children's cohorts, with 2- to 3-year-olds at 47.7%. Furthermore, the extended school-age programme has had a slower start, as a result of the COVID programme for 12- to 15-year-olds being in place. Across Hertfordshire and west Essex, HCT and EPUT have plans to accelerate the school aged flu vaccination programme

and are looking to extend this to 5- to 11-year-olds. Improved uptake in particularly vulnerable groups such as those living in care homes has been particularly successful with 90% of this population having received the Flu vaccine. Pregnant women remain a key focus area with 44% of people who are currently pregnant having been vaccinated.

A roving model with local community trusts is currently in place to support flu and COVID vaccination for care home staff and outstanding care home residents. All providers are committed to delivering the national trajectory[8] for their staff and where appropriate, those they care for.

Respiratory Hubs

Early on in the Covid Pandemic, local pathways were developed to support patients with suspected or confirmed Covid. These pathways were designed to support and monitor patients with covid symptoms who required a primary care intervention. In order to separate out the covid/suspected covid patients (amber) with the non-covid patients (green) a number of "hubs" were commissioned for practices to refer their Amber patients to.

At the start of the year the majority of practices in West Essex had established in-house practice solutions in order to safely see patients who were symptomatic of COVID-19. A review of the activity at the Harlow Hot Hub was carried out and as a result it was discontinued at the end of May 2021 with Harlow practices developing inhouse practice solutions together with agreed support from other services, if required, such as the Community Paediatric Nurses and the Rapid Intervention Service. The only hot hub currently remaining within West Essex is small facility in a practice branch surgery within North Uttlesford that is managed by the North Uttlesford PCN practices.

Oximetry at Home

NHS E/I offered CCGs free Adult Pulse oximeters to be implemented via GP practices, out of hours, care home and hospitals for people at greatest risk of COVID-19.

The use of oximetry to monitor and identify 'silent hypoxia' and rapid patient deterioration at home is recommended for this group. The service was designed to support patients in primary and community health settings, but could also be used for patients who were at an early stage of the disease and sent home from A&E or discharged following short hospital admissions, following assessment using the total triage model and a plan put in place using pulse oximetry.

[8] https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2021-to-2022-letter#achieving-high-vaccine-uptake-levels

A second tranche of NHS E/I General Practice Covid Capacity Expansion Funding of £120 million was awarded to general practice from April 2021 to Sept 2021, this was a reduced amount compared to the Nov 2020 to March 2021 of £150 million. One of the 7 key priorities as part of this funding criteria was - *Supporting the establishment of the simple COVID oximetry at home model.*

Patients were onboarded within 12hrs of being seen and received a pulse oximeter and instructions for use, reporting, and clear safety netting if saturations (Sats) dropped below the guidance levels. Monitoring patient recordings 3 times daily readings, with the option of regular calls to check deterioration. Escalation if saturation levels (sats) dropped, patients had clear escalation instructions both in and out of hours. Following clinical review patients were discharged from or retained on the service. The services were responsible for requesting, decontaminating, and delivering oximeters, however, following another delivery of oximeters, it was felt that patients should keep their devices as it would be beneficial to them for their ongoing care in the future.

West Essex had a practice run model, each Practice have their own process, linking in with Out of Hours Doctors and 111 for evenings and weekends with some guidance, then transfer care back to GPs on weekdays-Mondays. This helped with the recommendation of 24/7 coverage.

All 3 CCGs across the HWE were working with their community providers and their Acute Hospital Trusts to put pathways in place so that patients could be started on the service and then passed to general practices to take over the monitoring. The Hospitals were keen to set up these pathways and work with General practice in order that patients could be managed outside of hospital more effectively. This work continues and the numbers have significantly dropped towards the end of 2021, which has been attributed by the vaccinations programme, but the pathways remain in place, together with a supply of pulse oximeters available to those that require them.

Managed Quarantine Hotels

Throughout the pandemic, people arriving in England who had visited or passed through a country/territory where travel to the UK is banned ('red list' countries) were required to quarantine in a Managed Quarantine Scheme (MQF) hotel. In addition, families from Afghanistan were placed in isolation hotels when entering the country.

During this time, West Essex CCG worked with the Department of Health and Social Care (DHSC), Home Office, local authorities and voluntary sector partners to commission health provision for the MQF and isolation hotels.

Despite very short notice requests, mobilisation was successfully completed with the local GP surgeries, pharmacies and incumbent providers to minimise impact on general practice

and the wider system. Following confirmation that countries were being removed from the red list, the primary care team liaised with the DHSC to finalise arrangements for the existing guests and decommission the health provision.

The response from the local GP surgery in West Essex exceeded the commissioned provision, they sought support from their local communities to ensure individuals had access to the necessary care required and provided clothes and toys for the guests.

Blood Pressure at Home

Home blood pressure monitoring was identified as a priority for cardiovascular disease (CVD) management during the COVID-19 pandemic to ensure that patients who were vulnerable to becoming seriously ill with COVID, were able to manage their hypertension well and remotely, without the need to attend GP appointments.

Through the national Blood Pressure at home programme the CCG were able to access and distribute blood pressure monitors to practices to enable patients to measure and share their blood pressure readings with their GP from their home.

During 2021/22 the CCGs have distributed 3,250 monitors to practices in order for the practice teams to target clinically extremely vulnerable patients with uncontrolled hypertension, prioritising in people who are over 65 years old, BAME, and / or those who have had prior stroke or transient ischaemic attack (TIA).

Since the scheme started the number of people who have submitted home blood pressure readings each month has increased steadily. The data shows that the number of people submitting home readings has increase by approximately 50% since April 2021. Additional funding has been secured for the ICS to purchase further monitors and cuffs.

Afghan Relocations and Assistant Policy (ARAP) / Asylum Seekers Resettlement Programmes

The Home Office has commissioned four hotels in Hertfordshire and West Essex area to accommodate guests evacuated from Afghanistan under the Afghan Relocations and Assistance Policy (ARAP) scheme, these are known as Bridging hotels where the evacuees are placed pending resettlement by the Home Office across the UK.

There is one hotel located in the West Essex CCG. Two GP practices expressed a willingness to be commissioned to register the evacuees and put in place the necessary healthcare required to support them. The two practices have worked collaboratively with a wide range of system partners, the hotel management team, and the British Red Cross to ensure people are able to access the range of health and social care services they need. Public Health England have specifically worked to establish a TB testing programme.

All residents in the hotel in WECCG have been offered both COVID-19 and flu vaccines in line with guidance but uptake has been limited despite ongoing promotion by all agencies. Residents aged over 11 have also been offered blood borne virus screening. In line with the advice of the NHS E/I Public Health team, all children have commenced or been offered the full vaccination programme to ensure they have adequate cover starting with the measles vaccine.

Two GP partners from a practice within the wider ICS are from Afghanistan themselves and speak the three main languages used in Afghanistan, this has reduced a reliance on translators. The GPs have provided education sessions on understanding how to access health care in the UK.

Initial Accommodation Centres (IAC)

Initial accommodation Centres provide short-term housing 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. The amount of time people stay in initial accommodation can vary.

There is currently one IAC Hotel in West Essex is being supported by a Local Enhanced Service arrangement with a practice in East & North Herts, which has been commissioned by East & North Herts CCG, as whilst the Hotel falls within the boundary of West Essex CCG it is physically closer to East & North Herts Practices.

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

Primary Care Network Directed Enhanced Service (PCNDES)

NHS E/I PCN Plans for 21/22 and 22/23

In August 2021, NHS E/I published the plans for the PCN DES for the remainder of 2021/22 and 22/23, to take effect from 1st October 2021. These plans emphasised that the COVID-19 pandemic has clearly demonstrated the value and effectiveness of the PCN model as a basis for local partnership working. The previously anticipated new PCN DES service requirements and majority of Investment and Impact Fund (IIF) incentives had been deferred until Oct 21. 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.

The updated plans confirmed that in addition to existing service requirements (early cancer diagnosis, Enhanced Care for Care Homes) and limited IIF indicators, there has been a

gradual introduction of new service requirements (CVD, health inequalities, anticipatory care, personalised care) and a significant increase in IIF indicators to promote PCN service improvement goals from the Long-Term plan. As previously set out, the IIF will be worth £150m to PCNs for 2021/22 and £225m for 2022/23 and the indicators will compliment QOF indicators.

The new service requirements will be phased over 18 months, with the main implementation focus being 2022/23 rather than 2021/22, so that PCNs have the maximum possible time to prepare. The two specifications introduced in 2021/22 were introduced in a reduced or preparatory form, as below:

Cardiovascular disease (CVD) prevention and diagnosis - From October 2021, the requirements on PCNs will focus solely on improving hypertension case finding and diagnosis, where the largest undiagnosed prevalence gap remains and where the greatest reductions in premature mortality can be made.

Tackling neighbourhood health inequalities - PCNs have been asked to work from October 2021 to identify and engage a population experiencing health inequalities within their area, and to codesign an intervention to address the unmet needs of this population. Delivery of this intervention commenced in March 2022.

NHS E/I also confirmed new funding for PCN leadership and management to enable wider participation of local partners (e.g., community pharmacy, community service providers) and to support the success of ICSs - £43m nationally.

Temporary changes from December 2021

In response to the emergence of the Omicron variant of Covid-19 and the need to accelerate the delivery of booster vaccinations, NHS E/I made a number of changes:

The IIF immunisation indicators would continue to operate on the basis of PCN performance in 2021/22, however the remaining IIF indicators were suspended, with the funding allocated being provided to PCNs.

Extension to the deadlines associated with tackling neighbourhood health inequalities requirement; with the area of focus to be identified by 28th February 2022 and the ICS further agreeing an extension to agreeing a plan to 30th April 2022.

A further delay to the requirement to deliver Extended Access services as part of the PCN DES to October 2022.

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 were required to submit workforce plans for 21/22 by 31st August; these plans were reviewed, with a particular focus on those forecasting significant underspend versus budget; emphasising that PCNs planning underspend will not be able to carry this forward, so will lose this entitlement. PCNs that were planning to maximise utilisation of the ARR scheme budget for 21/22 were invited to bid for Unclaimed Funding; this is ARR scheme funding that other PCNs are not planning to utilise.

A summary of ARR scheme roles is provided below:

ARRS roles at end Q4	Planned roles end Q4
63	79

The most popular scheme roles include Clinical Pharmacists (115), Care Co-ordinators (98), Social Prescribing Link Workers (54), First Contact Physios (26).

The end of year ambitions for recruitment possibly now look optimistic, having undoubtedly been impacted by the additional pressures in General Practices, especially from December onwards. End of year data will be available at the end of May

PCN Development Fund

NHS E/I provided 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

Total funding of £721k was provided to the ICS in 21/22 to support PCNs. PCNs were requested to submit plans for 2021/22 by October, with submissions reviewed across the ICS in order to ensure consistency and parity in the approach. The key proposals and content of the vast majority of PCN plans were able to be agreed with some clarification and refinement being required.

Upon agreement of the plans the funding was released to each PCN to allow them to proceed in implementing their plans. A further report at year end, focusing on key outcomes, will be requested of PCNs. It is expected that the ICS will be required to report to NHS E/I confirming utilisation of the funding

PERFORMANCE ANALYSIS:

SUMMARY OF PERFORMANCE 2021/22

Nationally, as a result of the COVID-19 pandemic, some mandatory reporting was stopped from the 1 April 2020, with reporting only continuing in 2020/21 and the majority of 2021/22 for areas of statutory requirement: A&E 4 hour waits; ambulance response times; cancer pathways and waiting time ambitions.

In line with most of the acute sector nationally, the reconfiguration of services at providers in response to COVID-19 (to increase capacity for COVID-19 patients and put in place necessary infection control measures) and increased UEC activity pressures, together with the significant challenges to staffing, has impacted performance throughout 2021/22. Demand and Capacity plans have been put in place to recover performance during 2022/23 in line with national guidance.

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 with new Internal Professional Standards[9] being monitored weekly.

Over 2021/22 the total number of A&E attendances increased from 2020/21 and rose above pre-Covid levels for the majority of months putting further pressure on A&E departments and flow through the system. The increase has been most significant in Minors activity.

Performance at Princess Alexandra Hospital NHS Trust followed the national trend and failed to achieve the 4 hour standard:

A&E	Target	Q1	Q2	Q3	Q4	2021/22
Treated / Admitted / Transferred in under 4 Hours	95%	73.9%	67.4%	62.1%	65.9%	67.3%

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

- A new Streaming model has been implemented at the front door, triaging and streaming patients directly into either the Emergency Department, or the Urgent Treatment Centre
- The Urgent Treatment Centre has been re-located to enable an increase in capacity
- Additional investment has been made into Urgent Community Response services providing the ambulance service and community health and care professional with access to a 2 hour response service, aimed at reducing unnecessary hospital attendances
- Participation in National Hospital Discharge Programme has delivered improvements in long length of stay, improving flow through the hospital
- Ambulance handover performance remains a challenge. With the support of the ambulance service, a cohorting area has been implemented during periods of surge demand
- Clinical navigator role introduced to drive the use of alternative urgent care pathways for Same Day Emergency Care (SDEC), including ambulatory emergency care, frailty and surgical assessment

[9] www.england.nhs.uk%2Fsouth%2Fwp-content%2Fuploads%2Fsites%2F6%2F2016%2F12%2Frig-making-internal-prof-standards-work.pdf

- Transition ward created for patients that no longer meet the criteria to reside, to support patient flow. This is key to protecting elective activity
- Additional funding to strengthen workforce: senior operational staff and discharge co-ordinators to support patient flow

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)

The East of England Ambulance Trust (EEAST) has had a challenging year with continued high demand on services in 2021/22. C1 to C4 standards were not met for the year, and performance has deteriorated quarter on quarter in all categories:

EEAST Ambulance Response	Target	Q1	Q2	Q3	Q4	2021/22
C1 People with life threatening injuries and illness	<7 minutes	08:01	10:15	12:13	11:38	10:41
C2 Emergency calls	<18 minutes	30:52	49:57	69:51	69:34	54:33
C3 Urgent calls	<120 minutes	218:22	358:46	455:01	523:27	374:46
C4 Less urgent calls	<180 minutes	287:58	468:47	615:54	726:17	504:49

Demand into ambulance services continued to be a challenge nationally. In 2021/22, EEAST received approximately 5,000 more calls per week than the average of the last 3 years, and spent the majority of the year on the highest escalation level.

Reduced staffing levels also impacted on the delivery of services. The Trust has a workforce plan in place and continues to recruit staff from a range of backgrounds, including call handlers and non-clinical drivers. The plan also expects the outcomes from existing apprenticeship programmes to have a significant impact from the spring of 2022.

Hospital Handover delays continued to impact on EEAST performance, and the Trust worked with all partners on alternative pathways to conveyance, deploying local schemes and initiatives to meet the needs of individual patients e.g. mental health and frailty. Hospital Ambulance Liaison Officers (HALOs) remained in place at Acutes to support pathways.

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).

Princess Alexandra Hospital NHS Trust

Cancer referrals throughout 2021/22 have been consistently above pre-pandemic levels as patients with unidentified need from the first year of the pandemic have been referred on urgent cancer pathways.

The Trust has been unable to meet the expected standard for 2 week waits, but does benchmark well compared to national performance against the target for symptomatic breast referrals.

Whilst not consistently achieving the 31 day standards, again the Trust does benchmark relatively well and has had good achievement, particularly with regard to the subsequent anti-cancer drug and radiotherapy targets.

62 day performance has been particularly challenged in 2021/22 through a combination of high referrals and the Covid-19 impact on workforce and operating capacity. The CCG has agreed a wide ranging recovery plan with the Trust and a dedicated cancer recovery oversight regime is in place, including regulators.

The Trust continues to focus on diagnosing and treating the backlog of patients that has developed during the Covid period and the low 62 day performance reflects the increased number of longer waiting patients being treated.

Table: Cancer waiting times for all West Essex CCG patients [10]

[10] Q1 is April to June; Q2 is July to September; Q3 is October to December; Q4 is January to March.

Cancer Waiting Times at CCG level		Target	Q1	Q2	Q3	Q4	2021/22
Two Week Waits	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	82.0%	74.5%	70.9%	68.5%	74.0%
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	77.0%	91.8%	77.8%	48.6%	73.8%
28 Day Faster Diagnosis Standard (FDS) (Effective from Q3 2021/22)	Maximum 28-day wait from urgent GP referral to be diagnosed or have cancer ruled out	75%			67.6%	66.7%	67.2%
31 Day Waits	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	95.4%	90.8%	93.1%	92.5%	93.0%
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	86.7%	91.2%	87.9%	74.5%	85.1%
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%	98.9%	98.8%	98.0%	95.2%	97.7%
	Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy	94%	97.5%	96.2%	95.7%	92.4%	95.5%
62 Day Waits	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	73.9%	69.7%	56.6%	54.4%	63.7%
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	63.3%	57.7%	54.6%	61.1%	59.2%
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	85%	90.5%	80.7%	86.3%	73.1%	82.7%

Referral to Treatment Times (RTT)

Under the NHS Constitution there is a performance standard related to patients waiting for treatment; the standard being that 92% of patients on an incomplete pathway should be seen within 18 weeks. In response to COVID-19 and Urgent & Emergency Care (UEC) pressures, routine elective treatments have been stood down at peak times throughout 2021/22; this has caused an increase to numbers on elective waiting lists and the length of

time to treatment.

The table below [11] details the RTT performance for West Essex CCG patients for 2021/22.

RTT Waiting Times		Target	Q1	Q2	Q3	Q4	2021/22
18 Weeks	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	**92%**	**64.9%**	**61.0%**	**51.5%**	**55.1%**	**55.1%**

In line with UEC demand and pressure to increase capacity for COVID-19 patients, routine elective activity was paused at peak times throughout 2021/22. As a result, the number of CCG patients on an incomplete list increased over the year together with the number of long waiting patients.

The CCG has worked closely with The Princess Alexandra Hospital (PAH) to ensure that the very longest waiters (104 weeks +) are all treated in line with the deadlines set out with the National Elective Recovery Plan. Commissioners have additionally worked with providers to manage demand on services by reviewing pathways such as advice and guidance and triage services.

Clinicians have reviewed all patients on their elective waiting lists and risk-stratified patients according to clinical need in line with the national Risk Stratification programme; patients have been booked and treated in order of clinical priority. Independent sector capacity has been utilised for elective pathways where possible throughout the year, with NHS capacity being increased at peak times of pressure. Work is also underway across the ICS to jointly review demand and capacity and agree mutual aid where possible.

Moving into 2022/23, recovery plans and trajectories will be focused on restoring activity to 30% above pre-COVID levels by 2024/25 in line with the National Elective Recovery Plan, as well as ensure that no patients are waiting longer than 78 weeks by the end of March 2023.

[11] Data shown is a 'snapshot' from month 3 of each quarter and year end March 22 position

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 [2] details the Diagnostic performance for West Essex CCG patients for 2021/22.

Diagnostic Waiting Times		Target	Q1	Q2	Q3	Q4	2021/22
6 Weeks	Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request	**99%**	**69.5%**	**66.7%**	**68.8%**	**77.1%**	**77.1%**

COVID-19 pressures and reduced staffing and temporary service suspensions have impacted PAH diagnostic services across all modalities. The Trust was further impacted by the delayed replacement of an MRI scanner and a national / regional lack of Echocardiography capacity.

Despite the in-year challenges, performance has been steadily improving and reached 77.1% by year end, which is ahead of the national average.

Wide ranging recovery plans are in place and the Trust expects to achieve the ambitions set out in the National Elective Plan in its planning for 2022/23 and beyond.

Upcoming changes to Key Performance Standards

Access Standards

Following a national review, changes to standards in mental health services, cancer care, elective care and urgent and emergency care started to be field tested at a selection of sites across England. Revised standards were originally expected to come in during spring 2020, but the programme of work has been delayed due to COVID-19. NHS E/I and Improvement have sought views on the proposed recommendations[12] for urgent and emergency care standards which will inform final recommendations and guidance for 2022/23.

[12] **https://www.england.nhs.uk/wp-content/uploads/2021/05/B0546-clinically-led-review-of-urgent-and-emergency-care-standards.pdf**

NHS OVERSIGHT FRAMEWORK

How are local health services performing?

NHS Organisations will be assessed in 2021/22 via the NHS System Oversight Framework. The Framework contains a broad range of oversight metrics which are utilised by NHS E/I and NHS Improvement to flag potential issues and prompt further investigation of support needs.

There are more than 80 indicators which are grouped around 6 key themes:

- Quality of care, access & outcomes
- Preventing ill-health and reducing inequalities
- Finance and use of resources
- People
- Leadership & capability
- Local strategic priorities

Based on assessment against the Framework indicators, CCGs are assigned into one of four "Segments" described below, which then inform the level of regulator support required within the system.

1	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved
2	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues
3	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support

NHS E/I has a legal duty to annually assess the performance of each CCG. From 2015-2020 this was managed first under the auspices of the CCG Improvement and Assessment Framework, and for 2019/20 the NHS Oversight Framework. This provided an approach whereby NHS E/I provided each CCG with an overall assessment rating using the CQC rating terminology of 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

For 2020/21, a simplified approach to the annual assessment of CCG performance was taken as a result of the differential and continued impact of COVID-19. It provided scope to

take account of the different circumstances and challenges CCGs faced in managing recovery across the phases of the NHS response to COVID-19 and focused on CCG contributions to local delivery of the overall system recovery plan. A narrative assessment, based on performance, leadership and finance, replaced the ratings system previously used for CCGs.

This approach has been adapted for 2021/22. The annual assessment will include an end-of-year meeting between the CCG leaders and the NHS E/I and NHS Improvement regional team focused on:

- Key lines of enquiry relating to the 6 themes of the Framework
- Performance against the oversight metrics
- An assessment of how the CCG works with others to improve quality and outcomes for patients

The final narrative assessment will identify areas of good and/or outstanding performance, areas of improvement, as well as areas of particular challenge. This is not expected to be published until Summer 2022.

Further details of the assessment methodology can be found on the **NHS E/I** website.
The results for our 2021/22 assessment (the year that this Annual Report covers) will not be published until July 2022 at the earliest.

ENSURING QUALITY

The work of our nursing and quality team

The CCG's ambition is to commission high quality, safe and clinically effective services for our patients. The indicators in the NHS Outcomes Framework - clinical effectiveness, patient experience and patient safety - allow the CCG to gain assurance about the quality of services being delivered by our providers and enables us to challenge and intervene when necessary.

The COVID-19 pandemic has continued to significantly impact our health services during 2021/22 including how we commission and monitor services to deliver high quality care to our patients. The Nursing and Quality Team has maintained all core functions during the pandemic.

The team has:

- continued to monitor the quality, patient experience and patient safety of our commissioned services through regular meetings with our providers with a focus on quality improvement and sustainability
- monitored and reviewed data from several sources, including patient feedback and patient safety incidents to ensure early warnings of a potential decline in quality are identified and appropriate action taken.
- contributed to a regular integrated performance and quality report for the Board Meeting. This has been further strengthened by engaging with our primary care colleagues at the respective locality meetings across West Essex using data driven insights to share the learning and improve patient pathways as part of the One Health Care Partnership
- maintained a Quality Committee which reports to the Board, providing assurance on the quality of services we commission as well as core functions within the Nursing and Quality Team. The Committee is alerted to any key quality or safety issues relating to core services as well as the impact of COVID-19 and system pressures
- worked in partnership with providers and other commissioners to ensure quality priorities are aligned to the current and future health needs of the local population. This has been particularly key with the impact of COVID-19
- worked closely with wider stakeholders and system partners including neighbouring CCGs, the Care Quality Commission (CQC), NHS E/I and Improvement, Healthwatch and Essex County Council (ECC) to share intelligence and identify themes relating to the quality of care being provided
- continued to work proactively to monitor the quality of primary care. The CCG supports practices in relation to Care Quality Commission (CQC) inspections and uses the expertise of our own specialists and external partners to help practices improve the quality of their services

Maintaining quality during the COVID-19 pandemic

In addition to maintaining the core functions detailed above, the Nursing and Quality Team has supported all key areas of quality and safety as well as supported the response to COVID-19, helping our providers to deliver safe care to our patients.

Key focus areas of our work are:

Ensuring Quality

Maternity Commissioning & Assurance

Following publication of the Ockenden Report in December 2020 several essential and immediate actions were identified for national rollout. PAH have continued to work as part of the Hertfordshire and West Essex Local Maternity & Neonatal System (LMNS) to embed these to improve maternity services for the population it serves. A further Ockenden publication outlining the next steps framework is expected in the spring. Delivery of the national maternity transformation plan has continued with some significant advances during 2020/21. Working across the Hertfordshire & West Essex LMNS, some of the key activities have been summarised below:

- Continuity of Carer: The model continues to demonstrate improved outcomes for service users. Wider rollout of teams was paused due to increased clinical demands in response to Covid pressures. It is the ambition for the Continuity of Carer model to be the default model of care offered to all women by March 2023. PAH have successfully implemented a number of teams and there are plans to regrow the service and roll out further teams during the coming year.
- Better Birth: PAH has successfully recruited a physiotherapist to support the service. Support and information relating to Covid 19 vaccines continues and a pharmacist has been engaged to work with each trust to support this. Vaccination webinars have taken place and there are vaccination champions in each trust. Joined up working practices have been demonstrated as Health Visiting and Midwifery teams come together to align service provision. In line with national guidance an Equity and Equality analysis is being undertaken to determine the requirements to drive inclusion. Systems will align to the ICS Health Inequality Plan and to 5 priorities each of which will be implemented by the local maternity system (LMS).

https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf

- Maternity Voices Partnership (MVP): The Local West Essex MVP continues to engage and support PAH. Chairs have been undertaking walkabouts within the maternity department seeking service user feedback and sharing where improvements can be made. The MVP social media pages attract good attention and further pages, and

events are being planned with a focus on people with disabilities, BAME and LGBTQ+ groups.

- Safer Care: The HWE LMS continues to have oversight of and monitor all serious incidents. Learning from cases is discussed at the LMNS serious incident (SI) oversight and scrutiny group which meets monthly. Learning and any resources are also disseminated across the LMNS to improve care and service user experiences.

CQC published their inspection report following a series of visits between July and September 2021. The rating for maternity services was requires improvement which was unchanged from the previous inspection. PAH continue to work to close gaps in improvement work and complete must and should actions. West Essex CCG has continued to maintain oversight of the services delivered offering on-going support whilst seeking assurance that the needs of service users are being met.

Children, Young People & Families Commissioning

The national rise in children's respiratory syncytial virus (RSV) infections was experienced at PAH over the summer and into the winter months. Coupled with this, a change in behaviours and the way parents/ carers chose when and where to access healthcare for their children, compounded by difficulties in accessing primary care, resulted in an increase in children presenting at the PAH Emergency Department. The department had also begun to experience repercussions from the pandemic on recruitment and retention, creating an imbalance of demand and capacity. As a Trust, PAH responded operationally to ensure children were safe and built-up additional capacity with resource from the Urgent Treatment Centre. At a Primary Care level, pathways to the Children's Community Nursing Team were enhanced and promoted, PAH delivered a webinar on management of RSV and bronchiolitis, and oxygen saturation monitors were purchased for all practices. The CCG worked with PAH, the Hospital at Home Team and the Children's Community Nursing Team to streamline and enhance pathways out of hospital, thereby reducing length of stay and avoiding readmission. To better support parents and carers, the Essex Child & Family Wellbeing Service delivered a series of educational sessions through Family Hubs around prevention and caring for minor illnesses, and upskilled Healthy Family Teams to provide additional support to ensue confidence and understanding of when and where to go for extra support.

The Hertfordshire & West Essex Healthier Together website (**https://hwehealthiertogether.nhs.uk/**) was formally launched during 2021/22 to ensure parents and carers had timely access to reliable information, although continues to be

developed. The website provides information on childhood illnesses put together by local healthcare professionals, helping parents and carers to recognise what might be wrong, when to seek help, how to keep their child comfortable and how long their symptoms may last. The website also has an area of advice and guidance specifically for pregnant women and young people. As the site develops, there will be additional resources for professionals and greater functionality for the user.

During 2021/22, Virgin Care as the local provider of the Essex Child & Family Wellbeing Service (ECFWS), was acquired by Twenty20 Capital and rebranded as Health Care Resource Group [HCRG]. There were no changes to services or operational delivery; the ECFWS continued to deliver a blended approach of virtual and face-to-face contacts during 2021/22 across both pre-birth to 19 services and children's community healthcare. Family Hubs reopened for some activities with many other activities and groups continuing online, which for many become more accessible and allowed more parents and carers opportunity to engage. The integrated service has demonstrated improved outcomes for children and families including outcomes around avoiding hospital, children and their parents/carers feeling supported and empowered to reach personal goals, working in a multidisciplinary approach around the needs of the child, and facilitating a smooth and well-planned transition to adult services.

Working in partnership across the Hertfordshire & West Essex ICS, the CCG supported the development of a Children & Young People's Strategy outlining improvements to be seen in the health and care of children and young people as a result of the work of the ICS over the coming five years.

The strategy will demonstrate a commitment to tackling health inequalities and preventing ill health, working together to ensure children with long term conditions or complex needs are supported to achieve their fullest potential, changing the way we work together to improve access and integration of services, and ensure personalised care is delivered as close to home as possible. The strategy is in the process of being further developed with children, young people and families, with an aim for publication during 2022/23.

Special Educational Needs & Disability (SEND) Commissioning

Throughout 2021/22, and despite the ongoing pandemic, West Essex CCG continued to work alongside other CCG partners across Essex, the Local Authority and representatives from the Essex Family Forum in delivery of the Written Statement of Action following the Essex Local Area SEND inspection carried out by CQC and Ofsted in October 2019. An improved quality

assurance process for Education, Health & Care Plans (EHCPs) was launched and successfully implemented in West Essex.

Workstreams focusing on joint commissioning have made a number of developments including:

1) establishing a joint commissioning framework across all Essex partners.
2) mapping the commissioning, delivery and impact of all three children's therapy services (speech and language, occupational therapy and physiotherapy) across the whole of Essex and Southend.
3) designing and piloting a consistent Essex-wide minimum dataset for autism diagnostic pathway performance.
4) supporting the development and publication of a resource pack for families, written by families, with guidance and information for parents and carers on supporting their neurodiverse child.
5) producing a guide for accessing equipment for parents and carers; 6) initiated a whole scale redesign of the Essex Local Offer.

Like many other parts of the country, west Essex families continued to experience unacceptably long waiting times for autism diagnosis because of significant growth in demand, coupled with the impact of the pandemic on capacity and recovery. The Journey of Autism Diagnosis & Early Support (JADES) model in west Essex provides help and support and addresses immediate need while families are waiting for a diagnosis, however West Essex CCG recognised the need to halt the growth of the waiting list and bring waiting times back to more acceptable levels. The CCG therefore invested in additional capacity during 2021/22 and approved recurrent additional investment for the following five years. Unfortunately, the pandemic delayed progress, however additional resource was secured towards the end of the financial year to begin working on an improved position and experience for families going forward.

Emotional Wellbeing and Mental Health Service (EWMHS) Commissioning

West Essex CCG is the Lead Commissioner of the Southend, Essex and Thurrock Children and Young People's Emotional wellbeing and Mental Health (EWMH) Collaborative which consists of three local authorities and seven NHS clinical commissioning groups (CCGs). In 2021 the EWMH service underwent a re-procurement with the bid awarded to the incumbent provider North East London NHS Foundation Trust (NELFT). The service will commence on 1st April 2022 and mobilisation is well underway. The service, known as

Southend, Essex and Thurrock Children and Young People Mental Health Services (SET CAMHS), will continue to offer help and support to children aged up to 18, as well as people aged up to 25 with Special Educational Needs (SEN) and will be delivered in partnership with HCRG.

2021/22 was an unprecedented year that had a profound impact on children and young people pan Essex and saw increased requests for support, and pressure on all services increasing exponentially. Increased demand was seen in the eating disorder and Crisis services and the number of self-referrals into the service rose 80% peaking during November 2020 and January 2021.

In order to address the challenges and the need for increased emotional wellbeing and mental health support across Essex, commissioners made significant investment across all elements of EWMH Service; additional staffing capacity in the EWMHS Learning Disabilities team, development of home intensive support services in Children and Young People (CYP) Eating Disorder Service and the crisis team, providing intensive support in the home enabling CYP to stay in the community with their families, avoiding the need for hospital admission, reducing the length of stay if admitted, and facilitating early discharge from the acute or mental health inpatient setting. In addition to this further investment was made into voluntary care services to support CYP who would not meet the criteria for specialist mental health support.

Local Transformational Plan (LTP) Update

The LTP investment supported the continuation of service developments defined in previous years, with additional investment into new provision enabled by LTP growth monies. West Essex has enhanced emotional wellbeing of CYP through the provision of services to support CYP who may not be eligible for specialist support, some examples are outlined below:

Young Concern Trust [YCT] are specialist counselling services offering counselling and emotional support to children and young people with anxiety and increased emotional difficulties. Demand for the service has been high and additional investment has been made to enhance the service allowing it to meet demands.

N.O.W. is the Time for Change, delivers an early intervention programme for wellbeing. School wellbeing workshops delivered specifically for primary school year 6, teach children the tools and techniques of mindfulness, stress reduction and emotional wellbeing through interactive workshops with the aim of building resilience as these children move on to senior school.

Kooth digital for Young People delivers early intervention, easy to access online in and out of hours counselling and support services across Southend Essex and Thurrock for Children and Young People

SilverCloud is a digital mental health platform operational since January 2020 which can be offered to CYP at the beginning of the EWMHS care pathway supporting CYP as they wait to access specialist support.

Mental Health Support Teams (MHST) also support CYP in west Essex through delivering evidence-based interventions for mild-to-moderate mental health issues. West Essex MIND deliver the service ensuring schools are supported and children and young people get the right support enabling them to stay in education. **https://www.england.nhs.uk/mental-health/cyp/trailblazers/**

Patient Safety

Serious Incidents 2021/22 report

A serious incident (SI) in healthcare is an adverse event, where the consequences to patients, families, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

Providers of NHS Services are responsible for the safety of their patients, visitors and others using their services. They must ensure robust systems are in place to enable meaningful analysis to take place, including review of the human factors involved and that appropriate changes to practice are embedded where needed, as a result of serious incidents.

The West Essex Serious Incident Assurance Panel, comprised of clinical and non-clinical staff, meets weekly to quality assure serious incident reports submitted by provider organisations. The panel is a subcommittee of the Quality Committee.:

- 2020/2021 total SI reported 130, following full investigation 1 was de-escalated
- 2021/2022 total SI reported 56 following full investigation 4 were de-escalated

The significant difference in number of SI reported from 2020/21 to 2021/22 relates to the requirement to report every hospital acquired COVID 19 infection as an SI. The number of hospital acquired COVID 19 infections has dropped significantly as a result of the safety actions taken within the relevant hospitals.

- There were two never events –
    - One involved a guidewire being inadvertently left inside an intravenous line
    - One involved a medication being given via the incorrect route
      In both cases the patient involved did not come to any harm

Never events are a sub-set of serious incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.'

The number of serious incidents reported is less important than whether there have been trends or themes in the types of incident and that the learning has resulted in changes where they are required.

There has continued to be significant disruption to the serious incident process this year due to the COVID 19 pandemic. NHS E/I/NHS Improvement suspended the 60 day deadline for completion of investigations , this has enabled staff to prioritise their work load.

Planned national changes to serious incident investigation

Changes are being made to ensure there is learning from incidents to protect patients and staff with the introduction of the Patient Safety Incident Response Framework (PSIRF).

NHS West Essex CCG (and other Essex commissioners) has been working with Essex Partnership University NHS Foundation Trust during the pilot/early adopter phase of this change. Implementation of the PSIRF will be challenging and require structural and cultural changes within organisations – early indicators are that this will be constructive and beneficial for patient safety and result in more effective, safer care.

Infection Prevention and Control (IPC)

During 2021/22, IPC activity has once again been dominated by the pandemic response. However, where possible some other core functions have begun to be re-established. The ICS IPC team has therefore achieved the following:

- Provided advice and support to healthcare providers across the system to interpret and implement evolving national IPC guidance concerning COVID-19
- Provided IPC advice to all COVID-related workstreams within the three CCGs
- Developed a range of resources to support providers to implement and audit IPC practice
- Continued to undertake a programme COVID secure assessments across community healthcare providers and primary care to ensure that patients could be seen safely and staff protected
- Provided a programme of training for healthcare staff in relation to IPC and COVID-19 via a series of monthly webinars
- Took active part in the management of all outbreaks across the system, with membership of Incident Management Teams, and shared learning across the system

- Undertook face to face and virtual IPC quality visits to healthcare organisations where targeted support was required
- Developed a programme of monthly system wide network meetings for IPC practitioners across the Hertfordshire and west Essex system. The purpose of the meetings is to provide a forum which aims to support IPC teams, support shared learning across organisations, minimise harm caused by healthcare associated infections to patients and staff, and to drive forward improvements within local Infection Prevention and Control (IPC) practice.
- Undertook surveillance of key reportable healthcare associated infections across the system and identified key learning
- Worked collaboratively with healthcare providers across the system to establish a programme of IPC peer reviews across organisational boundaries
- Supported the on-going implementation of the new National Standards of Healthcare Cleanliness particularly within primary care

National Patient Safety Strategy

Planned national changes to serious incident investigation

Changes are being made to ensure there is learning from incidents to protect patients and staff with the introduction of the Patient Safety Incident Response Framework (PSIRF).

NHS West Essex CCG (and other Essex commissioners) has been working with Essex Partnership University NHS Foundation Trust during the pilot/early adopter phase of this change. Implementation of the PSIRF will be challenging and require structural and cultural changes within organisations – early indicators are that this will be constructive and beneficial for patients' safety and result in more effective, safer care.

The CCG has continued to progress implementation of key areas within the National Patient Safety Strategy, originally published in July 2019, and updated in February 2021. Key areas progressed include:

- Implementation of the Patient Safety Specialist role within the CCG and across the local system
- Establishment of a Patient Safety Specialist Network for all Patient Safety Specialists across Hertfordshire and West Essex
- The roll out of the national patient safety training for all staff within the CCG
- Participated in national workshops looking at how the patient safety strategy can be implemented within primary care

- Ongoing work to support our local Medical Examiner Offices with the roll out of the Medical Examiner system for community deaths, following successful implementation for deaths occurring in our acute hospitals.
- Supported areas of COVID 19 recovery, including working with our acute providers to ensure there is a robust process across our local system for undertaking harm reviews for those patients that have waited significantly longer than usual on the waiting lists, with consistent reporting of harm review outcomes and learning.
- Kept our Quality Committee, Primary Care Commissioning Committee and Board updated with national timelines and local implementation throughout the year.

Patient Experience

The CCG Patient Experience Team manages complaints, Patient Advice and Liaison Service (PALS) queries and compliments from service users and members of the community. People can make their complaints or comments either directly to the organisation who provided their care or to the CCG. If patients make their complaint/ask a question via their Member of Parliament, the team will also lead on these responses.

The Patient Experience Team also responds to requests from the Parliamentary Health Service Ombudsman for information relating to complaints where the CCG has been the lead.

In 2021/22 the Patient Experience Team have managed 1071 queries this level of activity has increased in year from 1050 at the end of 2021.

20% of all queries relate to the COVID 19 vaccination programme –. These queries have come from a combination of members of the public, NHS, social care and private health sector staff and MPs. The main issues raised with the team concern complex clinic situations and access to vaccination for persons unable to attend vaccination centres.

The number of MP queries has dropped slightly from 110 last year to 91 in 2021/22, a third of the queries relate to the COVID 19 vaccination programme. The remainder cover a wide range of issues from access to primary care, clinical treatment and funding decision made by the commissioning organisation.

In 2021/22 the CCG received 37 formal complaints.

Some of the complaints related to one organisation, others were multi organisational, the investigation and response into the complaints was coordinated by the team.

Half of the complaints received related to decisions taken by the CCG or the local acute Trust. Formal complaints about the CCG related to; funding decisions, continuing health care eligibility decisions and COVID 19 vaccinations.

Most of the complaints about primary care services were referred onto NHS E/I or were already being managed by the practice involved. A complaint can only be investigated once, so if an investigation is underway the CCG cannot investigate as well, this is not permitted by the NHS Complaint regulations.

In addition to complaints, the Patient Experience Team received 741 PALS contacts from patients, their families and members of the public.

The queries cover all commissioned services, 69% relate to issues or queries about: primary care services, decisions made by the CCG (including the covid vaccination programme), the rest were divided amongst other providers.

The team assists patients, their families, health professionals and members of the public to provide the information they need and/or assist them to resolve their concerns.

Primary Care

Collaborative working between the CCG's Quality and Primary Care Teams has enabled effective provision of bespoke support to practices with addressing issues identified within the CQC inspection reports.

- All 30 GP practices within West Essex currently meet the required CQC standards with 1 practice rated as 'Outstanding' and 29 practices rated as 'Good' overall.
- In 2021 the CQC introduced a new monitoring process for GP Practices. Monthly data reviews are now carried out by the CQC using data available to them.
- Primary care quality assurance and quality improvement have remained integral elements within the Primary Care Commissioning Committee and Quality Committee agendas over the last year.
- Support has been provided to practices with identification of learning and improvements in key areas of quality and safety throughout the pandemic.
- Practices have been supported with the implementation of infection, Prevention and Control (IPC) measures, national guidance and COVID Secure recommendations.

- Support has been provided to primary Care Network (PCN) vaccination sites such as identification of learning from incidents

Care Homes in West Essex

Support During the Pandemic

Since early in the Pandemic the West Essex Care Provider Hub has met at least twice weekly, bringing together system partners from WECCG, ECC and EPUT, with specialist input from colleagues in Infection Prevention and Control, Primary Care, Public Health, Track and Trace and Care Quality Commission.

The core functions of the Hub have been mapping covid outbreaks in the 51 care homes situated in West Essex and providing tailored support to homes as and where required. At times when the impact of covid on care homes has reduced, there has been more opportunity for the Hub to focus on the wider issues of quality control and safeguarding .

Support packages provided to care homes during the pandemic have included: -

- Help to access Personal Protective Equipment
- Provision of specialist IPC assessments to gain assurance of practice and to identify improvements required
- Provision of IPC training and advice
- Support to interpret and implement National Guidance and share best practice
- Support to access vaccines for residents and staff
- Clinical Support via Community Nursing, GP, Care Home Practitioners etc
- Provision of additional staff to maintain a safe service
- Multi-agency IMT Meetings to explore significant outbreaks

Care Home Monitoring Arrangements

The pandemic led to significant disruption to the normal business of quality assurance within care homes, as guidance advised against external visitors in all but the most extreme circumstances. When possible, visits have taken place from: -

- ECC has a Provider Quality Team, who undertake Provider Assessment and Market Management [PAMMS] assessments with associated action plans.

- ECC Organisational Safeguarding Team, who investigate significant safeguarding concerns. Some of these visits have been joint with the CCG.
- CCG Quality Assurance visits which resumed in the Autumn 2021.
- CQC who have focussed inspections on IPC measures within the homes as well as exploring any significant concerns around poor care and resident safety.

Feedback from these visits is discussed within the Care Provider Hub meetings.

Due to concerns about safeguarding and quality, 3 homes in West Essex were suspended by ECC in 2021.

CQC ratings in West Essex show that there are currently 6 homes rated as Requiring Improvement-3 of these are from 2021, others older.

Quality/Safety Issues and Themes/Trends

Themes identified since QA visits resumed: -

- Lack of leadership and turnover in management. Staff feeling unsupported and care provision becoming disorganised.
- Lack of internal auditing taking place effectively within the homes leading to problems not being identified and action plans not being put in place.
- Safeguarding concerns not being raised appropriately.
- Recruitment difficulties and low morale/exhaustion amongst staff.
- Concerns around Manual Handling techniques in some homes.

Impact of Covid Vaccinations/Workforce Challenges

There has been a significant amount of work co-ordinated via the Care Provider Hub to monitor progress within individual homes and to offer support in relation to clinical advice and access to vaccinations.

In advance of the November 2021 deadline for all staff working in care homes to have received 2 doses of the vaccine, ECC explored Business Continuity Plans with individual homes. No home in West Essex was identified as at risk of closure due to staff losses. A small number of homes indicated that they may need to close to admissions if they were

unsuccessful in recruiting new staff to replace those who declined vaccination. However, this did not become necessary.

Risks/Challenges for the System

Homes have reported difficulties in recruiting suitable staff and the reduced availability of agency staff to cover vacancies. This reflects the national picture among care homes and in the wider care system.

Occupancy in some homes has not returned to pre-pandemic levels for some care homes and this maybe a cause for concern in terms of their long-term viability.

Adult CHC

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need' as set out in the NHS National Framework for Continuing Healthcare and Funded Nursing Care (2018). Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.

NHS-funded nursing care (FNC) is the funding provided by the NHS to homes providing nursing to support the provision of nursing care by a registered nurse. Since 2007 NHS-funded nursing care has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS continuing healthcare before a decision is reached about the need for NHS-funded nursing care. The CCG is committed to ongoing improvement of the CHC service in a challenging financial climate and ensuring that patients are individually assessed and reviewed.

If an individual's condition is deteriorating rapidly, they may be approaching the end of their life, and a "fast track" continuing care assessment may be applicable to allow an appropriate care and support package to be put in place as soon as possible. This enables the individual to receive prompt NHS funding to meet the cost of care at the end of life stage. The only requirement for by-passing the normal NHS continuing healthcare assessment criteria and receiving the fast-track pathway is that the individual must have:

- "a rapidly deteriorating condition that may be entering a terminal phase."[13]

[13] **20181001 National Framework for CHC and FNC - October 2018 Revised (publishing.service.gov.uk)** page 63

- “where deterioration can be reasonably anticipated to take place in the near future, this should also be taken into account, in order to avoid the unnecessary or repeat assessments”

Since 2015 all patients in receipt of Continuing Healthcare funding to manage their care needs are able to request a Personal Health Budget (PHB) and within the West Essex CCG, the CHC team has focused on the care and support planning to give patients more autonomy as to how they wish to receive their care this may be by receiving the monies via a direct payment and arranging the care they wish to receive in the way they wish this to be carried out. If a patient chooses not to receive this, the CCG continues to manage the care, and this is called a notional budget. We continue to offer Personal Health Budgets and the uptake has increased in the last 12months. In April 2021 there were 93 people receiving PHBs and this has increased to 234 by 31st March 2022.

The CHC Team provides a first-class service, always striving to improve the patient experience/ journey by analysing feedback received through complaints/compliments. Feedback is anonymous and is sent to the team via an online survey portal, by post or via an email. Due to this feedback, the team has made improvements in the way of working and completing virtual assessments.

The performance in the provision of CHC is measured by NHS E/I through Key Performance Indicators referred to as Quality Premiums. In the last year from April 2021 to March 2022, the CHC Team has:

- Received 534 referrals
- Completed 391 assessments within 28days
- 1003 fasttracks were completed
- 897 FNC reviews have been completed

There has been an increase in patient numbers due to the pandemic and related illnesses from extremely vulnerable people

In terms of commissioning, the team have been part of shaping market and analysing trends by attending and contributing to Market Resilience Board

CARING FOR OUR VULNERABLE RESIDENTS

Safeguarding adults

The CCGs work alongside our partner agencies to identify and prevent all forms of abuse and neglect so that everyone living in Hertfordshire and West Essex are able to make a full and positive contribution to society.

Our ICS Director of Nursing and Quality and Associate Director of Adult Safeguarding are both members of the Domestic Abuse Executive Board and the Multi-agency Prevent Board.

Within Essex, due to the number of CCGs and Provider Organisations, there is an agreement in place that one Executive Nurse would attend on behalf of Health (currently from Mid and South Essex ICS). However, all partner organisations receive agenda, and associated papers. The 3 ICS Directors of Nursing meet on a regular basis and information is also disseminated and discussed via the Essex Health Executive Forum

The effects of the pandemic continue to increase the risk of abuse and neglect experienced by the most vulnerable people in our community due to changes in services, reduced family or professional visits, financial scamming, online grooming and increasing pressures within households.

The CCG Safeguarding Adult Teams have played a valuable role in Hertfordshire and West Essex to enable our partners to promote the culture of continuous improvement within their organisations as well as the CCGs by:

- Mental Capacity (Amendment) Act (2019): the April 2022 implementation date for the Liberty Protection Safeguards (LPS) that will replace Deprivation of Liberty Safeguards (DoLS) when the Act comes into force has been deferred by the Government. The revised implementation date will be agreed following the publication of the Code of Practice and Regulations for a 12-week period of consultation. Work to ensure a strong foundation in the knowledge and use of the MCA continues within the CCGs and our providers.

- We successfully delivered four level 3 safeguarding webinars, 2 domestic abuse webinars and 4 Mental Capacity Act webinars, presented by subject matter experts, with excellent feedback.

- As a member of the Prevent Multi-agency Board we enabled the Board to gain a better understanding of the challenges health organisations face in relation to Prevent and supported the development of the Training Programme.

- Our learning Approach to Adult Safeguarding is now embedded and has been revised to include Children's Safeguarding learning and competencies. CCG staff are supported to complete their learning through a blended approach of e-learning and participatory sessions. We continue to provide safeguarding supervision for all CCG staff who have patient contact to support them in their roles and promoted best practice.

- We worked in partnership with the Children's Safeguarding Team to complete Adult Assurance/ Section 11 meetings with provider organisations and gained assurance that safeguarding is embedded within organisations and action plans reflect innovation, management of risk and good practice.

- We worked with partnership agencies to support care homes and care providers to monitor quality and management of risk with the CCG chairing the HSAB Strategic Quality Improvement Group in Herts and the Care Home Hub now renamed Provider Hub led by the CCG in West Essex to drive forward a robust action plan which focuses on quality assurance processes, shared learning and responding to areas of concern.

- Represented the CCG in a number of domestic abuse work streams in response to the Domestic Abuse Bill including the development of a Strategy for 2022 – 2025 which was published January 2022 and the future development of the Independent Domestic Violence Advocate Service. We also chair the Quality and Innovation sub-group of the Domestic Abuse Partnership Board. One of the objectives of this sub-group is to identify learning ensuring that it is shared and implemented by partners.

- We worked with private providers to ensure safeguarding processes were in place for migrants seeking asylum and for those coming from Afghanistan. We sought assurance that hotel staff within Quarantine Hotels had received appropriate safeguarding training to enable them to support this vulnerable cohort of people.

- The team supported CCG staff in managing complex cases through individual case discussions and group supervision. Support and guidance were also given for colleagues in providers and primary care managing complex cases through individual

case discussions and interventions

The team communicated regularly with CCG colleagues and primary care and kept the CCG Boards briefed on key actions.

Safeguarding children

The CCG is committed to safeguarding and promoting the welfare of children. The responsibilities for safeguarding are a statutory requirement supported in legislation. The Children Acts 1989 and 2004, and Children and Social Work Act 2017 places a duty on local authorities to promote and safeguard the welfare of children in need in their area. The Act makes the child's welfare paramount. Section 27 imposes a duty on health bodies to cooperate with a local authority to support children and families. The duties are further clarified within Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019[14], which sets out how all NHS organisations, including those they may contract, should fulfil their responsibilities.

The Children and Social Work Act 2017 implementation was underpinned by the statutory guidance Working Together to Safeguard Children (2018), making CCG's equal partners with Local Authority and Police force in Hertfordshire and Essex.

The Hertfordshire and West Essex teams with support from the East of England regional team are in the initial stages of merging to work together around new structures for safeguarding to support transition to the HWE ICB. The teams have met regularly to discuss joint areas of work, alignment of policies and sharing best practice.

The NHS E/I/I safeguarding program funding in 2021 was used to support key pieces of safeguarding work within the local health economy, in particular upskilling the workforces understanding of MCA in preparation for the impending LPS.

Primary Care

- The CCG Safeguarding Children Primary Care team continues to support and offer expert safeguarding advice to GP Practices throughout the COVID-19 pandemic. A bespoke practice support tool underpins this activity in addition to an updated

[14] **https://www.england.nhs.uk/publication/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs-safeguarding-accountability-and-assurance-framework/**

safeguarding template incorporated within the supporting documentation used for CCG quality visits.

- Named CCG Safeguarding GPs and Nurses participate in CCG Primary Care Quality visits. These visits provide assurance opportunities in relation to safeguarding processes with the additional advantage of direct professional contact with Practice Safeguarding Children Leads, promoting good working relationships and strong local networks. Primary Care Networks also offer opportunities for collaboration, sharing of resources and enriched training opportunities.

- Learning from local reviews has resulted in changes and improvements to safeguarding practices within Primary Care to include enhanced information sharing processes. Following an audit reviewing the quality of returned information requests to Children's Services, an automated electronic form has been created to facilitate accurate, timely information sharing. This has recently been embedded within Primary Care electronic patient record systems enabling auto-population of much of the required information, vastly reducing the time taken to share this vital information. A training webinar planned for January 2022 will provide an overview and demonstration to Primary Care colleagues of this improved process. A 'gold standard' template has also been produced to support staff with the completion of these requests for information.
- The biennial Safeguarding Children and Adult audit was completed in 2020 by 77% of GP Practices in West Essex. Practices who either did not submit an audit, or identified areas requiring additional support are being offered a practice visit by Safeguarding team. An audit of the GP child protection case conference reports submitted to Children's Services has been completed. Identified learning will be addressed to achieve compliance. With standards set. The report and action plan has been shared with GP practices for comment. Discussions are planned with Primary Care to consider options moving forward.

Secondary Care

- The team continued business as usual throughout the pandemic and delivered increased levels of support to provider organisations especially focussing on solutions for presenting issues/incidents, facilitating joined up working and ensuring that multi-agency partner organisations were continually sighted on any changes in health service provision. Assurance workstreams continued via quarterly dashboards and statutory annual Section 11 assurance visits to large providers, along with supporting public health commissioners with the same. Action plans

continued to be monitored via provider organisation quarterly safeguarding meetings and close working with quality and contract teams where required.

The Designated teams have continued to work with agencies to ensure that protecting children remains a priority despite the pandemic, and to highlight identified risks to ensure our most vulnerable children were seen, with a focus on mental health issues, invisibility of children, exploitation and domestic abuse. The team are active members of the Safeguarding partnership, supporting a number of workstreams, consistently attending subgroups to drive change and improve outcomes for children. The risk to children emerged in serious incidents both locally and nationally; identified through reviews. Learning events with the safeguarding partnership were held to support front line practitioners to ensure robust approaches to identify invisible children and ensure they are not overlooked.

- The team have adapted to virtual platforms which has successfully increased the reach to front line staff and fundamental to learning from safeguarding reviews. Funds have been allocated for targeted training and the team have also focussed on quality improvement approaches with organisational safeguarding professionals to promote action in identifying gaps and improving practice following national and local reviews.

Looked after children (LAC) During the collation of the JSNA it was agreed that children in care would be referred to as Children Looked After (CLA) to avoid confusion. For the purposes of any further reporting the Designated team will refer to Children Looked After and CLA.

Capacity to complete initial health assessments for children entering local authority care within the 20-working day timeframe remains a challenge within west Essex due to competing work pressures for the Essex Child and Family Wellbeing Service (ECFWS) paediatricians. Work is on-going with the service to seek solutions. A SET wide IHA proposal is being considered and progressed through the Health Executive Forum.

- During the pandemic the Designated Children's Looked After team (CLA) has worked to develop closer working relationships between CLA Health and Social Care. Particularly in relation to identification and sharing of information around specific vulnerable children who are in crisis or requiring additional support. This has been helpful and, in some cases, has improved understanding of each other's roles in the care of CLA.
- The Designated CLA team contribute to the Partnership including a working group to establish an Exploitation hub. The partnership group - Vulnerable Adolescent

Strategic Group (formerly SAAG) will be able to identify hot spots of activity and risk by sharing data from all services/providers. This will enable development of targeted strategies to reduce child sexual/criminal exploitation and associated risks that present to young people.

- The Designated CLA team have audited records of children who have declined a statutory Health assessment over the last 18 months. Recommendations on how the refusal process may be improved by working with some children currently in care as well as some care leavers to develop an understanding of why young people refuse as well as use their skills to develop some more user-friendly information around the process.
- The NICE Quality Standard on Foetal Alcohol Spectrum Disorder (FASD) has yet to be published. As it is known that FASD affects many CLA the designated team have been doing some preliminary work. The team were lucky to secure national experts for an afternoon session to raise awareness of FASD across the partnership. Following this the Designated team are contributing to a round table exercise being run to share knowledge and expertise of others who have commissioned / work in FASD services with a view to contributing to a business case for a local service.
- Dental access for routine appointments for CLA has proved increasingly difficult over the last 2 years and current data suggests that the number of children in care with a dental check in the last year is 52%. The designated team are working with local dental commissioners to improve this over the next year. This is a national problem, and a regional workshop has taken place – follow up meeting is in February.
- During the last year the number of children coming into care has increased with the number from Hertfordshire currently 1015. This number has been impacted by an increase in separated migrant children[15] coming into Hertfordshire although numbers remain consistent at around 85 as the age of becoming CLA is usually around 16 -18yrs.
- There has been an increased requirement for Tier 4 beds[16] where the demand has exceeded availability the Designated team have been sighted on concerns and attended meetings where appropriate.
- The Designated CLA team have been involved with creating a survey to establish the impact of trauma on professionals working with and those that have experienced trauma first-hand. The survey findings will contribute to the Trauma Informed Practice strategy work that is taking place by Hertfordshire County Council for implementation across the partnership.

[15] Formerly known as unaccompanied asylum-seeking children or UASC.

[16] Tier 4 are specialised services that provide assessment and treatment for children and young people with emotional, behavioural or mental health difficulties.

Separated Migrant Children (formally Unaccompanied Asylum-Seeking Children)

HWE safeguarding teams contributed to support children and young people who arrived in Hertfordshire and West Essex in 2021. Harlow continues to see a significant number of Separated Migrant Children placed in semi-independent accommodation which has had a direct impact on the capacity of the local paediatricians to complete the Initial Health Assessments within timescales. The service forms part of the Essex Child and Family Wellbeing Service. A solution has been agreed that should increase the IHA capacity within the service.

West Essex Bridging Hotel

Hotel accommodation in Harlow has been commissioned as a temporary 'bridging hotel' for Afghanistan refugees, predominantly families since September 2021. Multi-agency Essex-wide Afghan Planning meetings are held regularly to coordinate the response and identify any emerging concerns. Additional safeguarding training has been offered to the hotel staff by the local Stay Safe group membership.

Asylum Contingency Accommodation

Hotel accommodation was commissioned by the Home Office in August 2021 to provide accommodation for Asylum Seekers arriving in the UK. The hotel continues to have approximately 120 guests, including families and single individuals. Due to the location of the hotel and its proximity to Bishops Stortford. Additional safeguarding training has been offered to the hotel staff by the local Stay Safe group membership.

Stansted Hotels

The three hotels at Stansted Airport have been intermittently commissioned by the Managed Quarantine Service (MQS) on behalf of the Department of Health and Social Care to act as quarantine accommodation for residents returning the UK from 'red list 'countries/ Afghanistan refugees for the mandated 10-day isolation period. The CCG safeguarding team provide oversight of the health based safeguarding arrangements within the hotels.

Child Deaths

- The CCG have worked closely with QES (electronic child death recording system provider) to facilitate a virtual seminar for Named GPs in the completion of child

death reporting forms to enable support to be offered to the wider system. This has led to increased participation in the use of the virtual platform.

- To ensure continual awareness raising and support for the child death process the team have collaborated with Providers and Region to provide training on all aspects of child death and supporting process, including contributing to the updated Safe Sleep leaflet.

The Essex Child Death final report is awaited following a thematic analysis, undertaken by the Strategic Child Death Overview Committee, of Sudden Unexpected Deaths in Infancy across SET to identify any specific local learning in the light of findings from the Child Safeguarding Practice Review National Panel analysis '*Out of routine: A review of sudden unexpected death in infancy in families where the children are considered at risk of significant harm*', published in July 2020. In most cases it was noted that families experienced additional adversities.

Section 11 and NHS E/I/ Improvement Safeguarding Assurance Tool (SAT)

The 3 CCGs submitted the safeguarding assurance tool to NHS E/I in November /December 2021. West Essex submitted the SAT to the Essex Safeguarding Children Board (ESCB) with work in progress to address outstanding actions related to updating the safeguarding policies to reflect the new Integrated Care System (ICS) landscape.

West Essex will review the Designated Doctor for Looked After Children allocated hours across Southend, Essex and Thurrock to meet the requirements outlined within national guidance.

The Essex Safeguarding Clinical Network (SCN) is a professional network that supports the delivery of the Safeguarding Children, Looked After Children and Adult work-streams across the 7 Southend, Essex and Thurrock (SET) CCGs/ 3 Integrated Care Systems (ICS). The purpose of the network group is to have a shared vision for safeguarding across the Essex health economy, to provide co-ordination and consistency across the CCGs and to create capacity in the system, for the shared and collective responsibility with the Essex Safeguarding Children Board (ESCB).

Within the new multi-agency safeguarding arrangements the Stay Safe forum's purpose is to coordinate and lead the local safeguarding agenda for each quadrant. The focus is on improving local outcomes and highlighting emerging issues and risks so that they can be appropriately addressed at operational level. Strengthening communications from the ESCB Board and Stay Safe has been undertaken and continues to progress.

Improving the health of people with a learning disability

- West Essex Learning Disability services are commissioned by Essex County Council and service delivery is monitored via the Essex Learning Disabilities Health Equalities Board which meets every month. These meetings are inclusive of those living with a learning disability and their families.
- Service users involvement has been instrumental in quality improvement work with care homes, including undertaking care home visits, interviewing staff and providing the training required for people to better understand the needs of individuals with learning disabilities.
- In line the aims of Transforming Care [17] which aims to improve health and care services so that more people can live in the community, with the right support, and close to home; there were 2 CCG funded placements and 5 NHS E/I Specialised Commissioning Funded placements. Both achieving NHS E/I national targets.
- A new national LeDeR Learning from Lives and Deaths policy was introduced in March 2021. The Southend Essex and Thurrock (SET) LeDeR Steering Group meet bi-monthly to discuss the reviews of the Essex wide population, to ensure requirements of the policy are met and that learning from reviews leads to cross system service improvement. West Essex are committed to a 3 year SET delivery plan for LeDeR to achieve better outcomes for those living in Essex.
- Delivery of Annual Health Checks for people with learning disabilities continues to be a priority. An easy read Annual Healthcheck preparation tool has been promoted to increase the quality of completed checks and embed a collaborative approach. The national target for Annual Health Check delivery is 75%.
- The official year end national data is usually published in June for the preceding year. Monthly data from NHS Digital released for April – December 2021 shows cumulatively that WECCG completed 73% annual health checks. (Data source: **Learning Disabilities Health Check Scheme - NHS Digital**) 2% of patients did not access their annual health checks and insight provided by GPs practices indicated that individuals were still reluctant to attend clinical practices during the COVID pandemic. West Essex began work with ECC and North East Essex CCG to review Cancer Screening programmes and how to support people with a learning disability to access services.
- The STOMP/STAMP programme to address over-medication of people with a learning disability or autism with psychotropic medications was restarted during Q4 of 2021-22 after a pause due to the pandemic. This work will continue into 2023.

[17] https://www.england.nhs.uk/learning-disabilities/care/

- Significant effort has been focused on the Covid vaccination programme. A collaborative approach between health and social care has ensured maximum uptake of both the primary vaccinations and boosters for people with a learning disability.
- Care and Treatment Reviews have continued in a virtual adapted format for both community and inpatient settings.
- Safe and Wellbeing reviews have taken place for all WECCG inpatients in specialist learning disability/autism beds, these were undertaken by a team consisting of representatives from the Learning Disability Health Equalities Team and the pan Essex Individual Placement Team as they both commission hospital placements on behalf of the Essex CCGs. With ICS panel review of findings in February 2022, and learning feeding to the national team by the end of March 2022. (Programme information source: **https://www.england.nhs.uk/learning-disabilities/care/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/**)

Emotional Wellbeing Mental Health Service Learning Disabilities Team (EWMHS LD) The service supports CYP with both a mental health problem and a range of related complex developmental disorders and helps establish behavioural management strategies which can be used effectively with each child within a neutral and therapeutic environment, before supporting families/schools to replicate this within the home/school environment. Where this is not possible by EWMHS/LD staff, liaison with Social Services and/or Educational Services will take place to ensure consistency across all environments and to encourage long-term success. The service continues to offer assessment, treatment and support, assessment for referrals to Tier 4 (inpatient) services, and advice, consultation and training to parents, carers and other professionals, working in an integrated way across Health, Social Care and Education.

There is a requirement for clinical commissioning groups (CCGs) to develop and maintain registers to identify people with a learning disability, autism or both who display, or are at risk of developing, behaviour that challenges or mental health conditions who were most likely to be at risk of admission.

This register called the Dynamic risk register (DSR) is held by the Clinical Education Treatment team (CETR) on behalf of all 7 CCGs across Southend, Essex and Thurrock. Due to increased demand on the service, the DSR is still in the early phases of development and an agreed increased capacity within the team will allow for an enhanced programme with involvement from partner agencies to make sure that all best practice for children and young people with a Learning Disability and/or Autism is in place.

REDUCING HEALTH INEQUALITIES

West Essex CCG is committed to taking action on the inequalities experienced by the population that we serve. 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.

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

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

There are differences in people's health outcomes in different districts[18]. 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.

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

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 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 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 2021/22 following disruption this year from the COVID pandemic. 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

ENGAGING PEOPLE AND COMMUNITY

Priorities in 2021 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 around health inequalities picked up pace throughout 2021-22, partly because of the work to increase uptake of the COVID-19 vaccinations and boosters.

Working closely with the voluntary sector, partners including Essex County Council, Healthwatch Essex and colleagues, programmes of work have begun to address issues around topics including digital access, clinical care, housing needs, socio-economic support, and healthy behaviours. Medium term priorities are being set and include work around healthy weight, access to services and mental health.

Through the resources of the Contain Outbreak Management Fund Programme (COMF), the CCG has focussed efforts on partnership working with numerous delivery partners. Efforts have ranged from mobilising social prescribing activities with communities to recruiting and deploying 40 volunteers to support the COVID 19 Vaccination Programme.

The establishment of three community hubs is engaging individuals and communities most in need and who have multiple health and social care needs. The work of Epping Forest Citizens Advice in Waltham Abbey is offering a range of support to address the impact of the pandemic.

Working with the voluntary sector
The voluntary sector in west Essex has, and continues to, play a key role in a wide range of programmes and public engagement.

The CCG continues to regularly meet with voluntary sector colleagues, seeking advice on the best way forward, communication, consideration for events and engagement. The relationship with voluntary sector colleagues has been key to establishing networks,

sharing information, and reaching communities within the west Essex population that require additional support.

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.

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 and the Integrated Care Board going forward.

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 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 forum 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.

In 2021/22 we remained fully compliant with all nine areas of **NHS E/I's Core Standards for Emergency Preparedness, Resilience and Response.**

COVID-19

The NHS continues to respond to COVID-19. The virus has been named "SARS-CoV-2" and the disease it causes has been named "coronavirus disease 2019" (abbreviated "COVID-19"). On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the outbreak a "public health emergency of international concern" (PHEIC). On 11th March 2020, the World Health Organisation publicly characterized COVID-19 as a pandemic. A pandemic is a global outbreak of disease.

NHS E/I and NHS Improvement (NHS E/I) declared an NHS Level 4 incident during March 2020, as the country moved to a confirmed pandemic. A 'Level 4' incident is one that requires NHS E/I/I national command and control to support the NHS response.

The incident level was stepped down to Level 3, an incident that requires the response of a number of health organisations across geographical areas within NHS E/I at the end of March 2021, when the UK started to see a decline in cases, the vaccination programme had progressed and was providing the public with protection against the Delta variant, preventing serious illness and hospital admissions. The incident level was raised to a level 4 incident in December 2021 due to the new Omicron variant causing infection rates to once again, rise rapidly. The NHS E/I incident alert level currently remains at level 4 (February 2022) with no indication from NHS E/I to step down to a level 3 incident in the immediate future.

Clinical Commissioning Groups (CCGs) Role in the Response

NHS E/I co-ordinate the response in collaboration with the CCGs whom in turn, as Category 2 responders, provide support at a tactical level through a local health leadership role.

In response to national requirements ENHCCG, HVCCG and WECCG established Incident Coordination Centre (ICC) teams at the start of the Pandemic, and these continue to function 7 days per week, as per NHS/I requirements. The ICCs provide focal points of coordination for the Covid-19 response and allows the CCGs to process, gather and disseminate information across all partners as required. The ICC teams have managed and supported a variety of issues including Personal Protective Equipment (PPE) demands, European Union (EU) Transition, Managed Quarantine Service Hotels, implementing a testing strategy for Hertfordshire and Essex, establishment of vaccination centres and outbreaks management. They continue to provide a single point of contact for providers in the system for Covid related issues and increasingly for escalation of other system pressures. Command and Control structures were implemented for all 3 CCGs including, two-tier Senior Manager on Call rotas, ICC Managers and administrative support. ICC action cards and other supporting documentation have been developed for all key roles to manage the incident response.

The Command-and-Control structure for the CCGs is as follows:

- Strategic: CCG Executive Team (ENHCCG), Senior Management Team (WECCG) and Incident Management Team (HVCCG)
- Tactical: Incident Coordination Centres
- Operational: Cells/key work programmes.

ENHCCG has led the health response to Covid on behalf of Hertfordshire, supported by HVCCG. ENHCCG chair the Health Economy Tactical Coordination Group (HETCG) and is the health representative at the Hertfordshire Strategic Coordination Group (SCG) and the Health Protection Board (HPB). WECCG represented health for West Essex on the Essex SCG and continues to lead the Covid Testing TCG.

During wave 1 of the Covid-19 pandemic the CCGs implemented internal cell structures comprising of representation from all teams within their organisations to support command and control and to deliver critical pathway and service changes in response to the incident. These cells have continued throughout the pandemic and their function includes scrutinising service provision and performance. The main CCGs cells are (some variations per CCG):

- ICC
- Communications
- Primary care and localities
- Planned care

- Unplanned care (Urgent Care and System Resilience)
- Contracts and Performance, including service changes across all key providers
- HR and Governance
- Pharmacy
- Recovery
- Continuing Health Care
- Voluntary Services
- Mental Health
- Children and Young People
- Human Resources

The CCGs internal governance structures developed have supported them to:

- Engage at the Hertfordshire and Essex Strategic Co-ordinating Groups to represent their populations from a strategic multi-agency health perspective
- Engage at the Hertfordshire and Essex Tactical Co-ordinating Groups to ensure involvement at a local level with joint working from their local county or area systems
- Continue to engage with the Hertfordshire and Essex Directors of Public Health on the Health Protection Outbreak Board
- Provide updates about CCG and system progress to their respective governing bodies through the reporting routes established
- Continue to work with NHS E/I/I for situational awareness and reporting
- Chair Hertfordshire and Essex-wide meetings with the other commissioners and providers on the health TCGs to provide a tactical health response
- The CCGs also work as part of the Hertfordshire and Essex communications cell to plan and deliver COVID communications for the public, staff and stakeholders.

Mass vaccination and outbreak cells

A mass vaccination cell was established to support the roll out of the Covid vaccination programme. However, when gaps in uptake were identified, a further cell was established to address the inequalities across different cohorts of the population and reduce the gaps. The CCGs have also supported the booster campaign with several staff being redeployed to support the effort.

Due to the increased number of outbreaks and clusters occurring after the initial influx of reports an Outbreak Cell was formed with standard templates for action cards and reporting documents circulated to General Practice, in addition to duty managers and the ICCs internally. Roles and responsibilities and escalation frameworks were included on IMT

agendas to ensure all members of outbreak IMT calls were clear on reporting requirements and understood what needed to be done by each organisation.

Debriefing and Recovery

Due to the longevity and scale of the Covid-19 response, the CCGs have run a live, ongoing debrief process. The objective of this process is to identify learning in a timely manner to ensure solutions are implemented to adapt or enhance the ongoing incident response. The CCGs have also facilitated and taken part in formal debriefs with incident response staff, system and multi-agency partners to produce debrief reports with action plans to implement lessons identified to improve the CCGs response to future incidents.

Workforce

Although sickness absence levels remained below the national average for CCGs during the pandemic, Covid-19 has had a significant impact on the health and wellbeing of staff. Recognising this, the CCGs have continued to build a culture which supports staff health and wellbeing, evaluating existing support offers to staff and ensuring they were supported with access to available health and wellbeing services and resources.

The CCGs continue to promote flexible working arrangements such as homeworking to encourage work-life balance for staff and to provide a Covid secure environment for those that attend the offices. In making the offices Covid secure, extensive improvements were made to the staff environment; measures include wearing face masks in general office building areas, socially distanced desks and meetings room, enhanced office cleaning schedules for both equipment and the offices themselves.

The CCGs have recognised the impact that Covid-19 has had on staff members from ethnic minorities and continue to take every effort to support them ensuring access to and completion of risk assessments, psychological support services and Covid-19 vaccinations. The CCGs will continue to support their ethnic minority staff groups and will engage in national and local improvement programmes to promote equal opportunities for them.

Concurrent Incidents

The CCGs have responded to several concurrent incidents, listed below, throughout the Covid-19 Pandemic. These incidents have all been managed within the existing command and control structure for the Covid response.

- Fuel Crisis
- Afghanistan Refugees - Managed Quarantine Services Hotels
- Beckon Dickson Medical Supplies Disruption

- Death of Prince Phillip (Operation Bridges)
- EU end of Transition

The Immediate Future

The CCGs continue their attendance at national leader's webinars, together with representation at strategic and tactical meetings as required by multi-agency partners, NHS E/I and system operational rhythms.

The CCGs also continue to respond to the Covid-19 Pandemic itself, maintaining command and control in line with national NHS E/I requirements; these can be scaled up and down dependent on the level of Covid activity. There is also a strong focus on recovery and restoration of services, working with providers and staff to ensure lessons learned are an integral part of the ongoing discussions at recovery team meetings and will enhance and improve existing plans, procedures, processes and policies.

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

Locally for NHS West Essex CCG and, in line with government legislation, during 2020/21 the organisation successfully moved largely to remote working because of the Covid-19 pandemic. Our health and safety arrangements were reviewed, and the risks assessed, which continue to be monitored. 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.

Plans

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)[19]

West Essex CCG spent £ 103,541 on energy in 2021-22

[19] 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.

REVIEW OF FINANCIAL PERFORMANCE

Financial Overview

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

The CCG has a statutory duty to manage their finances within the resources available. key duties and the performance of the CCG are set out in the table below:

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 Breakeven with a cumulative underspend of £10.000m
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 Breakeven with a cumulative underspend of £10.000m
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 underspent by £0.092m in 2021/22
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 normal financial planning process for the year 2021/22 was suspended at the end of March 2020, when NHS E/I removed the routine burdens on NHS bodies, freeing up resource to focus on the operational response to the COVID-19 pandemic. NHS E/I instigated an emergency financial regime for all NHS organisations to ensure financial viability for the NHS and to remove unnecessary administrative burdens. Funding was made available to CCGs, NHS and non-NHS providers and Local Authorities to cover costs arising from managing COVID-19 patients.

These emergency financial arrangements effectively simplified financial management and allowed greater focus on health system partnership working to manage overall resources. The regime included providing funding to be distributed to individual organisations within the Hertfordshire & West Essex Integrated Care System (ICS) with funding envelopes, incorporating mandated block values to NHS Providers, prospective top-up, growth and COVID-19 allocations for 2021/22. A summary of the framework over the full period of the emergency financial regime is shown in the table below:

Category	Months 1 to 6 2020/21	Months 7 to 12 2020/21 (H2)	2021/22
Allocations and Budgets	Budgets were set based on 2019/20 actual expenditure at Month 11, uplifted for inflation. Allocations were adjusted retrospectively to achieve a breakeven position against actual expenditure, on each service line, and including expenditure in response to the pandemic	Financial Envelope for HWE ICS provided by NHSE. The CCG's allocation within this has been set against NHSE estimations of budgets required. "Top-ups" are provided through the ICS for growth and COVID-19 expenditure to achieve breakeven positions. Financial performance will be measured against a breakeven control total	
Contracting and Commissioning	Contracting and commissioning stood down. No invoicing for NHS Non-Contracted Activity (NCAs)		
NHS providers	Block payments above £250k mandated from commissioners to providers, top-ups made by NHSE to allow providers to breakeven against shortfall in income and COVID-19 expenditure	Block payments above £500k continue. Ability to adjust these payments to recognise newly-commissioner services not in the baseline in 2019/20. Requirement to top-up mental health providers to achieve MHIS. Providers supported within the overall ICS financial envelope	
Independent Sector	Nationally commissioned		Commissioning returned to CCGs, working with main providers.
Non-NHS Providers	"Light touch" contract management to support sustainability and recovery	Expectation that support to providers is phased out and normal activity resumes	
Primary Care	Protected income at 2019/20 levels. COVID-19 expenditure is reimbursed	Additional requiremens of Care Home DES and Additional Roles Reimbursement Scheme have been included in the CCG's baseline budgets	
Efficiencies and QIPP	No requirements to deliver efficiencies and all QIPP schemes deferred	Expectation that a level of efficiency will be delivered, although no formal efficiency reporting	

The total allocation received by the CCG during the financial year 2021/22 was £825.023m. This included the CCG's annual allocation and retrospective top-up and COVID allocations. In addition, West Essex CCG is 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	472,589
Devolved Commissioning	55,250
Running Costs	6,274
Cumulative Surplus *	10,000
Retrospective CCG Top-up and COVID-19 funding **	3,683
Service Development Funding (SDF)	18,274
Prospective System Top-up, growth and COVID-19 funding	258,593
TOTAL	**825,023**

* The CCG is not authorised to spend the cumulative surplus

** The allocation received for the Hospital Discharge Programme (HDP) of £3.475m is included within the COVID-19 funding allocation

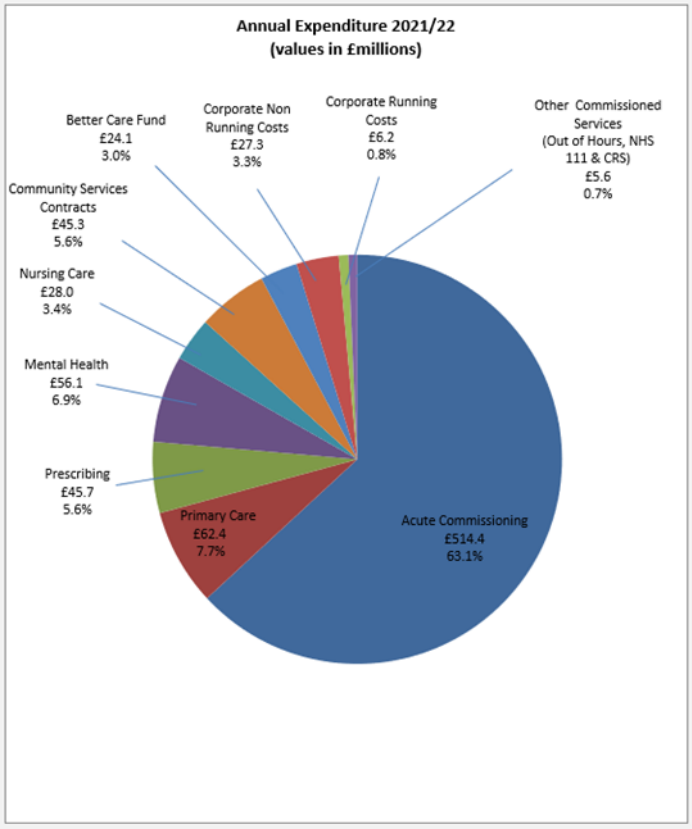
The CCG met the statutory requirement to keep spend within the resources allocated and maintain the 1% cumulative surplus of £10.000m. Of the total available resource of £825.023m, the CCG spent and distributed £815.023m, and maintained the cumulative surplus of £10.000m.

The table below shows the source of the £10.000m cumulative surplus.

Source of Surplus 2021/22	Value £'000
Return of prior year cumulative surplus	10,000
Surplus from other CCG budgets	0
Cumulative Reported Surplus in 2021/22*	10,000

**Cumulative surplus to be returned to the CCG in 2022/23*

Details of how the CCG spent its allocation during 2021/22 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.



Directorate	Annual Expenditure £m	%
Acute Commissioning	514.4	63.1%
Primary Care Services	62.4	7.7%
Prescribing	45.7	5.6%
Mental Health	56.1	6.9%
Community Services Contract	45.3	5.6%
Nursing Care	28.0	3.4%
Better Care Fund	24.1	3.0%
Other Expenditure	5.6	0.7%
Corporate Non Running Costs	27.3	3.3%
Corporate Running Costs	6.2	0.8%
Grand Total	815.0	100.0%

NHS E/I 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 as 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 2021/22.

Hospital Discharge Programme

The Hospital Discharge to Assess model has been operating in Hertfordshire in various forms for several years. The model is that decisions about a person's care and support needs, particularly in the longer term, are best made after or during a period of enabling care when any immediate crisis period is passed.

In response to the COVID-19 pandemic and the need to ensure hospital beds were available to those who needed them most, the government introduced new hospital discharge arrangements based on the expanding of Discharge to Assess (DTA) model. Health and Care

systems were financially supported by NHS E/I under the Hospital Discharge Programme (HDP) to ensure people who no longer needed to stay in hospital were discharged safely from hospital to the most appropriate place and continue to receive the care and support they needed after they left hospital. Any expenditure incurred by the system under this programme represented the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to four weeks following discharge from hospital with reimbursed by NHS E/I. The programme ensured Social Care needs assessments and NHS Continuing Healthcare (CHC) assessments of eligibility were made in a community setting and did not take place during the acute hospital inpatient stay.

For the financial year 2021/22, the total amount spent by the CCG under the Hospital Discharge Programme was £3.535m.

Mental Health Investment Standard

A very important requirement in the 2021/22 planning guidance related to the Mental Health Investment Standard (MHIS), under which all CCGs are required to increase their spending on mental health services by at least the percentage increase on the CCG's programme allocation growth. In 2021/22 the CCG's programme allocation growth was 4.25%. However, during the year the CCG received additional funding to manage the impact of a higher NHS staff pay award. The adjusted MHIS target after allowing for this increase was a growth in expenditure of 4.87%.

In additional, the CCG received non recurrent allocations such as funding for improved access to psychological therapies and national funding such as service development (£2.083m) and spending reviews (1.625m).

The CCG targeted the increased investment at delivering the Mental Health Five year forward view and other national priorities. This included investment in:

- Continued expansion and growth in both community and specialist perinatal mental health services e.g., increasing access to women who can access the service
- Expansion of IAPT services to people with Long Term Conditions, such as diabetes, respiratory and MSK. Development of Long Covid pathways
- Embedding the 24/7 CAMHS Crisis helpline
- Crisis resolution and home treatment team
- Early intervention in psychosis – support for people in the "At Risk Mental State" group

- Adult eating disorders day treatment
- Individual placement and supports (employment support)
- Annual physical health check for adults with serious mental illness
- Improving the therapeutic offer in inpatient care to support a reduction in length of stay and better outcomes
- Core 24 standard for psychiatric liaison
- GP health checks and vaccination rates for the people on the GP Learning Disabilities register
- Increased focus on delivering the nationally set trajectory for the reduction of Out of Area Placements to zero
- Commitment as a system to reducing the number of suicides across Hertfordshire and West Essex and maintain effective suicide bereavement support services

Spending on Learning Disability and Dementia services is currently excluded from the Mental Health Investment Standard calculation, although the CCG did invest in the learning disabilities community forensic service, Section 117 service and to reduce the reliance on inpatient care for people with a learning disability and/or autism to meet the NHS Long Term Plan commitments.

Achievement of the Mental Health Investment Standard is measured by comparing expenditure in 2021/22 to that in 2020/21, after adjustment of all non-recurrent allocations received by the CCG in either of these years. These adjustments are made to ensure that changes in spending are not distorted by non-recurrent allocations and are limited to expenditure funded from the CCG's general allocation.

CCGs are required to confirm their spending meets the Mental Health Investment Standard and to publish a formal declaration on whether in 2021/22 West Essex CCG's spending on mental health services increased by at least 4.87%.

The table below provides the CCG's calculations demonstrating that in 2021/22 West Essex CCG did meet the requirements of the Mental Health Investment Standard.

Description	£000 unless stated otherwise

2021/22 Mental health spending	55,643
Less spending on Learning disability and dementia	(13,249)
Less spending covered by allocations received	(3,708)
2021/22 spending funded by general allocation	38,686
2020/21 spending funded by general allocation*	36,305
Increase in spending	2,381
Increase in spending (%)	6.56%
Has the Mental Health Investment Standard	**Yes**

** In 2021-22, a re-categorization exercise took place the net effect of which resulted in a reduction in the spending reported under MHIS. For 2020-21, the previously published MHIS spending was £45,044k.*

Financial outlook for 2022/23

In recognition of the impact of the COVID-19 pandemic, NHS E/I has maintained the same financial framework that was introduced in the second half of 2020/21 (H2) during 2021/22. However, all NHS organisations will transition out of the emergency financial regime during 2022/23.

The financial envelope for Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) has been provided by NHS E/I and comprises of the adjusted CCG allocation, based on agreed spend, including costs incurred as a response to managing the pandemic, with allowances for inflation and policy priorities. This will be delegated to the respective CCGs for the 3-month period before the establishment of the ICB, which is expected to occur on 1 July 2022 (subject to the passage of the Health and Care Bill through Parliament).

The commissioning of services from the NHS and non-NHS providers will return to a negotiated contractual basis, with the development of the Aligned Payment Incentive Agreements (APIA) for contracts with NHS Providers above £30m.

The requirement for the CCG to continue to increase funding within Mental Health in line with their allocation growth continues and West Essex CCG is planning to meet the Mental Health Investment Standard (MHIS) in 2022/23.

Performance process

The CCG has a robust performance management regime for its internal performance against national and local targets as well as key clinical and financial indicators. These targets and indicators are monitored on a monthly basis by the Executive Team and the Finance and Performance Committee, with each target having an identified senior lead. This is reported to each Board meeting in public, to provide an open and transparent view of performance in all areas of the business.

The Board receives a summary finance report at every public meeting. A full finance report is reviewed in detail by the Finance Committee.

Commissioning Activities

A key priority for the CCG is to ensure that maximum value for money is being achieved through effective commissioning arrangements, as the majority of the CCG's expenditure is spent on commissioning healthcare services. Whilst healthcare providers are required to deliver a continuous programme of efficiency and productivity improvements, the CCG also must demonstrate that it is properly considering the health needs of the local population and commissioning those services that address those needs.

An analysis of the key contracts by value is as follows[20]:

Provider	Outturn 2021/22 £'000

[20] Please note that the figures above include Herts and West Essex system funding that has flowed through West Essex CCG as the host for ICS finances

Princess Alexandra NHS Trust	226,677
West Herts Hospital Trust	96,749
East & North Hertfordshire Trust	66,754
Essex Partnership University FT	58,788
Cambridge University Hospital NHS FT	29,260

The CCG continues to ensure it achieves value for money in all of its contracting activities through its performance management framework including the monitoring of a range of key indicators and performance reviews with all key service providers.

Audit Arrangements

External audit services are provided by KPMG LLP.

The total fee for 2021/22 was £82,500 excluding VAT.

Internal Audit services are provided by West Midlands Ambulance Service.

The total fee for 2021/22 was £27,000 excluding VAT.

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 functions.

ACCOUNTABILITY REPORT

Dr Jane Halpin
Accountable Officer

Date signed: 16 June 2022

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 31 March 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 2021/22, 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 April 2021 to the date this report was signed (16 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 127 provides details of the membership of the Remuneration Committee.

The Governance Statement, from page 105 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 2021/22

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 (NHS E/I). NHS E/I 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/I 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/I, 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: 16 June 2022

GOVERNANCE STATEMENT

Introduction and context

NHS West Essex Clinical Commissioning Group (CCG) is a body corporate established by NHS E/I 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.

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS E/I 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 Boardin 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 8th July 2021 in order to publish and present the annual report and audited accounts for the year ending 2020-21;
- 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 on page 111. Attendance of the Board meetings is detailed below:

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[21]

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.

During its work, activities and areas of review throughout the year, the committee ensured that any areas of particular concern were brought to the Board's attention through the

[21] The Board, Renumeration Committee and Primary Care Commissioning Committee met in Common with Herts Valleys CCG and East and North Hertfordshire CCG for most of 2021/22

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 for 2021/22

Members' attendance records are detailed in the following table.

		WECCG Only	In Common*
Number of meetings held during 2021/22		**2**	**4**
Name:	**Title/Locality:**	**Attendance:**	
Dr Rob Gerlis	Chair	2	4
Dr Angus Henderson	Deputy Clinical Chair	1	3
Dr Jen West	GP Representative - Uttlesford	1	2
Dr Shawarna Lasker	GP Representative – Epping Forest	1	3
Dr Ian Perry	GP Representative – Epping Forest	1	3
Dr Amik Aneja	Clinical Lead – Urgent Care	2	4
Dr Duncan Forsyth	Secondary Care Consultant	1	3
Stephen King	Lay Member - Governance	2	4
Bobbie Graham	Lay Member – Patient and Public Involvement	2	3
David McConnell	Lay Member – Primary Care	2	4
Dr Jane Halpin	Chief Executive (Accountable Officer)	2	2
Peter Wightman	Managing Director	2	4
Dr Rachel Joyce	Director of Clinical and Professional Services	1	3
Jane Kinniburgh	Director of Nursing and Quality	1	2
Avni Shah	Director of Primary Care Transformation	2	4
Alan Pond	Chief Financial Officer	2	4

* For much of 2021/22 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 2021-22	**6**
Title:	**Attendance:**
Lay Member, Governance*	6/6
Lay Member, Public and Patient Engagement	0/6
Lay Member, Primary Care	5/6

* Chair of Audit Committee

Primary Care Commissioning Committee

Number of meetings held during 2021-22	6
Title/Locality	
Lay Member - Primary Care (Chair)	6/6
Lay Member (Vice Chair)	6/6
Joint Chief Executive Officer H&WE ICS & CCGs	0/6
Managing Director	6/6
Chief Finance Officer	4/6
Acting Primary Care Lead & Chief Pharmacist	6/6
Director of Primary Care Transformation H&WE ICS & CCGs	6/6
Director of Nursing & Quality – (deputy)	5/6
Independent GP Member	5/6
Independent GP Member	6/6

* Chair of Primary Care Commissioning Committee

Quality Committee

Number of meetings held during 2021-22	6
Title/Locality:	**Attendance:**
Special Advisor to the Board for Clinical Quality *	6/6
Secondary Care Consultant	4/6
Chief Medical Officer OHCP	2/6
Director of Nursing & Quality	6/6
GP Board Member - Uttlesford	2/6
GP Board Member – Epping Forest	2/6
GP Board Member - Harlow	0/6
Primary Care Lead	5/6
Performance Lead	5/6

* Chair of Quality Committee

Remuneration Committee

Number of meetings held during 2021-22	4
Title/Locality:	**Attendance:**
CCG Chair	4/4

CCG Lay Member, Patient and Public Engagement*	4/4
CCG Lay Member	4/4
Special Advisor to the Board for Clinical Quality	3/4
CCG Lay Member, Primary Care	4/4
CCG Clinical Vice Chair	1/4

* Chair of Remuneration Committee

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.

NHS
West Essex
Clinical Commissioning Group

Risk Assessment

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 the end of March 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 end of March 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)
NHS Constitutional Standards PAH. A&E 4 Hours 95% RTT 92% 62 Day Cancer 85% Diagnostics 99%	Feb 2022 Performance 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. Negotiations with HUC are ongoing.		**20**

There is currently no formal contract (NHS Standard contract or other contract) in place with providers of nursing home care and domiciliary care for CHC patients. Contracts were issued in February 2022 to parent companies of homes that expressed an interest in contracting with us.	**15**
Lack of tier 4 provision: children and young people being inappropriately admitted into paediatric settings. Monitoring system pressures in acute trusts across the system and how the system is working to manage this. Risk is currently under review with ICS Quality and Mental Health leads with interim measures in place.	**25**
PAH: 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 and skill mix, 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. This may result in patient harm. Trust have submitted their action plan in Dec to the CQC and continue to work on Section 31 elements. Internal Chief Oversight Scrutiny Panel established and facilitating early conversations with CQC around what closure of Section 31 looks like.	**25**
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. BEAT (VCSE Provider) commissioned to provide intervention to patients in primary care & train PCN Teams. EPUT currently writing up business case for further investment for medical monitoring & core service.	**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. If these risks remain on the WECCG corporate register at 30 June 2022, they will be transferred to appear as equivalent risks on the Integrated Care Board corporate risk register.	

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, page 99.

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 2021-22 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 2021/22

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 is required to complete and publish a DSPT assessment by 30 June 2022 and the CCG is on course to meet 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
No significant control issues have been identified that are currently facing the CCG

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.
The Board is required to approve the annual financial plan and the WECCG System Financial Plan 2021-22 went to the Board on 25th March 2021

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 Auditor also reports on an exception basis where they are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022. The External Auditor had no matters to report in relation to these matters for the year ended 31 March 2022.

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[22].

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. There were no NHSCFA quality assurance concerns identified following the 2021/22 submission.

[22] **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 31 March 2022, the risk management training compliance for the CCG was 83.24%. Work to increase training uptake was undertaken.

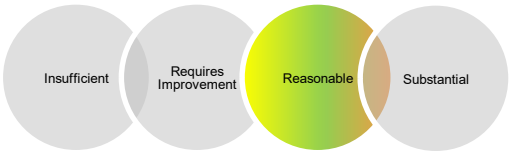
Risk Assessment

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

For the 12 months ended 31 March 2022, our draft Head of Internal Audit Opinion for 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.

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

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 2021-22. One has received “requires improvement”: Cyber Security. Detailed actions have since been undertaken and reported to the Audit 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 there are no significant internal control issues identified for the Clinical Commissioning Group.

PART TWO: REMUNERATION AND STAFF REPORT

REMUNERATION REPORT

The information on pages 128 and 129 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. The committee met four times during 2021/22 and members attendance is noted on page 112.

- 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.

SALARIES AND ALLOWANCES IN 2021/22 (AUDITED SECTION)

Note	NAME	TITLE	2021-22 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	Dates served 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	5454	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-21	
	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	2020-21						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	

SALARIES AND ALLOWANCES IN PREVIOUS YEAR 2020/21

TABLE 2: SINGLE TOTAL FIGURE

Note	NAME	TITLE	2020-21						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	15-17.5	70-75	27-Jul-15	
2	Andrew Geldard	Chief Officer	60-65	0	0	0	0	60-65	15-Jan-18	30-Jun-20
1	Dr Jane Halpin (15.21%)	Accountable Officer	20-25	0	0	0	0	20-25	01-Jun-20	
3	Dr Christine Moss	Chief Medical Officer	25-30	0	0	0	0	25-30	01-Apr-13	30-Sep-20
3	Dr Christine Moss	Clinical Director, one health and care partnership	25-30	0	0	0	0	25-30	01-Oct-20	
1	Alan Pond (15.21%)	Chief Finance Officer	10-15	0	0	0	5-7.5	20-25	01-Aug-20	
4	John Leslie	Interim Director of Finance, Contracting and Performance	45-50	200	0	0	0	45-50	10-Dec-18	30-Jun-20
5	Toni Coles	Director of Transformation	35-40	0	0	0	0	35-40	01-Apr-13	31-Jul-20
5	Toni Coles	Director of Integrated Care Partnership Development for the West Essex area	70-75	0	0	0	0	70-75	01-Aug-20	
1	Avni Shah (15.21%)	Director of Primary Care Transformation	5-10	0	0	0	10-15	15-20	01-Dec-20	
1	Frances Shattock (15.21%	Director of Performance & Delivery	0-5	0	0	0	0-2.5	0-5	01-Mar-21	
6	Jane Kinniburgh	Director of Nursing and Quality	35-40	0	0	0	0	35-40	17-Mar-14	31-Jul-20
1,6	Jane Kinniburgh (15.21%)	Director of Nursing & Quality	10-15	0	0	0	0	10-15	01-Aug-20	
	Peter Wightman	Director of Primary Care & Localities	25-30	0	0	0	7.5-10	35-40	01-Oct-14	30-Jun-20
	Peter Wightman	Managing Director	95-100	0	0	0	20-22.5	120-125	01-Jul-20	
1	Rachel Joyce (15.21%)	Director of Clinical & Professional Services	10-15	0	0	0	15-20	25-30	01-Oct-20	
7	James Roach	Programme Director Accountable Care Programme	55-60	0	0	0	0	55-60	24-Apr-17	30-Sep-20
	Ian Tompkins	Director Corporate Services	105-110	0	0	0	0	105-110	18-Feb-19	
	Dr Amik Aneja	GP Member	45-50	0	0	0	0	45-50	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 - Andrew Geldards post was redundant from 30 June 2020, the salary figure above includes redundancy pay in band 20-25k .

3 - Dr Christine Moss was appointed as Clinical Director to the One Health and Care Partnership on 1 October 2020.

4 - John Leslie left 30 June 2020 and was replaced by Alan Pond who was appointed to the ICS post of Chief Finance Officer from 1 August 2020.

5 - Toni Coles was appointed as Director of Integrated Care Partnership Development 1 August 2020

6 - Jane Kinniburgh left the post of Director of nursing 31 July 2020 and was appointed as Director of Nursing to the ICS 1 August 2020

7 - James Roach left 30 September 2020

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	2020-21						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
Dean Westcott	Director of Finance Herts and West Essex Integrated Care system (ICS) until 31 Jul	40-45	0	0	0	0	40-45	17-Dec-18	31-Jul-20
Paul Burstow	Independent Chair Herts and West Essex Integrated Care System (ICS)	45-50	0	0	0	0	45-50	01-Dec-18	
Dr Jane Halpin	Accountable Officer (from 1 June 2020)	140-145	0	0	0	0	140-145	01-Jun-20	
Jane Kinniburgh	Director of Nursing (until 31 July 2020) ICS Director of Nursing & Quality (from 1 August 2020)	120-125	0	0	0	0	120-125	17-Mar-14	
Frances Shattock	Director of Performance & Delivery (from 1 March 2020)	10-15	0	0	0	0-2.5	10-15	01-Mar-21	
Alan Pond	Chief Finance Officer (from 1 August 2020)	90-95	0	0	0	47.5-50	135-140	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)	145-150	0	0	0	90-92.5	235-240	01-Apr-20	
Beverley Flowers	ICS Accountable Officer (until 31 May 2020), ICS Director of Integration and Transformation from (1 June 2020)	135-140	0	0	0	25-30	160-165	01-Apr-20	
Avni Shah	Director of Primary Care Transformation (from1 Dec 2020)	40-45	0	0	0	12.5-15	55-60	01-Dec-20	

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 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

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, (2021-22 £49,771: 2020-21 £50,425) this is due to engagement of ICS administrative staff which reduced the average and offset the effect of the 3% payrise.

In 2021-22 no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £2,102 to highest paid director (2020-21 £9,850 to highest paid director). Remuneration for the lowest paid employee relates to a time commitment below the normal contractual hours, and therefore the annualised FTE calculation reflects the different terms.

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
2021-22	**172,500:33,210**	**172,500:47,784**	**172,500:60,866**
	5.19	**4.03**	**2.85**
2020-21	172,500:32,145	172,500:46,294	172,500:63,792
	4.12	2.86	2.08

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 E/I 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.

PENSIONS BENEFITS 2021/22 (SUBJECT TO AUDIT)

TABLE 3: PENSIONS BENEFITS

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.

OFF-PAYROLL ENGAGEMENTS

Table 1: Off-payroll engagements longer than 6 months (not subject to audit)

For all off-payroll engagements as of 31 March 2022, for more than **£245** per day and that last longer than six months.

Number of existing engagements as of 31 March 2022	2021/22	2020/21
	0	**1**
Of which…		
Number that have existed for less than one year at time of reporting	0	0
Number that have existed for between one and two years at time of reporting	0	1
Number that have existed for between two and three years at time of reporting	0	0
Number that have existed for between three and four years at time of reporting	0	0
Number that have existed for four or more years at time of reporting	0	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months (not subject to audit)

Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	2021/22	2020/21
	5	1
Of which…		
No. not subject to off-payroll legislation(2)	5	1
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	0	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0	0

No. of engagements reassessed for compliance or assurance purposes during the year	0	0
Of which: no. of engagements that saw a change to IR35 status following review	0	0

Note

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

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

Table 6: 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 2021 and 31 March 2022.

	2021/22	2020/21
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	0	0
Number of individuals that have been deemed 'board members, and/or senior officials with significant responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements	0	0

EXPENDITURE ON CONSULTANCY (NOT SUBJECT TO AUDIT)

The increase since 2020-21 in expenditure on external consultancy fees reflects the progress made during 2021-22 in three ICS projects:

Community Diagnostic Centres – where spend relates to a demand & capacity review, patient & public engagement work and strategy development work.

Population Health Analytics – where there is a contract with consultants in relation to business information.

Digital – where spend reflects support to create a roadmap and high-level investment plan to meet NHSX deadlines, and to create a Digital Strategy that reflects a shared view from the partner organisations.

	2021-22 Total £'000	2021-22 Admin £'000	2021-22 Programme £'000
Expenditure on Consultancy	683	6	678

Prior Year

	2020-21 Total	2020-21 Admin	2020-21 Programme

	£'000	£'000	£'000
Expenditure on Consultancy	430	35	395

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

There were no payments made for exit packages in the financial year 2021-22 (one in 2020-21).

The total cost was zero (£22,756 in 2020-21).

Redundancy and other departure costs are paid in accordance with the provisions of Agenda for change.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

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)[23]	12	2.76

[23] 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.

Equality and Diversity

The Equality Act 2010: The Public Sector Equality Duty

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

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

Throughout 2021/22, 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.

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 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 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 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 2021/22 was 0.50%

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

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)

For information relating to staff costs please refer to the annual accounts from page 176

HR shared service model

In order to continue to respond to the developing needs of the CCG, 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. In 2020/21, the HRXtra service held monthly face-to-face clinics at the CCG to increase accessibility and build rapport with managers. HRXtra have also provided a suite of management awareness sessions on people management topics such as having wellbeing conversations and compassionate leadership.

Staff Policies

The HR Shared Service has developed and HR policy manual for use across the three CCGs and the ICB with a working group comprised of HR, management, staff-side and staff representatives from each CCG working together to adopt best practice in people management policy across the organisations.

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.

During 2021/22, 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 31 March 2022 is 83.29%. Non-compliance is being 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.

During 2021/22 a wide range of optional learning and development opportunities were offered to staff via the MindTools web portal and face-to-face through the HR ODL shared service. There are 837 users registered with MindTools across the Hertfordshire and West Essex CCGs.

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.

During 2021/2022 the CCG also completed its Fire Risk Assessment in line with its Annual Plan. Staff Mental Health First Aiders were trained online and existing first aiders refreshed their training to ensure their skills were up to date. The CCG ensured compliance with The Health and Safety (Display Screen Equipment) Regulations 1992 by issuing additional 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 reviewed and refreshed our stress management policy and the developed a violence and aggression policy in 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, virtually during much of 2021/22, and is a chance for staff to discuss key issues affecting their working lives with executive members and make plans for improvements.

This year the forum has worked to address key issues that were raised in previous years' national staff surveys, which included opportunities for flexible working patterns and tackling bullying. 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

Despite most CCG staff working remotely, the Chair of the group has received many more staff questions and enquiries than in previous years. The CCG would like to encourage staff to keep coming forward to raise their suggestions, ideas or concerns and these will be addressed in the most appropriate forum.

Staff Survey

The 2021 NHS National Staff Survey 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 set out plans to co-create action plans through 'The Big 5' campaign, which will take place across 5 months (May to September) with 5 themes with one Executive lead sponsoring each month. Staff will collaborative through various fora including focus groups and engaging with staff partnerships and the joint 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 introduced a new Employee Assistance Programme (EAP) in 2020, provided by Vita Health group accessed through a free and confidential helpline.

The CCG now have a total of 8 members of 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
- Launched Health and Wellbeing internet site so staff have a central point to access health and wellbeing resources and information for key services
- 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 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 146 staff across Herts and West Essex CCGs have attended

COVID-19 - The take up of risk assessments and vaccinations to BAME colleagues has been monitored to ensure this higher risk group have support in place to mitigate the risk of catching the virus.

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 2021/22.

ACCOUNTS 2021/22

Entity name:	NHS West Essex CCG
This year	2021-22
Last year	2020-21
This year ended	31-March-2022
Last year ended	31-March-2021
This year commencing:	01-April-2021
Last year commencing:	01-April-2020

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Other operating income	2	**(6,146)**	(3,690)
Total operating income		**(6,146)**	(3,690)
Staff costs	4	**11,957**	11,765
Purchase of goods and services	5	**808,154**	613,597
Depreciation and impairment charges	5	**111**	78
Provision expense	5	**660**	476
Other Operating Expenditure	5	**287**	224
Total operating expenditure		**821,169**	626,140
Net Operating Expenditure		**815,023**	622,450
Net expenditure for the Year		**815,023**	622,450
Total Net Expenditure for the Financial Year		**815,023**	622,450

The notes on pages 168 to 189 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	8	**3**	114
Total non-current assets		**3**	114
Current assets:			
Trade and other receivables	9	**4,391**	4,422
Cash and cash equivalents	10	**(3,921)**	(214)
Total current assets		**469**	4,208
Total assets		**472**	4,322
Current liabilities			
Trade and other payables	11	**(55,392)**	(50,143)
Provisions	12	**(1,035)**	(551)
Total current liabilities		**(56,427)**	(50,694)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(55,955)**	(46,372)
Non-current liabilities			
Provisions	12	**(34)**	(170)
Total non-current liabilities		**(34)**	(170)
Assets less Liabilities		**(55,989)**	(46,542)
Financed by Taxpayers' Equity			
General fund		**(55,989)**	(46,542)
Total taxpayers' equity:		**(55,989)**	(46,542)

The notes on pages 168 to 189 form part of this statement

The financial statements on pages 164 to 167 were approved by the Governing Body on 16 June 2022 and signed on its behalf by:

Dr Jane Halpin
Chief Accountable Officer
16 June 2022

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	**(46,542)**	**(46,542)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(46,542)**	**(46,542)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	**(815,023)**	**(815,023)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(815,023)**	**(815,023)**
Net funding	**805,576**	**805,576**
Balance at 31 March 2022	**(55,989)**	**(55,989)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	(30,095)	(30,095)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	(30,095)	(30,095)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating costs for the financial year	(622,450)	(622,450)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(622,450)	(622,450)
Net funding	606,003	606,003
Balance at 31 March 2021	(46,542)	(46,542)

Statement of Cash Flows for the year ended 31 March 2022

	Note	**2021-22 £'000**	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		**(815,023)**	(622,450)
Depreciation and amortisation	5	**111**	78
decrease in trade & other receivables	9	**32**	436
(decrease) in trade & other payables	11	**5,248**	15,949
Provisions utilised	12	**(311)**	(56)
(decrease) in provisions	12	**660**	476
Net Cash Inflow (Outflow) from Operating Activities		**(809,283)**	(605,567)
Net Cash Outflow before Financing		**(809,283)**	(605,567)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		**805,576**	606,003
Net Cash Inflow (Outflow) from Financing Activities		**805,576**	606,003
Net (Decrease) Increase in Cash & Cash Equivalents	10	**(3,707)**	436
Cash & Cash Equivalents at the Beginning of the Financial Year		**(214)**	(650)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(3,921)**	(214)

The notes on pages 168 to 189 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups 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 2021-22 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 clinical commissioning groups, 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 clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 **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 clinical commissioning group 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 Clinical Commissioning Group is a going concern and the financial statements are prepared on the going concern basis.

As explained more fully on page 189 following the approval of the Health and Care Bill on 28 April 2022 NHS West Essex CCG (the CCG) will be dissolved on 30 June 2022. Whilst the CCG as an entity will cease 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.

1.3 **Accounting Convention**

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

1.4 **Joint arrangements**

Arrangements over which the clinical commissioning group 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 joint venture.
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 clinical commissioning group 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 15

1.5 **Operating Segments**

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

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
•As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
•The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
•The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group 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 pyment of invoices within 30 Days of receipt.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the financial statements cont.

1.7.2 **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 clinical commissioning group commits itself to the retirement, regardless of the method of payment.

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.9.2 **Measurement**

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Subsequent Expenditure**

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

Notes to the financial statements cont.

1.10 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.12 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.13 **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 clinical commissioning group's cash management.

1.14 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.15 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group 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 clinical commissioning group.

Notes to the financial statements cont.

1.16 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group 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.

1.17 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.19 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.20 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group 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.

1.20.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Notes to the financial statements

1.21 **Value Added Tax**

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

1.22 **Foreign Currencies**

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

1.23 **Losses & Special Payments**

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

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

1.24 **Critical accounting judgements and key sources of estimation uncertainty**

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

1.24.1 **Critical accounting judgements in applying accounting policies**

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

- Since 2015/16 the clinical commissioning group 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.

1.24.2 **Sources of estimation uncertainty**

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

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 34 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.

Notes to the financial statements cont.

1.25 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

Work undertaken by the CCG in preparation for the implementation of IFRS 16 suggests that its application will not have a material impact.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2021-22 Total	2020-21 Total
	£'000	£'000
Other non contract revenue	**6,146**	3,690
Total Operating income	**6,146**	**3,690**

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). £5.783m (3.495m in 2020-21) of the income above relates to the ICS.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**2021-22**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**8,990**	**273**	**9,263**
Social security costs	**1,065**	**0**	**1,065**
Employer Contributions to NHS Pension scheme	**1,597**	**0**	**1,597**
Other pension costs	**1**	**0**	**1**
Apprenticeship Levy	**31**	**0**	**31**
Gross employee benefits expenditure	**11,684**	**273**	**11,957**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	**11,684**	**273**	**11,957**

There was a decrease in permanent pay costs. Although there was a 3% increase in pay for staff on agenda for Change terms and conditions, this was more than offset by the partial reversal of an ICS commitment for workstream projects made in the prior year, but which was not fully utilised. This commitment recognised the employer NI and NHS Pensions costs, although these were not separately coded.
There was an increase in other employee pay relating to posts seconded into ICS during the year.

4.1.1 Employee benefits	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	9,300	196	9,496
Social security costs	925	0	925
Employer Contributions to NHS Pension scheme	1,296	0	1,296
Other pension costs	1	0	1
Apprenticeship Levy	25	0	25
Termination benefits	23	0	23
Gross employee benefits expenditure	11,570	196	11,766
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	11,570	196	11,766

4.1.2 Recoveries in respect of employee benefits

The CCG had no recoveries in respect of employee benefits (nil in 2020-21)

4.2 Average number of people employed

	2021-22			**2020-21**		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
	159.39	**19.37**	**178.76**	140.70	2.44	143.14
Number of whole time equivalent people engaged on capital projects	0	0	0	0	0	0

The table above details the average number of whole time equivalent (WTE) employees during the year. Increase in permanently employed is due to staff engaged on ICS workstream projects. ICS directors on the payroll of East & North and Herts and Herts Valleys CCGs, are shown in Other number. The increase in other is due to seconded staff employed on ICS workstream projects.

4.3 Staff annual leave liability

Staff annual leave liability of £183.19k was accrued in 2021-22 (£183.52k 2020-21)

4.4 Exit packages agreed in the financial year

There were no redundancies in the period (1 in 2020-21 £22,756)
There were no departures where special payments were made (nil in 2020-21)

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 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 employers.

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

The 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	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services			
Services from other CCGs and NHS England	(i)	**411**	1,695
Services from foundation trusts	( )	**138,307**	133,733
Services from other NHS trusts	(i)	**467,686**	305,273
Services from Other WGA bodies		**1**	0
Purchase of healthcare from non-NHS bodies	(ii)	**83,475**	65,320
Purchase of social care		**884**	836
Prescribing costs		**45,130**	43,609
GPMS/APMS and PCTMS	(iii)	**58,610**	48,169
Supplies and services – clinical		**43**	81
Supplies and services – general		**8,044**	8,901
Consultancy services		**683**	430
Establishment		**1,561**	1,464
Transport		**1**	6
Premises	(iv)	**1,692**	2,291
Audit fees	(v)	**90**	68
Other non statutory audit expenditure			
• Other services		**0**	9
Other professional fees		**166**	81
Legal fees		**165**	136
Education, training and conferences		**1,205**	1,494
Total Purchase of goods and services		**808,154**	**613,597**
Depreciation and impairment charges			
Depreciation		**111**	78
Total Depreciation and impairment charges		**111**	**78**
Provision expense			
Provisions		**659**	476
Total Provision expense		**659**	**476**
Other Operating Expenditure			
Chair and Non Executive Members	(ix)	**287**	233
Expected credit loss on receivables		**0**	(9)
Total Other Operating Expenditure		**287**	**224**
Total operating expenditure		**809,212**	**614,375**

(i) Decrease is due to a reduction in expenditure with Hertfordshire CCG's relating to a GP IT project.
(ii) Increase is due to additional funding for growth, top up funding, covid funding and increased mental health costs offset by a reduction due to change of service provider for psychological therapies.
(iii) Increase is due to additional funding for growth, top up funding and covid funding which were paid directly by the CCG for the whole of 2021-22 whereas in the first six Months of 2020-21 these payments were made by NHS England and Improvement (NHSEI)
(iv) Increase is due to a change in service provider for psychological therapies, additional expenditure for elective recovery, and an increase in continuing healthcare expenditure. In addition to this the commissioning for independent sector acute providers reverted back to CCG's in 2021-22, whereas in 2020-21 services were commissioned directly by NHSEI
(v) Increase is due to additional funding for winter access across the ICS, along with general Primary Care uplift.
(vi) Decrease due to resolution of disputes with NHS property services Ltd
(vii) Expenditure relates to external audit fee of £75k plus VAT of £15k. The liability for loss contained in this contract is limited to a maximum aggregate of £2m, claims must be made within 4 years.
(viii) Internal audit fees of £27k (£27k 2020-21) recorded in other professional fees.
(ix) Increase is due to appointment of the ICS Chair.

6.1 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**11,734**	**131,934**	12,114	112,756
Total Non-NHS Trade Invoices paid within target	**11,483**	**129,802**	11,916	110,787
Percentage of Non-NHS Trade invoices paid within target	**97.86%**	**98.38%**	98.37%	98.25%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,369**	**633,993**	1,510	439,441
Total NHS Trade Invoices Paid within target	**1,297**	**629,635**	1,455	434,005
Percentage of NHS Trade Invoices paid within target	**94.74%**	**99.31%**	96.36%	98.76%

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2021-22			2020-21		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	**477**	**7**	**484**	405	16	421
Total	**477**	**7**	**484**	405	16	421

7.1.2 Future minimum lease payments

	2021-22			2020-21		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	**16**	**0**	**16**	16	6	22
Between one and five years	**0**	**0**	**0**	0	3	3
Total	**16**	**-**	**16**	16	9	25

NHS West Essex CCG occupies property owned and managed by NHS Property Services Ltd (NHS PS). Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangements.

Of the Total buildings costs £66k relates to payment to NHS East & North Herts CCG for ICS headquarters, along with £16k of future minimum lease payments.

Other relates to £1k for vehicles, and £6k for photocopiers. No future minimum payments are shown for vehicles as they have been returned, no future minimum payments are shown for photocopiers as leases have expired for these.

8 Property, plant and equipment

2021-22	Plant & machinery £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April 2021	**27**	**447**	**474**
Additions purchased	**0**	**0**	**0**
Cost/Valuation at 31 March 2022	**27**	**447**	**474**
Depreciation 01 April 2021	**23**	**337**	**360**
Charged during the year	**4**	**107**	**111**
Depreciation at 31 March 2022	**27**	**444**	**471**
Net Book Value at 31 March 2022	**0**	**3**	**3**
Purchased	**0**	**3**	**3**
Total at 31 March 2022	**0**	**3**	**3**
Asset financing:			
Owned	**0**	**3**	**3**
Total at 31 March 2022	**0**	**3**	**3**

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	2	5

9 Trade and other receivables

	Current 2021-22 £'000	Current 2020-21 £'000
NHS receivables: Revenue	**2,905**	3,461
NHS accrued income	**546**	616
Non-NHS and Other WGA receivables: Revenue	**231**	200
Non-NHS and Other WGA prepayments	**616**	45
Expected credit loss allowance-receivables	**(3)**	(3)
VAT	**93**	92
Other receivables and accruals	**3**	11
Total Trade & other receivables	**4,391**	4,422

There are no Non Current receivables (nil in 2020-21)

No prepaid pension contributions are included in the above.

The large majority of trade is with NHS England. As NHS England is funded by Government to provide funding to CCGs to commission services no credit scoring of them is necessary

9.1 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	**127**	**30**	958	57
By three to six months	**0**	**5**	99	2
By more than six months	**0**	**19**	0	3
Total	**127**	**54**	1,057	62

£71k of the amount above has subsequently been recovered post the statement of financial position date.

The CCG does not hold any collateral against receivables outstanding at 31 March 2022 (nil in 2020-21)

9.2 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Total £'000**
Balance at 01 April 2020	**(3)**	**(3)**
Lifetime expected credit losses on trade and other receivables	**0**	**0**
Total	**(3)**	**(3)**

There has been no material change in loss allowance.

10 Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	**(214)**	**(650)**
Net change in year	**(3,707)**	**436**
Balance at 31 March 2022	**(3,921)**	**(214)**
Made up of:		
Cash with the Government Banking Service	**(3,922)**	**(215)**
Cash in hand	**1**	**1**
Cash and cash equivalents as in statement of financial position	**(3,921)**	**(214)**
Balance at 31 March 2022	**(3,921)**	**(214)**

The CCG holds no Patients' money (nil in 2020-21)

The negative balance in Government Banking Service is due to a timing issue relating to committed BACs payments of £4,073k due to clear 1st and 4th April 2022.
Cash was drawn down from the Department of Health on 1st April 2022 which offset this. The actual Cash at Bank figure as at 31 March 2022 was £239k.

11 Trade and other payables	**Note**	**Current 2021-22 £'000**	Current 2020-21 £'000
NHS payables: Revenue		**4,957**	3,582
NHS accruals	(i)	**1,778**	9,173
Non-NHS and Other WGA payables: Revenue		**9,506**	10,694
Non-NHS and Other WGA accruals	(ii)	**29,750**	21,474
Social security costs		**149**	122
Tax		**151**	120
Other payables and accruals	(ii)	**9,101**	4,978
Total Trade & Other Payables		**55,392**	50,143

(i) Reduction due to West Herts Hospital £8m in 2020-21 now paid

(ii) The increase is due to £4.9m Primary Care Co-Commissioning additional funding, £1.392m ICS Digital Health and training commitments, £1.492m for elective Recovery fund accruals and £1.952m to Essex. county council for iBCF and Winter Funding.

There are no Non-Current payables (nil in 2020-21)

Other payables include £476k outstanding pension contributions at 31 March 2022

22 **12 Provisions**

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
Legal claims	**0**	**34**	0	0
Continuing care	**863**	**0**	551	0
Other	**172**	**0**	0	170
Total	**1,035**	**34**	551	170
Total current and non-current	**1,035**	**34**	551	170

	Legal Claims £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2021	**0**	**551**	**170**	**721**
Arising during the year	**34**	**863**	**172**	**1,069**
Utilised during the year	**0**	**(293)**	**(18)**	**(311)**
Reversed unused	**0**	**(258)**	**(152)**	**(410)**
Balance at 31 March 2022	**34**	**863**	**172**	**1,069**
Expected timing of cash flows:				
Within one year	**0**	**863**	**172**	**1,035**
Between one and five years	**34**	**0**	**0**	**34**
Balance at 31 March 2022	**34**	**863**	**172**	**1,069**

The CCG has made a provision of £863k for retrospective CHC redress and assesment backlog as there is a high probability that a liability to the CCG will crystalise during the next 12 months for the 34 cases identified. The CCG has based this provision on a 50% expected value basis of the maximum liability.

Following completion of a survey conducted by NHSE & I Pensions review Team, the CCG has a requirement to ensure the appropriate contribution payments are made to the GP Practitioner Scheme on behalf of employed GP's. Accordingly, the CCG has made a provision of £65k in respect of GP Pension liabilities following this review, this along with £107k for dilapidation of buildings is shown in other provisions.

13 Financial instruments

13.1 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 clinical commissioning group 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 clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

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

13.1.1 Currency risk

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

13.1.2 Interest rate risk

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

13.1.3 Credit risk

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

13.1.4 Liquidity risk

NHS clinical commissioning group 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 NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

13.1.5 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 nonfinancial 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.

13 Financial instruments cont'd

13.2 Financial assets

	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)**

	Financial Assets measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	3,163	3,163
Trade and other receivables with other DHSC group bodies	914	914
Trade and other receivables with external bodies	211	211
Cash and cash equivalents	(214)	(214)
Total at 31 March 2021	4,074	4,074

13.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	**Total 2021-22 £'000**
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	**48,132**	**48,132**
Total at 31 March 2022	**55,092**	**55,092**

	Financial Liabilities measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Trade and other payables with NHSE bodies	2,394	2,394
Trade and other payables with other DHSC group bodies	18,225	18,225
Trade and other payables with external bodies	29,283	29,283
Total at 31 March 2021	49,902	49,902

The movements in Financial Liabilities relates to a reclassification of the Prescribing creditor by NHS England, payment of a large NHS creditor, and increase in primary care and ICS creditors.

14 Operating segments

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

	2021-22 £'000
Gross expenditure	821,168
Income	(6,146)
Net Expenditure	815,023
Total Assets	472
Total liabilities	(56,461)
Net Liabilities	(55,989)

15 Joint arrangements - interests in joint operations

The clinical commissioning group was not party to any joint operations during 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 fund was set up. The CCG's expenditure on BCF in 2021-22 was £22.463m (£21.300m in 2020-21). 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 £8.724m (£8.254m in 2020-21).
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 £13.738m (£13.046m in 2020-21).

16 Related party transactions

2021-22

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	685	(39)	0	0
Uttlesford Health Ltd	617	(2)	0	(16)
Stroke Association	48	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 2021-22

	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)	183	0	89	0
Moss CE & partners (DR C Moss, medical Director)	71	0	10	0
Newport surgery (Dr Jen West)	382	0	95	0
Old Harlow health centre (Dr Amik Aneja)	358	0	88	0
Stansted surgery (Dr Angus Henderson)	580	0	112	0
Maynard Court (Dr Ian Perry)	121	0	61	0
Kings Medical Centre (Dr Shawarna Lasker)	439	0	76	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	58	0	26	0
Addison house surgery	296	0	161	0
Angel Lane surgery	144	0	67	0
Barbara Castle health centre	0	0	0	0
Chigwell medical centre	136	0	72	0
Church Langley medical centre	175	0	98	0
Crocus practice (Previously Rectory practice)	291	0	156	0
Elsenham surgery	110	0	53	0
Forest practice	208	0	86	0
Hamilton practice	200	0	96	0
Eden surgery Hatfield Heath	161	0	82	0
High Road Loughton	164	0	82	0
High Street surgery	93	0	44	0
John Tasker house	325	0	97	0
The Limes medical centre	667	0	235	0
Lister house	573	(101)	182	0
Loughton health centre	148	0	79	0
Market Square surgery	559	0	133	0
Nuffield House	286	0	91	0
Ongar health centre	267	0	146	0
Sydenham House	39	0	20	0
Taylor & Briggs surgery	61	0	38	0
Thaxted surgery	286	0	150	0
Gold Street surgery	319	0	109	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 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 2021/22.

2020-21

16 Related party transactions cont

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 £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Stellar Healthcare	565	(33)	48	0
Uttlesford Health Ltd	584	(8)	148	0
Stroke Association	48	0	0	0

A financial Risk-Share agreement is in place across Hertfordshire and West Essex ICS (formally STP). It was agreed through the governance of each system partner that the Risk-Share agreement be enacted in 2019-20. The final revenue resource limit values included in the 2020-21 annual accounts of each relevant CCG reflect the outcome of the Risk-Share agreement.

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 2020-21

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
The Ross practice (Dr R Gerlis, CCG chair)	141	0	58	0
Moss CE & partners (DR C Moss, medical Director)	96	0	33	0
Newport surgery (Dr Jen West)	210	0	50	0
Old Harlow health centre (Dr Amik Aneja)	182	0	52	0
Stansted surgery (Dr Angus Henderson)	283	0	64	0
Maynard Court (Dr Ian Perry)	125	0	40	0
Kings Medical Centre (Dr Shawarna Lasker)	250	0	40	0

The CCG also had transactions with the following GP Practices

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Abridge surgery	44	0	14	0
Addison house surgery	204	0	74	0
Angel Lane surgery	118	0	42	0
Barbara Castle health centre	0	0	0	0
Chigwell medical centre	107	0	31	0
Church Langley medical centre	124	0	45	0
Crocus practice (Previously Rectory practice)	217	0	76	0
Elsenham surgery	79	0	26	0
Forest practice	187	0	62	0
Hamilton practice	140	0	52	0
Eden surgery Hatfield Heath	186	0	52	0
High Road Loughton	155	0	51	0
High Street surgery	67	0	26	0
John Tasker house	241	0	65	0
The Limes medical centre	485	0	109	0
Lister house	488	0	100	0
Loughton health centre	109	0	44	0
Market Square surgery	278	0	65	0
Nuffield House	273	0	60	0
Ongar health centre	174	0	73	0
Sydenham House	31	0	12	0
Taylor & Briggs surgery	37	0	13	0
Thaxted surgery	172	0	64	0
Gold Street surgery	235	0	59	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 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

16 Related party transactions cont

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, Uttlesford Council and Herts County Council.

17 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 approves the formation of Integrated Care Boards (ICB's) and for them to take over the functions of Clinical Commissioning Groups. As a result NHS West Essex CCG will be dissolved on 30 June 2022 and Herts and West Essex ICB will be formed from the following day. In line with the provisions of the Group Accounting Manual the assets and liabilities of the CCG will transfer to the newly formed Integrated Care Board at book value. Further details are provided on page [x] of the annual report and in the accounting policies on page [x].'

18 Financial performance targets

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

	2021-22	**2021-22**	**2021-22**	2020-21	2020-21	2020-21
	Target	**Performance**	**Duty achieved?**	Target	Performance	Duty achieved?
Expenditure not to exceed income	**831,169**	**821,169**	**Yes**	636,145	626,140	Yes
Revenue resource use does not exceed the amount specified in Directions	**825,023**	**815,023**	**Yes**	632,455	622,450	Yes
Revenue administration resource use does not exceed the amount specified in Directions	**6,274**	**6,182**	**Yes**	6,198	6,088	Yes

The CCG had a total available resource of £825.023m in 2021-2022, against which it spent £815.023m and achieved a surplus of £10m, thereby ensuring delivery against the CCG's statutory duty to break even in-year and achieving the revised cumulative surplus target of £10m.

19 Losses and Compensations

There was one administrative write off in the reporting period, the value of this was below de-minimus of £500 (nil in 2020 - 21)

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS WEST ESSEX CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS West Essex Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.2 to the financial statements which explains that on 1 July 2022, NHS West Essex CCG will be dissolved and its services transferred to Herts and West Essex Integrated Care Board. Under the continuation of service principle, the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

Going concern basis of preparation

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks to the CCG's operating model and analysed how those risks might affect the CCG's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the CCG will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals where one side posts to cash and the other side posts to an unusual account, post-close journals with unusual entries to expenditure, material post close journals and the last five non-material post-close journals.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Performing cut-off testing of expenditure in the period 1 March to 31 May 2022 to determine whether amounts had been recognised in the correct accounting period.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

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

The CCG is subject to laws and regulations that directly affect the financial statements including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information;
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements; and
- in our opinion the other information has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 105, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the 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 they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

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

We have nothing to report in this respect.

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

As explained more fully in the statement set out on page 105, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs

and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the 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.

We have nothing to report in this respect.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS West Essex CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Ben Lazarus
for and on behalf of KPMG LLP,
Chartered Accountants
15 Canada Square
London
E14 5GL

21 June 2022