Mid Essex CCG Annual Report 2021/22

This document can be provided in alternative formats upon request, such as larger print, easy read, braille, audio format and different languages.

## Contents

[Contents 2](#_bookmark0)

[Chair’s Foreword 4](#_bookmark1)

[PERFORMANCE REPORT 6](#_bookmark2)

[Performance Overview 6](#_bookmark3)

[Accountable Officer’s Introduction 6](#_bookmark4)

[What Mid Essex CCG does 7](#_bookmark5)

[Our Purpose 7](#_bookmark6)

[Our Strategy 9](#_bookmark7)

[Mid and South Essex Health and Care Partnership 10](#_bookmark8)

[How we have performed 12](#_bookmark9)

[Key issues and risks 12](#_bookmark10)

[Performance analysis 13](#_bookmark11)

[Improve Quality 16](#_bookmark12)

[Reducing Health Inequality 19](#_bookmark13)

[Engaging People and Communities 21](#_bookmark14)

[Health and Wellbeing Strategy 23](#_bookmark15)

[Financial Review 24](#_bookmark16)

[Risks 26](#_bookmark17)

[Sustainable Development 28](#_bookmark18)

[ACCOUNTABILITY REPORT 31](#_bookmark19)

[Corporate Governance Report 31](#_bookmark20)

[Members Report 31](#_bookmark21)

[Member profiles 31](#_bookmark22)

[Composition of Governing Body 32](#_bookmark23)

[Committees, including Audit Committee 35](#_bookmark24)

[Register of Interests 35](#_bookmark25)

[Personal data related incidents 36](#_bookmark26)

[Statement of Disclosure to Auditors 36](#_bookmark27)

[Donations to political parties and charitable organisations 36](#_bookmark28)

[Modern Slavery Act 36](#_bookmark29)

[Complaints to Parliamentary and Health Service Ombudsman 36](#_bookmark30)

[Statement of Accountable Officer’s Responsibilities 37](#_bookmark31)

[Governance Statement 38](#_bookmark32)

[Remuneration and Staff Report 57](#_bookmark33)

[Remuneration Report 57](#_bookmark34)

[Staff Report 71](#_bookmark35)

[Parliamentary Accountability and Audit Report 77](#_bookmark36)

[INDEPENDENT AUDITOR’S REPORT 78](#_bookmark37)

[ANNUAL ACCOUNTS 84](#_bookmark38)

## Chair’s Foreword

In what has been another challenging year for our teams right across the NHS, NHS Mid Essex Clinical Commissioning Group (CCG) has continued to ensure our residents receive safe and effective patient care.

We have continued to widen collaboration with our local authorities, service providers and voluntary organisations so we are all working together for better lives. I’m hugely proud of all my NHS colleagues – health and care professionals and non-clinical staff alike – for the efforts they continue to make for the residents of Braintree District, the City of Chelmsford and Maldon District.

The ongoing vaccination programme has continued to dominate our COVID-19 response in 2021/22. I am pleased the large majority of people in our area have taken the opportunity to receive their vaccine. It’s never too late to protect yourself if you haven’t yet had your jab – there are plenty of opportunities to come forward which our residents can find out about at [www.essexcovidvaccine.nhs.uk](http://www.essexcovidvaccine.nhs.uk/).

Our partnership has helped more remote and seldom-asked communities to receive their vaccine closer to home through our “Essex Vax Van” programme and mobile vaccination units. Working with public health colleagues and Essex Partnership University NHS Foundation Trust we have offered dozens of pop-up vaccination opportunities across our area over the past year.

I must also mention the local vaccination site in Maldon, one of the first in Essex to open in premises made available by the local authority. It has helped people living in the surrounding area to achieve one of the highest proportions of vaccinated residents in the county.

Such collaboration and new models of care have played key roles in helping us to continue supporting residents’ wellbeing while making sure infection prevention and control measures protect NHS patients and staff alike. During the past year we have seen a wider range of health and care professionals begin to work in our local GP practices. Paramedics, physiotherapists and mental health workers are now based in the heart of local communities.

A great local example is the “Freshwell Low-Carb Project” pioneered by Dr Oliver and Dr Andrews at Freshwell Health Centre in the north of Braintree District. This programme is delivered across the Colne Valley Primary Care Network of GP practices thanks to health coaches working on site and through online support.

Working with us and with residents and partners, Colne Valley GPs have built a programme that makes a real difference to health outcomes for scores of residents who have between them lost a metric tonne of weight! Much of this growth has been from the ‘ground-up’, with something of a social movement developing among the people taking part.

Community involvement has also been a key element of positive lifestyle changes championed by our Chelmsford West Primary Care Network for the people it serves.

Working with the Royal Horticultural Society and the Centre Supporting Voluntary Action, which represents local charities, the NHS in Chelmsford West has introduced a community garden for residents that they are now maintaining – increasing their physical activity and improving their wellbeing. Chelmsford West is also running a pilot scheme for early oesophageal cancer detection with local residents experiencing persistent heartburn.

We do recognise that many people have had challenges accessing healthcare in recent months. The “digital first” approach that NHS England and NHS Improvement have asked all CCGs to follow has made accessing services easier for some people, but many people have also found such significant and rapid change a challenge. The CCG continues to listen to our communities and work with them to develop models of care that meet everyone’s needs.

As we move into the new financial year, a robust plan is also being developed within national guidelines to significantly reduce the number people waiting for operations and treatments. Momentum on this programme will build as we move into our new partnership for local working, which our Joint Accountable Officer talks more about in his introduction.

The Mid and South Essex Health and Care Partnership of which the CCG is part continues to support hundreds of people to receive timely care in their own home or care home through the launch of a new “virtual hospital”. This is already reducing some of the pressure on our physical acute wards, helping us continue more of our elective work.

As we move into the new financial year, I commend the teams working together to improve the lives of people in mid Essex and look forward to pushing forward together as an alliance with our local authority, trusts, community providers and wider community and voluntary sector.

**Dr Anna Davey**

Chair, NHS Mid Essex Clinical Commissioning Group 30 June 2022

# PERFORMANCE REPORT

## Performance Overview

**Accountable Officer’s Introduction**

It has been another extraordinary 12 months. Amid unprecedented world events, the NHS faced new COVID-19 variants and had to respond rapidly by expanding its vaccination programme. Waiting lists have inevitably grown as a result, with delays and capacity a continuing concern. The timescales for implementing local reforms have also slipped.

All this has made 2021/22 a very unsettling time.

Yet despite the pressures, our NHS and other institutions have generally succeeded in helping people get through these unique circumstances. When mid and south Essex residents looked for guidance or essential services, the NHS and its partners from the public and voluntary sectors stepped up, often in new and innovative ways. We were the trusted source of information and support.

Public services depend on trust. Every time the question of trusted professions comes up in Britain, doctors and nurses are near the top of the list. This shows the mutual confidence our residents and healthcare professionals have in one another and in the public services we all rely upon. During difficult times collaboration and confidence in one another can help us deal with difficulties and uncertain futures.

People have trusted the science behind new treatments and the support available from our institutions. In a similar way, our transition to an “integrated care system” – ICS for short – should also inspire confidence. As we restore more normal operations, the new ICS will build on the legacy of its clinical commissioning groups to show that people’s best interests and improved health outcomes are at the heart of everything we do. Now and in the future.

As well as sharing what this CCG has achieved for mid Essex residents through well- planned NHS services and partnership working, this document also reflects the seriousness with which we take our responsibilities as part of an ICS.

Strengthening relationships across the old CCG areas – what are now called “places” – is vital to better health outcomes and just one example of the focus we are putting on that is the appointment of our first Head of Engagement. This role will focus on nurturing broadly based relationships with our public and partners so that we can design services, identify local health challenges and set standards together.

As part of this work, “Moments that Matter” will showcase the best of what coordinated health and social care can do. It celebrates examples of professionalism and personalised care that have stood out for patients and colleagues. Anyone who has worked in or for one of our CCGs will understand how ‘little touches’ can sometimes make all the difference to those who look to the NHS for help.

This latest phase of NHS development will certainly bring new opportunities, but it is right that we should mark the passing of a final and tumultuous full year for CCGs by noting the distinct contribution they have made recently in developing place-based services and Primary Care Networks of GP practices. That emphasis on delivering health and wellbeing services for residents at a neighbourhood level will not change.

Too many people have contributed to the CCG’s success to name them all here. I would nevertheless like to pay tribute to CCG colleagues for the continued support they have shown one another – and most importantly, to the 1.2m people we serve – during these uniquely challenging times.

By planning and delivering services across organisations and at the appropriate level – whether in neighbourhoods served by a Primary Care Network or in place-based Alliances – we can continue to respond to the needs of communities across Mid & South Essex, building on what has been accomplished to date.

**Anthony McKeever**

Executive Lead for the Mid and South Essex Health and Care Partnership and Joint Accountable Officer for its five CCGs

30 June 2022

**What Mid Essex CCG does**

##### Our Purpose

NHS Mid Essex CCG is a clinically-led organisation responsible since April 2013 for the planning, buying and monitoring – a process called commissioning – of most NHS care in Braintree District, Chelmsford City and Maldon District. These three “localities” cover an area of about 520 square miles and are collectively known as mid Essex.

As of 31 March 2022, the CCG is made up of 39 general practices in mid Essex. They are listed in full on pages 31-32 of this report.

|  |  |
| --- | --- |
| **NHS Mid Essex CCG – facts and figures** | |
| Population (registered with a GP) at 1 April 2022 | Total Mid Essex GP registered population is 399,976 |
| Number of member GP practices at 31 March 2022 | 39 (with about 250 GPs between them) |
| CCG Headquarters | Wren House, Hedgerows Business Park, Colchester Road, Chelmsford, Essex, CM2 5PF |

|  |  |
| --- | --- |
| Number of CCG employees | 133.74 Whole Time Equivalents permanently employed on 31 March 2022 |
| Expenditure for 2021/22 | Healthcare expenditure of £920.5m, plus running costs of £7.9m, for a total spend of £928.4m |

Our member practices elect GPs to represent local views on our governing body, the Board. Our Chair, Clinical Vice Chair and some of the other Board members are experienced mid Essex GPs.

The CCG’s most immediate working relationships are with:

* the 4 south Essex CCGs covering Basildon and Brentwood, Castle Point and Rochford, Southend, and Thurrock
* the 3 “top-tier local authorities” responsible for local social care (Essex County Council, Southend Borough Council and Thurrock Council)
* the second-tier local authorities within mid and south Essex, including the 3 in mid Essex
* Mid and South Essex NHS Foundation Trust, comprising the former Basildon and Thurrock University Hospitals Trust, Mid Essex Hospitals Trust and Southend University Hospitals Trust
* the 3 major NHS community and mental health service providers commissioned locally

Together, these organisations cover the area of 1.2m people mentioned above and comprise the [Mid and South Essex Health and Care Partnership](https://www.msehealthandcarepartnership.co.uk/). More information about this can be found on page 10.

We also work closely with other organisations that have similar goals. For example, [Essex County Council](http://www.essex.gov.uk/Pages/Default.aspx)’s Director of Public Health works with us to reduce health inequalities – in other words making sure everyone has access to the healthcare they need and experiences the same outcomes. The Public Health teams from Essex County Council, Thurrock Council and Southend-on-Sea Borough Council provide health intelligence, advice and support to the mid and south Essex CCGs through dedicated Consultants in Public Health under a local agreement. These consultants attend CCG Board meetings and the Director of Public Health supports a Joint Health and Wellbeing Strategy for Essex under the guidance of the [Essex Health and](http://essexpartnership.org/content/essex-health-and-wellbeing-board/) [Wellbeing Board](http://essexpartnership.org/content/essex-health-and-wellbeing-board/).

In mid Essex the health and social care system is made up of NHS Mid Essex CCG, Essex County Council, Chelmsford City Council, Maldon District Council and Braintree District Council plus key providers Mid and South Essex University Hospital NHS Trust, Essex Partnership University NHS Foundation Trust, Provide Community Interest Company, East of England Ambulance Service NHS Trust and a range of smaller providers working together.

We regularly work with national and local charities, community organisations and voluntary groups on a variety of projects that bring health benefits to local people. The CCG is also in regular contact with [Healthwatch Essex](http://www.healthwatchessex.org.uk/), an independent organisation that represents local people’s views about health and care to help improve services.

The key providers from which the CCG buys health services for the residents of Mid Essex are:

* Mid and South Essex NHS Foundation Trust (MSEFT) is the main provider of acute hospital services from its sites at Basildon, Southend and Broomfield.
* Essex Partnership University NHS Foundation Trust (EPUT) is the main provider of mental health services, along with Hertfordshire Partnership University NHS Foundation Trust.
* EPUT and the North East London NHS Foundation Trust (NELFT) are our main providers of community services.
* Emergency health services and transport are provided by the East of England Ambulance Service NHS Trust (EEAST) and urgent care services by IC24.

In addition, the CCG has a range of contracts with other providers of services such as palliative care and end of life services, specialist health services for fertility and termination of pregnancy and community elective care services. We also buy services from a number of Independent Sector providers.

##### Our Strategy

The MSE Health & Care Partnership developed its five year strategy in December 2019. The strategy outlines 4 key ambitions, with the underpinning aim to **reduce health inequalities.** The strategy outlines that we intend to achieve this through:

* **Creating opportunity for our residents** – supporting education, employment and socio-economic improvements for our residents. We have developed this ambition further - for example, extending the successful work led by MSEFT on hospitals as Anchor institutions, and achieving agreement to a system-wide Anchor Charter in 2021.
* **Supporting health and wellbeing** – including a focus on prevention, self-care, lifestyle support. We have undertaken much work in this area – particularly through the Covid pandemic, where we were able to use targeted engagement techniques to link with different communities, understanding their needs and barriers to accessing care, vaccinations and so on. We have also continued to work in partnership to target prevention opportunities and we have agreed with public health colleagues to focus particularly on obesity and continued work on vaccine hesitancy in the coming months.
* **Bringing Care Closer to Home** – where this is safe and possible. Again, we have seen many examples of this, with our Covid vaccination van that has now been transformed to a “long-Covid van”, taking assessment and testing to our communities. We are progressing with the integrated medical centres in Thurrock, again as a new model of care to bring services closer to home.
* **Improving and Transforming our Services** – we know that our services are under considerable pressure and we are not providing the level or quality of service that we would like. There are several transformation programmes progressing, underpinned by system working on workforce, digital, and finance to bring improvements in primary care, cancer care, elective recovery, urgent care, community diagnostics, flow through the system and care arrangements. Our

Stewardship programme will be key in our future approach to service improvement and transformation.

While the strategy was set in the pre-Covid era, we consider that the key ambitions have stood the test of time and have underpinned our partnership working during the pandemic.

We will therefore take the 5 year strategy into the new Integrated Care System (ICS) and use the early period of Integrated Care Partnership (alliances of NHS providers that work together to deliver care) formation to begin work to develop the Integrated Care Strategy – taking our local authority Joint Strategic Needs Assessments (JSNAs) and health and wellbeing strategies to develop a single strategy for Mid & South Essex.

A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform planning and commissioning of health, wellbeing and social care services. They are often, but not always, led by the local authorities of an area but require participation from all appropriate partners to:

1. Collect, analyse and interpret health and care needs information.
2. Participate in engagement work between partners or with the population.
3. Follow up and implement recommendations.

As a partner in the provision of health and care services to the population PCNs will be expected to fully participate and help shape, where appropriate, in the production of these needs assessments.

The plan for achieving this, by April 2023, will be agreed with the ICP once it is formed. We have been clear that we want the hallmarks of our ICS to be:

* + Evidence and data driven
  + Have a true partnership with our communities and use their lived experience and insight to help us shape our work
  + Ensure clinical and care professionals are leading strategy formation and supporting decision-making

##### Mid and South Essex Health and Care Partnership

During 2021/22 the system has progressed towards establishment of the ICS by:

* + Submitting a successful application to be formally designated as an Integrated Care System
  + Refreshing our primary care strategy and established PCN support programmes
  + Further establishing our population health management capacity and engaging with a national Population Health Management (PHM) programme to support turning data into intelligence to design interventions through our PCNs
  + Our four Alliances have agreed their initial delivery plans to support their local populations, working in partnership with local authority, Healthwatch and community and voluntary sector organisations
  + Developing a data and digital roadmap to transform our digital and data capacity and capability – and we have employed a Chief Digital Information Officer for the ICS to move forward on this important work that will underpin everything we do
  + Agreeing an engagement strategy that defines how we will gain and use insight from our communities in the work that we do.
  + Launching a Citizens’ Panel of 1500 residents with whom we share ideas and obtain insights to help us design services appropriately.
  + Developing and agreeing a system wide quality strategy, bringing together all aspects of the system.
  + Further developing our system finance approach through the System Finance Leaders Group
  + Embedding joint accountability and assurance through our System Oversight and Assurance Group, co-chaired by the Accountable Officer and the NHSE Regional Director for Strategy and Transformation – and further developing our embedded assurance model with NHSE colleagues so as to reduce traditional transactional assurance processes between the system and NHSE.
  + Developing a new approach to clinical and professional leadership, including introducing a new clinical and professional congress to support the ICS to ensure the expertise of clinicians and care professionals is at the heart of our work.
  + Launching MSE Partners as a means to supporting innovation and improvement.

**Establishing the ICS**

In preparation for the forthcoming legislation to form the ICS on a statutory footing (which has a national target date of 1 July 2022), we have introduced an ICS Transition Programme Board with seven workstreams to manage and oversee the technical aspects for development of the ICS including the disestablishment of the CCGs and the commencement of the new Integrated Care Board (ICB) as an organisation. The work streams are:

* + Quality and safety
  + Finance and resources
  + Governance and accountability
  + Data and digital
  + Communications and engagement
  + Workforce
  + Future system operating model

**Integrated Care Board**

The Integrated Care Board (ICB) will take on all of the functions of current CCGs and, over time, some commissioning functions from NHS England. It will be responsible for the system’s entire NHS finance allocation and will take responsibility for workforce, digital, data and engagement.

Anthony McKeever has been appointed as Chief Executive designate of the new ICB and Professor Mike Thorne CBE has been appointed as chair designate of the ICB. We have appointed our non-executive members for the new Board and are finalising appointments to the executive team.

The Transition Programme Board has overseen the due diligence requirements to establish the ICB and will complete a “Readiness to Operate” statement to enable NHS England to formally establish the new organisation.

**Integrated Care Partnership**

The ICP will be a joint and equal partnership between the NHS and our upper tier local authorities. Together, we have agreed that the ICP will be chaired by Professor Thorne so as to ensure consistency and coherence across the ICS, with the three Health and Wellbeing Board chairs of our upper tier local authorities acting as vice chairs for the ICP. We have agreed membership of the ICP and we are currently progressing discussions to agree its work programme. The first task of the ICP will be to develop a new Integrated Care Strategy for the ICS and for the population of Mid & South Essex.

**How we have performed**

The CCG monitors health outcomes against a range of NHS Constitutional Standards that are set nationally. Performance across the system has generally been below the set standards due to capacity pressures throughout the health and care system.

The CCG is working with local providers of services and NHS England/Improvement (which is the regulatory organisation for the CCG and providers of services) to agree the system transformation required to support improvements in care for patients.

As seen nationally, performance against the standards has been directly impacted by the Covid-19 pandemic. A key issue experienced nationally is the increased waiting list and backlog sizes for planned elective care during the Covid-19 pandemic. As directed by national guidance whilst capacity was reduced, non-urgent diagnostic tests together with elective planned appointments and procedures were paused to prioritise emergency, urgent and cancer work.

**Key issues and risks**

The Covid-19 pandemic had a significant impact upon the operation of NHS services across the country, which brought with it several associated risks, firstly in relation to the effects of the virus itself and secondly in relation to the effects that management of the pandemic has had on core services and the achievement of constitutional standards.

The former has been managed well during the year, which is reflected in the lowering of risk in relation to the effects of the virus as a result of the success of the Covid-19 vaccination programme and greater understanding of how to care for patients with the virus. The Mid and South Essex CCGs continue to manage the impact of risks on core services, focusing on restoring performance back to pre-Covid levels.

Further information on the CCG’s key risks and risk profile is provided in the Risks section of the Performance Analysis report.

## Performance analysis

**Introduction**

The CCG monitors health outcomes against a range of NHS Constitutional Standards’ that are set nationally. Performance across the system has generally been below the set standards due to capacity pressures throughout the health and care system.

The CCG is working with local providers of services and NHS England Improvement (which is the regulatory organisation for the CCG and providers of services) to agree the system transformation required to support improvements in care for patients.

As seen nationally, performance against the standards has been directly impacted by the Covid-19 pandemic. A key issue experienced nationally is the increased waiting list and backlog sizes for planned elective care during the COVID19 pandemic. As directed from national guidance whilst capacity was reduced, non-urgent diagnostic tests together with elective planned appointments and procedures were paused to prioritise emergency, urgent and cancer work.

A key risk that could affect the delivery of future performance and recovery is ensuring workforce is in place to meet the delivery of the increased capacity required to recover from the COVID-19 pandemic and meet demand.

**Performance summary**

The following is an overview of how the system has performed against the constitutional standards.

**NHS Constitution – Urgent and Emergency Care (UEC)**

For UEC the NHS constitution includes standards for both Ambulance Response Times and Emergency Department (ED) waiting times.

Ambulance response times are significantly challenged as per following Mean and 90th centile summary by call category against the standards (format: hh:mm:ss) for 2022/23:

* One calls - for life-threatening injuries and illness:
  + Mean: 00:10:54 (standard <=7min)
  + 90th Centile: 00:20:06 (standard <= 15min)
* Two calls - for emergencies:
  + Mean: 00:53:53 (standard <= 18min)
  + 90th Centile: 01:55:13 (standard <= 40min)
* Three calls - for urgent:
  + 90th Centile: 07:41:27 (standard <= 2 hours)
* Four calls - for less urgent:
  + 90th Centile: 09:13:45 (standard <= 3 hours)

ED waiting times are also challenged. For Mid and South Essex NHS Foundation Trust (MSEFT), 77.6% of patients arriving within A&E were seen, treated, and discharged, or

admitted to a ward with four hours of arrival (below standard of >= 95%) during 2021/22.

As a system the CCG are working with all partners including MSEFT, Community providers, Local Authorities and EEAST to improve response times and ED waiting times.

All partners are members of the Strategic Partnership Urgent and Emergency Care Board for oversight and input into the improvement of the system UEC performance. Daily operational calls (Daily Tactical Care call) are in place with system partners, ensuring plans are in place or reviewed to mitigate presenting pressures across the system.

Mid and South Essex system, through collaborative working between partner organisations, are working on several initiatives to improve ambulance offload times (for conveyed patients) and flow through ED.

For example Community providers are supporting, through the Urgent Community Response Team (UCRT) team working with EEAST, an alternative to conveying patients to acute hospital where appropriate. The Virtual Wards work is continuing to be developed to support admission and reduce the need for conveyance of frail elderly patients where more appropriate.

Another example of collaborative working between partner organisations is EEAST Hospital Ambulance Liaison Officer (HALO) work within MSEFT Emergency Departments (ED) to facilitate the triaging and handover of patients arriving via ambulance to release EEAST staff.

To facilitate optimal flow through the hospital, Local Authorities ensure continued support for timely discharges from the acute.

**NHS Constitution – Diagnostics**

As seen nationally during the COVID-19 pandemic, waiting times for diagnostic tests or procedures has increased significantly with a large increase in the number of patients waiting over six weeks and 13 weeks.

During 2021/22, 68% of patients waited less than six weeks (below standard of >= 99%) with circa 14% of patients waiting over 13 weeks (below standard of zero) at MSEFT.

**NHS Constitution – Cancer waiting times**

As seen nationally during the COVID-19 pandemic, demand in terms of the number of two week wait (2WW) referrals decreased significantly and now, as expected demand on cancer services particularly the 2ww referrals is increasing as the country comes out of the pandemic.

For Mid and South Essex NHS Foundation Trust (MSEFT) during 2021/22:

* 69.8% of patients were seen by a specialist within 2 weeks of being booked on a 2WW pathway (below standard of >= 93%).
* 68.8% of patients were informed within 28 days whether they have cancer or not (below standard of >= 75%).
* 85.7% of patients started first definitive treatment for a new primary cancer within 31 days of the decision to treat (below standard of >= 96%).
* 55.3% of patients started first definitive treatment of cancer from receipt of urgent referral for suspected cancer within 62 days (below standard of >= 85%).

Delivery of the 62-day performance continues to be the most challenged cancer standard.

The CCG is working with MSEFT and Cancer Alliance through plans to transform the diagnosis, treatment, and care for cancer patients to recover performance for the local population.

**NHS Constitution – Planned Care**

As seen nationally during the COVID-19 pandemic, waiting times from referral to first definitive consultant led elective (non-urgent) treatment (RTT) have increased significantly with a large increase in the number of patients waiting over 18 and 52 weeks.

During 2021/22, 34.5% of patients waited less than 18 weeks (below standard of >= 92%) with circa 4% of patients waiting over 52 weeks (below standard of zero) at MSEFT.

Mid and South Essex system, through collaborative working between partner organisations including MSEFT, Independent Sector Providers, Community Providers and primary care, are working together to ease pressure at the acute trust, ensuring patients with 2ww or urgent referral are prioritised and available capacity is maximised across the system.

Community providers are working with MSEFT to, where appropriate, provide an alternative place for treatment instead of waiting and being treated at MSEFT. Local Independent Sector providers are providing additional system capacity for patients waiting at MSEFT facilitated by commissioners and MSEFT. Primary care is supporting with demand management/referral diversion plans.

**NHS Constitution – Improving Access to Psychological Therapies (IAPT) and waiting times**

The number of people accessing psychological therapies is below target during 2021/22.

The waiting list for IAPT service is meeting the six and 18 week standards for receiving first treatment as follows:

* 99.5% of patients received first treatment within six weeks (above standard of

>=75%)

* 100% of patients received first treatment within 18 weeks (above standard of >= 95%)

Of the people who complete treatment, 49% moved into recovery (below the standard of >= 50%).

**NHS Constitution – Psychosis waiting times**

During 2021/22, 78% of people experiencing first episode psychosis started treatment, with NICE recommended package of care, within two weeks from referral (above the standard of >= 60%)..

**Severe Mental Illness (SMI) Health Checks**

Circa 3,000 people are living with Severe Mental Illness (SMI) within the CCG population. As at February 2022, 37.7% of people living with SMI have received their full physical health assessments (below standard of >= 60%).

The CCG is working closely with primary care GP Practices to increase coverage of people living with SMI receiving their health checks ensuring the 60% standard is met during 2022.

**NHS Constitution – Children and Young People access to mental health services and eating disorders treatment waiting times.**

The number of Children and Young People accessing Mental Health Services is above national trajectory of 35% at 39.9% (as at January 2022).

**NHS Constitution – Dementia**

The standard is for the number of people on the dementia GP Practice register to be at least 66.7% of the estimated prevalence. The CCG register is at 54.5% (as at January 2022). The CCG is working closely with primary care GP practices to encourage GP referrals into the commissioned Memory Assessment Service to increase dementia diagnosis rate.

**Improve Quality**

2021/22 has continued to bring challenges and demands on our services, during which time colleagues from all sectors have done so much to ensure we continue to maintain quality care to thousands of patients across our system.

Mid and South Essex (MSE) CCGs have maintained core quality functions, such as serious incident monitoring and investigation, safeguarding, quality assurance and infection prevention and control, whilst recognising the challenges created by the pandemic. At times having to prioritise our work to flex with the needs of the system and continuing, where able, to work towards the transformation of services and processes in readiness for transition into an Integrated Care System (ICS).

Throughout 2021/22 the Quality team has adopted a continued response to the management of COVID-19 and associated workforce challenges, whilst continuing to influence the provision of safe, clinically effective healthcare locally.

**Care Quality Commission (CQC)**

The ratings of our main providers remain as ‘outstanding’ for Provide Community Interest Company, ‘good’ for Essex Partnership University Trust (EPUT) community services and ‘requires improvement’ for Mid and South Essex Foundation Trust (MSEFT), EPUT Mental Health Services, North East London Foundation Trust community services and East of England Ambulance service.

As part of a new risk-based approach to inspections CQC undertook a formal reinspection of MSEFT Maternity services, and Emergency Departments. In terms of Maternity services, CQC gave an overall rating of ‘Requires Improvement’. This represents an improvement and acknowledges the hard work being undertaken as part of the MSE wide Maternity Improvement Programme. The CQC Section 31 notice for Maternity remains in place, as well as ongoing support as part of the NHSE/I Maternity Safety Support Programme. The Maternity Improvement Programme has been updated to reflect CQC’s most recent recommendations and strengthened to include learning from the Ockenden Report. Both will support and further improve the transformation of Maternity services across MSE.

CQC undertook a review in June 2021 of care for people with a learning disability during the Covid-19 pandemic. The report published looked at how providers worked collaboratively in a system in response to the Covid-19 pandemic and the experiences of people with a learning disability living independently within the community. The report showed positive aspects, that care was provided, and communication was good at the height of the pandemic. Advocacy was also seen as a positive aspect displayed at this time.

**System Quality**

In line with national NHSE guidance, the MSE CCGs Executive Director of Nursing and Quality has successfully established the Mid and South Essex System Quality Group. This has significantly strengthened the quality surveyance, oversight and wider system learning from all key providers and partners. This group will be instrumental in developing system strategy leading into the Integrated Care Board and Partnership.

MSE CCGs have also initiated the Patient Safety Specialist meeting as one of the elements from the National Patient Safety Strategy. This meeting aims to share knowledge and learning across our system through the collaboration of all acute and community partners.

MSE Quality teams have also supported MSEFT to undertake deep dive harm reviews on all patients whose care pathways breached cancer standards and those breaching referral to treatment standards. This has enabled the Trust to identify where harm has occurred and for learning to be used to change pathways and processes moving forward.

For Mental Health service provision across the population of Mid and South Essex the Quality teams have been working closely with EPUT, the newly formed Mental Health Provider Collaborative and other local providers to ensure robust oversight of the quality and safety of care provided. During 2020/21 the CCGs have robustly reviewed their

mental health commissioning arrangements through the CCG Mental Health Taskforce and supported the ongoing Parliamentary commissioned Essex Mental Health Independent Investigation.

**Special Educational Needs and Disability (SEND)**

Thurrock - Ofsted and CQC visited Thurrock in December 2021 to assess the levels of progress made by the Council in addressing areas identified as needing focus and development as highlighted through a joint local area SEND Ofsted inspection report in April 2019. The report found sufficient improvements on the storage of accurate records and oversight of the provision for children and young people. The rigorous quality assurance for services provided to 0- to 25-year-olds with SEND, and the quality and reviewing of Education, Health and Care (EHC) plans were also highlighted as key improvements.

Southend - An Ofsted and CQC revisit to SEND services in Southend-on-Sea in November 2021 found sufficient progress made in three out of four areas of significant weakness as identified through the 2018 SEND Inspection. The report highlighted improvements to the Local Offer, the multi-agency approach to Education Health and Care (EHC) plans and better evaluation of education needs, as well as commenting on the ‘palpable’ change in culture and greater commitment to joint working for the best outcomes for children and young people with SEND in Southend.

Essex - The SEND team are currently working up their plans prior to the forthcoming inspection due in April and May 2022.

**Infection Prevention and Control**

The Infection Prevention and Control team has been integral to the Covid-19 pandemic system response during 2021/22. They have maintained high levels of oversight and partnership working with local agents such as Public Health to ensure information, advice, and rapid learning has been robustly available.

The team have also maintained oversight of healthcare associated infections such as Meticillin resistant Staphylococcus aureus bacteraemia (MRSAB) and Clostridioides difficile infection (CDI) cases. In the year there were a total of 33 CCG and 9 Acute MRSAB cases and 382 CCG and 221 Acute CDI cases. Learning from these infections has been identified and we will be supporting providers moving forward to ensure this learning is embedded into practice.

With reference to the 2019 Group A Streptococcus (iGAS) outbreak in Mid and West Essex, work has continued to ensure that all learning has been taken forward and disseminated regionally and nationally during 2021.

**Patient Experience**

During 2021/22 as part of the development of the Quality strategy, the Quality teams have strengthened the voice of the patient through ways such as a programme of patient stories which capture authentic lived experiences. This, in turn, is shared with commissioners and has directly influenced commissioning decisions. Furthermore, as part of stakeholder development of the MSE Quality strategy, a key priority highlighted

going into 2022/23 is the call for ongoing focus to ensure robust co-production with patients and services users .

**Care Sector**

The Quality team helped to progress the provision of Enhanced Care in Care Homes providing support to homes during the Covid-19 pandemic with training, new technology to support our patients remotely and daily hub calls to enable support to our homes in a timely way.

**Reducing Health Inequality**

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

Addressing health inequalities is a core strategic ambition of the MSE Health & Care Partnership (HCP). The significant increase in collaborative working accelerated by the Covid pandemic has enabled us to tackle these issues across the HCP. The MSE ICS five-year HCP strategy outlines our commitment through working with our partners to reduce inequalities. We aim to achieve this by:

1. Creating opportunities through education, employment, housing and growth
2. Supporting health and wellbeing
3. Bringing care closer to home and
4. Transforming and improving health and care services.

The Health Inequalities Oversight Group (HIOG) was established to provide oversight, focus, and ensure the delivery of requirements to reduce inequalities. The HIOG group has cross organisational representation from NHS Providers, Local Authority Community and Voluntary Services, Public Health, Primary Care and other NHS organisations This group reports into the System Leadership Executive and MSE Healthcare Partnership Board.

Dr Sunil Gupta, Chair of Castle Point and Rochford CCG, is the designated Senior Responsible Officer (SRO) for the HCP. Dr Gupta is supported by a Senior Executive Sponsor for Inequalities (Mark Tebbs, Thurrock Alliance Director) and by a Senior Clinical Fellow. Dr Sophia Morris, Inequalities Programme Lead, has also taken a lead in driving our work and is supported by a secondment role enabled by some non-recurrent seed funding to co-ordinate the work of the HIOG. The work to reduce health inequalities is driven by a maturing network of equity leadership. All system providers have a named Inequalities SRO, and each Alliance has named inequalities leads who will support the incoming Primary Care Network (PCN) Inequalities leads. Development of leadership within inequalities has been proactive and within MSE we have hosted a successful first cohort of five GP Trailblazer Deprivation Fellows with recruitment now open for cohort two.

Progress in health inequalities improvement is established through the use of the System Outcomes Framework which are health inequalities indicative metrics aligned to system ambitions. The system outcomes framework is being collated into an interactive system- wide dashboard. System and Place-based inequalities plans are focused on the amalgamation of Prevention, Population Health Management, Personalised Care, Self- Care and strengthening our community-based approach. A place-based approach to addressing inequalities is being delivered with our four Alliances which sees NHS organisations, Primary Care, Health and Wellbeing Boards, Local Authority Public Health, Social Care and children’s services, voluntary sector organisations working collaboratively through a single, shared “place plan” to address agreed key priorities.

Addressing the wider determinants of inequalities, particularly in our most deprived areas, is crucial in reducing inequality gaps. With an explicit focus on the social determinants of health - at system and place level - partnership working is embedded in our approach to inequalities improvement. This can be seen in areas such as Better Start Southend, which delivers targeted provision to children aged 4 and under in the most deprived wards in Southend, and the Mid and South Essex Foundation Trust (MSEFT) Anchor programme initiatives that are targeting employment opportunities to young people and adults in the most deprived wards.

To realise our ambition to reduce inequalities, we have identified community asset engagement as a core principle within our engagement strategy - which is driven by our aim to ensure local voices are heard, improved local confidence and to be unified to creating changes. Embedding co-production into the equalities workstream has been a key part of the MSE equalities approach. Much co-production was seen within the Covid Inequalities Programme and this will continue as we learn and distill the good practice from this period. Following a co-design initiative for people with Learning Disabilities accessing hospital services in 2021-22, MSE FT will implement a detailed action plan in 2022-23 to improve access for people with Learning Disabilities across hospital sites. We are also working with providers in other parts of Essex to jointly take actions for the benefit of our population.

The latest planning guidance for NHS organisations outlines five priority areas for tackling health inequalities:

* Priority 1: Restore NHS services inclusively
* Priority 2: Mitigate against digital exclusion
* Priority 3: Ensure datasets are complete and timely
* Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
* Priority 5: Strengthen leadership and accountability

The Core20PLUS5 approach to tackle health inequalities was also introduced in 2021. This approach outlines a framework to accelerate health inequalities improvement through focused approaches targeted at the Core20 (the most deprived 20% of the population) PLUS (other inclusion groups) and 5 (clinical areas of focus). This Core20PLUS5 framework has been adopted across the system and health inequalities improvement plans at system and place have been refined to reflect the Core20PLUS 5 approach.

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

It is expected that an overarching ICS Health Inequalities Strategy will be deployed by July 2022.

**Engaging People and Communities**

We put patients and the public at the heart of our CCG. Working in partnership with patients, carers, families and local people within their own communities brings a different perspective to our understanding and can challenge our view of how we think services are received and should be delivered in the future. Service provision can be improved if we can learn more about the views, experiences and concerns of patients, service users, carers and our wider communities. We believe that better decisions are made when patients and professionals work together. In line with a [system](https://www.msehealthandcarepartnership.co.uk/become-involved/introduction/) [engagement framework](https://www.msehealthandcarepartnership.co.uk/become-involved/introduction/) we strive to make sure we get the community involved at the very beginning of a project and build things around local need rather than organisations.

**The impact of the Covid-19 pandemic**

The Covid-19 pandemic continued to pose challenges to how we went about meeting our usual duties to engage and communicate with our local communities and continued to postpone all face-to-face engagement. However, we recognised a critical need to engage and have constructive dialogue with local people and patients throughout this time.

**Our legal duties and principles of engagement**

The CCG has a duty, under Section 14Z2 of the NHS Act 2006, to involve the public in commissioning. Here we provide an overview of the consultation and engagement activities that have taken place over the past year (April 2021 – March 2022).

We know from experience that engagement with patients, carers and our local communities can result in:

* Better outcomes and patient experience
* Improved services
* Reduced demand
* Deliver change

**Engagement from Mid Essex CCG within the Mid and South Essex Health and Care Partnership**

Collectively the CCGs and partner organisations across mid and south Essex have benefitted from sharing best practice. So, we have been expanding the ways we work with local people and to join the conversation in a way that suits them:

* + The Mid Essex Patient and Community Representatives Group, held every two months with invitees including delegates Healthwatch Essex, GP patient participation groups, charities and local authorities.
  + Attending CCG meetings held in public, including our Annual General Meeting and Governing Body meetings in public.
  + Attending virtual events such as the mid Essex mental health service users’ forum.
  + Seeking involvement with mid Essex Primary Care Networks (PCNs) as they begin to deliver on their obligation to engage with their residents.
  + Joining ad hoc meetings to inform our work – for example, we hosted gatherings of patient representatives who helped us to design recent communications campaigns on GP pressures and other key topics.
  + Being part of our Citizen Panel, called Virtual Views, that can be found [here](https://www.msehealthandcarepartnership.co.uk/become-involved/citizens-panel/). In 2021 we asked for their views on; immunisation and changes to services re the pandemic response.
  + Following and interacting with the CCG on social media or visiting our website or subscribing to one of our newsletters.
  + Contacting the CCG with specific ideas, questions or concerns.
  + The Colne Valley Primary Care Network, in the north of Braintree District, ran a successful patient-led “low carb programme”.
  + In Chelmsford, members of a local “heart and sole” walking group – a wellbeing programme run by the local authority – helped to co-design our long covid respiratory rehabilitation pathway.

Details of all the groups and meetings, as well as the CCG’s contact details and social media, can be found on the CCG website [Get Involved – NHS Mid Essex](https://www.midessexccg.nhs.uk/get-involved) [CCG](https://www.midessexccg.nhs.uk/get-involved).<https://www.midessexccg.nhs.uk/>

**Partnerships across the health and care system**

We actively work and collaborate with our local Healthwatch and voluntary, community and faith sector colleagues.

We partnered with Ford to develop the world’s first custom-built Covid-19 vaccination vehicle called the Essex Vax Van. This enabled a new model of outreach and ensured a culturally sensitive approach for communities not engaging in the national Covid-19 vaccination programme.

Having successfully increased the uptake of Covid-19 vaccinations in areas of low uptake, the team built on its success to bring much needed spirometry testing into the community. The initiative was a finalist for ‘Most impactful project addressing healthcare inequalities’ at the prestigious HSJ Partnership Awards 2022. For more information, please visit [Essex Vax Van](http://www.essexcovidvaccine.nhs.uk/coronavirus-vaccine/essex-vax-van/).

We have also, for example, designed the new adult ADHD service shortly being introduced across mid and south Essex with the direct involvement of a patient who has the condition.

We used the lived experience of a resident who had accessed the tier 2 weight management service we commission as part of training for primary care clinicians at a “time to learn” event run by the CCG in September 2021. The residents’ suggestions and feedback have helped us to update the local weight management clinical pathway and will form part of the new model launching in 2022/23 to cover the whole of mid and south Essex.

**Improving accessibility to healthcare information**

The CCGs have been improving accessibility to healthcare information with the support of the Council for Voluntary Services (CVS). This collaboration provided residents with resources such as; Easy Read, information in different languages or for learning disabilities and videos produced by the CCG with subtitles and where possible a British Sign Language interpreter on the screen.

My Health Matters**:** Deliver support to parents and carers of children aged 0-5 living in Mid Essex to better manage childhood Illnesses, through a series of co-production workshops for health and care professionals, parents and carers of 0-5 year olds. It provided an opportunity for them to influence local communications and behaviour interventions and support our campaign.

**Social media and digital marketing**

Collective planning, developing and delivering of social media and other online content for our communities. Posting regular messages offering information on COVID, self- care and other healthcare matters, the digital team produced a number of campaigns to support CCG priorities.

**Our ambition**

Our ambition is to place engagement at the forefront of all we do in mid and south Essex, creating healthier communities that people recognise and feel a part of.

Together we will aim to co-design and deliver new models of care and different ways of working that make a real difference to people and their local communities. We will work collaboratively across local authority, health, and voluntary sector to understand and build our communities, maximising the collective impact we can have on the health of our population.

**Health and Wellbeing Strategy**

The MSE Health & Care Partnership’s 5 year strategy is built upon the priorities agreed through the three upper tier Health and Wellbeing Boards and, as we move towards creating the statutory ICS, we have agreed the importance of continuing to ensure that the Health and Wellbeing strategies underpin the work we do together.

Through the ICS and our four Alliances we have been involved with and contributed to the development of refreshed joint Health and Well Being strategies, including the Essex Health and Wellbeing Strategy for 2022-26, and will continue to ensure our plans are supportive of delivering the aims of these strategies at system, alliance and PCN level.

Senior leaders from the CCGs have engaged with all three upper tier local authority health and wellbeing boards, as well as district, borough and city fora, throughout the year. CCG leaders are core members of the Health and Wellbeing Boards and have proactively participated in attending meetings, workshops and events, contributing to the refresh of joint health and wellbeing strategies and co-producing Alliance plans. Across the three Upper Tier Local Authorities (UTLA) we have commenced work on a joint mental health strategy, as well as a children’s partnership plan.

The chairs of the three UTLA Health and Wellbeing Boards sit on the MSE Health & Care Partnership Board, as do senior officers including Directors of Adult Social Care and Directors of Public Health.

As we move into the formation of the statutory ICS, the Integrated Care Partnership will be an equal partnership arrangement between the NHS and upper tier local authorities. We have agreed that the ICB Chair (Professor Mike Thorne CBE) will chair the Integrated Care Partnership and the three Health and Wellbeing Board chairs will act as vice chairs. A wider range of local authority colleagues will play a role in the ICP – which may include, alongside the HWB chair, the Director of Adult Social Care, the Director of Children’s Social Care, and the Director of Public Health. A representative from each district/borough/city council will also be on the ICP, broadening the range of local authority partners in this arrangement.

**Financial Review**

**Financial overview**

Our full statutory financial accounts are included from page 84 onwards. This section provides a summary of our 2021/22 financial position. Our Head of Internal Audit offers an opinion on Financial Systems Key Controls and other matters which can be found on page 55. whilst our overall financial management arrangements and financial statements were subject to audit review and opinion by our external auditors, [KPMG](https://home.kpmg.com/uk/en/home.html), as part of their annual review of our accounts (see page 78 for their full audit opinion).

**CCG funding**

During 2021/22 the NHS largely continued to operate under the financial regime and allocation methodology put in place at the beginning of 2020/21 to support the ongoing response to the Covid pandemic.

Funding of our NHS providers remained under national directed levels. However, our contracts with our independent sector providers reverted back to CCG arrangements after being funded directly by NHS during the emergency period.

The NHS financial year was split across two halves with separate funding being allocated for Half 1 and Half 2. Whilst the CCG received its traditional allocations for Programme Services including Primary Care Services (£568.7m) and Running costs (£7.4m), it also had access to a funding stream to support Discharges from Hospital throughout the year under the nationally directed Hospital Discharge Programme.

We also received additional income to support our Elective recovery, alongside our System Development funding and Spending Review investment.

Mid Essex CCG continued as the nominated lead CCG for receiving and managing the distribution of most non-organisational specific system allocations. As a CCG we received and managed funds across and on behalf of our CCG partners in Thurrock, Southend, Castle Point and Rochford and Basildon and Brentwood. This included

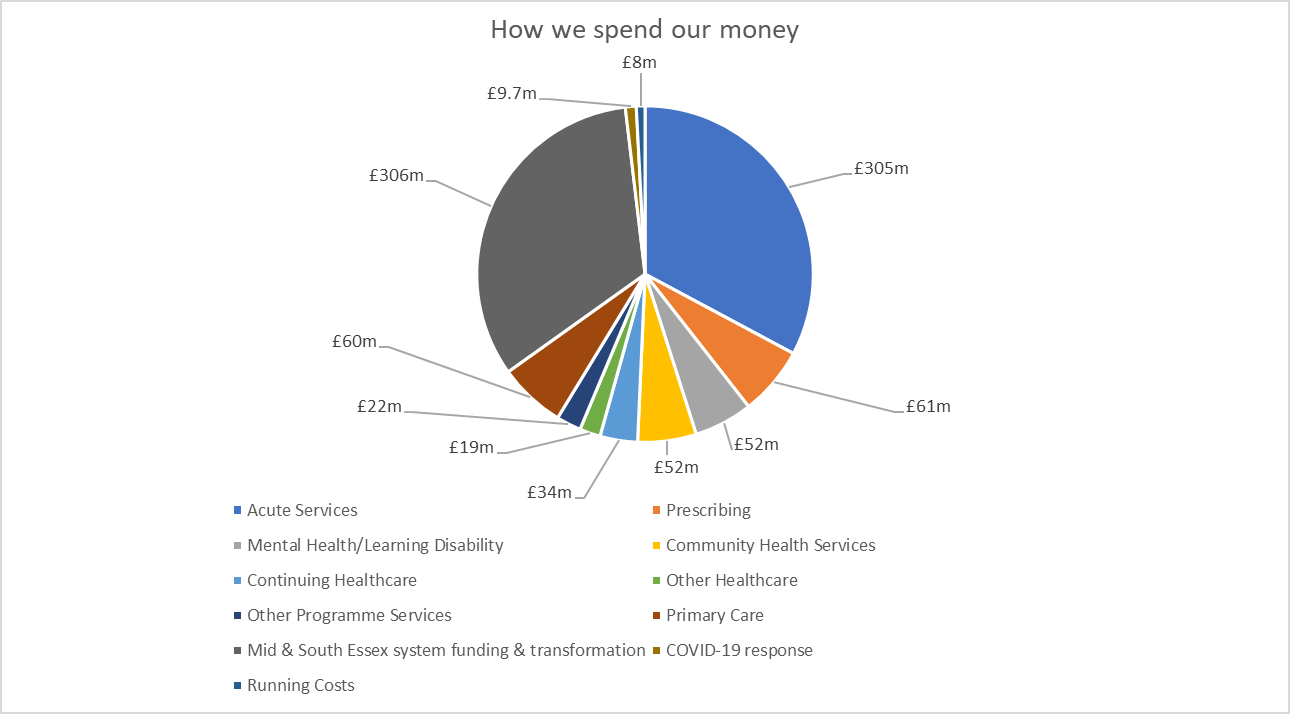
£161.2m of ‘Top-up Funding’ across the year and £84.1m of Covid funding.

In 2021/22 our in year total healthcare funding including system funding was £920.8m and funding for running the CCG (called ‘running cost expenditure’) was £7.8mm, resulting in total overall of £928.6. CCG expenditure was £928.3m, resulting in a net surplus position of £0.3m.

NHS planning guidance requires CCGs to meet the ‘Mental Health Investment Standard’ (MHIS). This requires CCGs to demonstrate that expenditure on mental health services has grown year on year. In 2021/22 the CCG has achieved the MHIS by increasing all Mental Health related expenditure by 4.5%.

**How your money was spent**

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



In 2021/22 the CCG spent £9.7m on Covid related expenditure. The main areas of expenditure were £7.67m on the hospital discharge programme – of which £1.46m was for Continuing Health Care, £4.74m was for Essex County Council and £1.47m was for MSEFT. Additional funding was made available to address these costs.

The CCG did not incur additional costs or receive additional funding in relation to EU exit.

**Capital spending**

We did not require a CCG capital allocation for 2021/22, but the Mid and South Essex Health and Care Partnership footprint was awarded Estates and Technology Transformation Funding (ETTF) towards primary care estates projects and GP IT. ETTF expenditure is accounted for by NHSEI.

**Paying our suppliers and providers**

National rules mean we must aim to pay all valid invoices by the due date or within 30 days of receiving them, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. In 2021/22 we met all four targets (based on invoice numbers and value of expenditure) for NHS and non- NHS invoices – see Note 6 of the Financial Statements for details.

We are also an [approved signatory](https://www.smallbusinesscommissioner.gov.uk/ppc/signatories/?signatory=n) of the Prompt Payment Code. The government designed this initiative with the [Chartered Institute of Credit Management](https://www.cicm.com/) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence that any organisation signed up to the code will pay them within clearly defined terms and that proper processes are in place to deal with any disputed payments. Approved signatories have committed to:

* + Paying suppliers on time
  + Giving clear guidance to suppliers and resolving disputes as quickly as possible
  + Encouraging suppliers and customers to sign up to the code.

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

**2022/23 financial plans and looking to the future**

The unprecedented impact of the Covid pandemic has inevitably delayed the return to normal financial arrangements. CCGs will cease to exist on 30 June 2022 and on 1 July 2022 the 5 CCGs will become Mid and South Essex Integrated Care Board.

Allocations for 2022/23 have been published on a system level and it is expected that the CCGs will produce a set of Accounts for the first quarter of 2022/23.

We will continue to work with system partners over the coming months to prioritise programmes of work towards achieving a financially sustainable health and social care system.

**Risks**

The CCG’s risk profile as a 31 March 2022 is detailed in the table below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Workstream** | **RAG Rating** | | | **Total No of Risks** |
| **Green** | **Amber** | **Red** |
| Cancer and End of Life | 0 | 1 | 1 | 2 |
| Children and Young People | 0 | 6 | 0 | 6 |
| Community | 2 | 4 | 0 | 6 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Workstream** | **RAG Rating** | | | **Total No of Risks** |
| **Green** | **Amber** | **Red** |
| Digital and Business Intelligence | 1 | 3 | 0 | 4 |
| Estates | 0 | 2 | 0 | 2 |
| Finance | 1 | 3 | 1 | 5 |
| Health Inequalities | 0 | 1 | 0 | 1 |
| Integrated Care System | 2 | 3 | 0 | 5 |
| Maternity | 0 | 2 | 1 | 3 |
| Medicines Optimisation | 1 | 1 | 0 | 2 |
| Mental Health and Learning Disability | 0 | 4 | 2 | 6 |
| People | 1 | 1 | 1 | 3 |
| Planned Care | 1 | 2 | 2 | 5 |
| Population Health Management | 0 | 3 | 0 | 3 |
| Primary Care | 2 | 5 | 0 | 7 |
| Stewardship | 0 | 0 | 0 | 0 |
| Urgent Emergency Care | 2 | 5 | 0 | 7 |
| Vaccination | 0 | 1 | 0 | 1 |
| **Total as at 31 March 2022** | **13** | **47** | **8** | **68** |

During 2021/22 the MSE CCG’s risk profile has seen the number of red rated risks decrease. As of 31 March 2022, there were 8 red-rated risks, which related to the following 5 areas of the CCG’s business:

**Referral to Treatment (RTT) standard, cancer, access to service and capacity**

The CCGs continue to work with the Mid and South Essex NHS Foundation Trust (MSEFT) to address Licence Undertakings. Arrangements are in place to ensure oversight of the required actions to address RTT poor performance. There has been a significant impact on performance as a direct result of the Covid-19 pandemic. Delayed discharges and capacity out of hospital, both within health and social care, have also impacted upon performance. In partnership with NHS England, plans, oversight groups and reporting processes have been established to oversee restoration.

The System Quality section of this report provides an overview of action taken by the MSE Quality teams to support MSEFT to undertake deep dive harm reviews on all patients whose care pathways breached cancer and RTT standards.

**Maternity services**

Arrangements are in place (as part of the MSEFT Licence Undertakings) to address significant concerns relating to maternity services, particularly those identified in the Care Quality Commission report for Basildon Hospital. The Mid and South Essex Local Maternity and Neonatal System (LMNS) are working with MSEFT to support workforce recruitment and retention measures and the Maternity Improvement Plan, including a review of the findings set out Donna Ockenden’s reports following her independent review of maternity services to assure the system and identify any further action required. Further information on maternity services is provided under the Care Quality Commission section of this report.

**Mental health services**

The Essex Mental Health Independent Inquiry is investigating matters surrounding the deaths of mental health inpatients across NHS Trusts in Essex between 2000 and 2020. The Inquiry is in Phase 2 and will hear evidence from families, carers, and friends of those who died; others with experience of mental health inpatient care in Essex during the 21 year period; as well as staff, former-staff, relevant professionals, and organisations. The Inquiry is independent of government and the health care system.

The Inquiry has recently expanded its review of cases to 1500 to be considered as part of the investigation. This was reported in local and national media

**Workforce**

Workforce vacancy levels persist across MSE particularly in nursing and midwifery areas. Ongoing international and domestic recruitment initiatives are in place with a targeted retention strategy running in parallel. The MSE system has recently trialled a large in-person recruitment event for entry level roles, which resulted in 170 plus offers being made in one day. Similar initiatives will be rolled out across the system during 2022/2023.

**Financial Impact of Elective Recovery**

The submitted plans for Half 2 (H2) 2021/22 did not include additional Elective Recovery Fund income (ERF) within the system. This led to an income shortfall which has been mitigated by a mixture of additional efficiency savings within the system and some additional non-recurrent funding.

**Sustainable Development**

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. 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. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012).

We acknowledge this responsibility to our patients, local communities, and the environment by working hard to minimise our carbon footprint.

In October 2020, the Greener NHS National Programme published its new strategy, Delivering a Net Zero National Health Service. This report highlighted that left unabated climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer. The report set out trajectories and actions for the entire NHS to reach net zero carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence (such as the supply chain). As part of the NHS, public health and social care system, it is our duty to contribute towards the targets set out in this document.

As a commissioner of services, the CCG sets out a commitment to sustainable procurement in its Procurement Policy. The CCG has taken measures to encourage greater awareness among staff. In November 2019 the Governance Committee

recommended adoption of the NHS England pledge to eliminate single use plastics. In December 2019 the Staff Engagement Group supported an initiative for staff to make a “Green Pledge” for the start of the New Year.

An ICS Green Plan has been development and sets out actions to achieve Net Zero Carbon across the ICS. The CCG is fundamental to the delivery of this plan.

Sustainability will become business as usual across all service areas.

**Modelled Carbon Footprint**

In England, the NHS is estimated to account for 5.4% of the country’s greenhouse gas emissions. The health and social care system reduced its carbon footprint by an estimated 62% between 1990-2020, however, drastic action is now required.

Figures 1 and 2 below illustrate the key areas of focus that the NHS must deliver on to reduce its carbon footprint and meet the Greener NHS targets of being a net carbon zero health care service by 2045.

Figure 1: Greenhouse Gas Protocol (GHGP) scopes in the context of the NHS

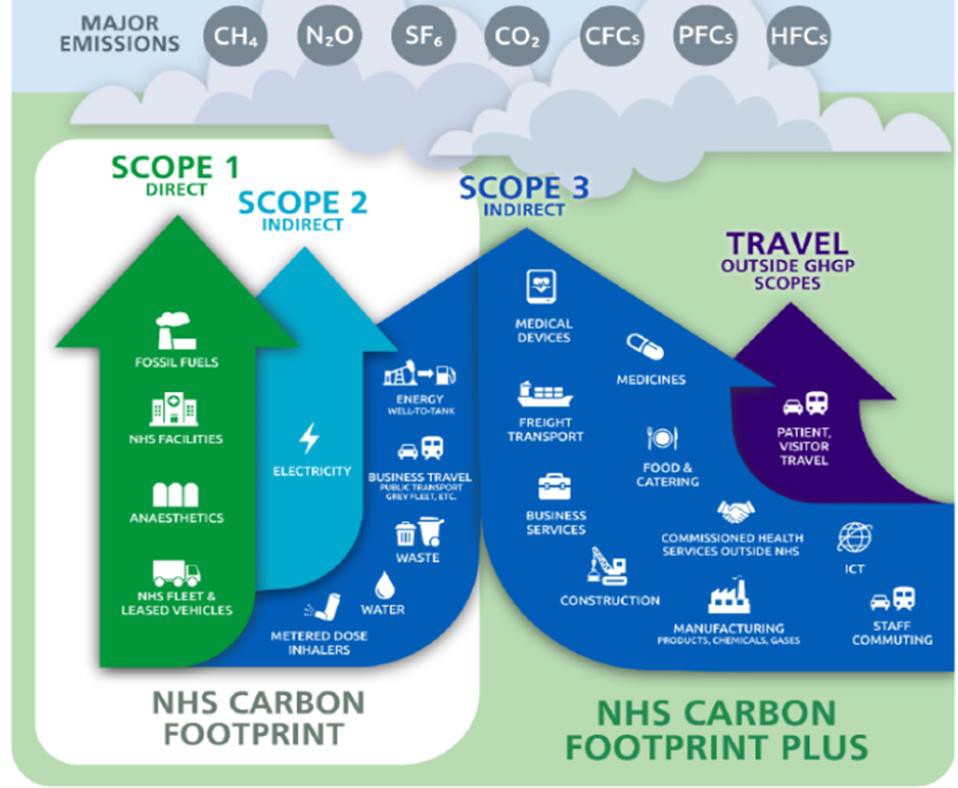
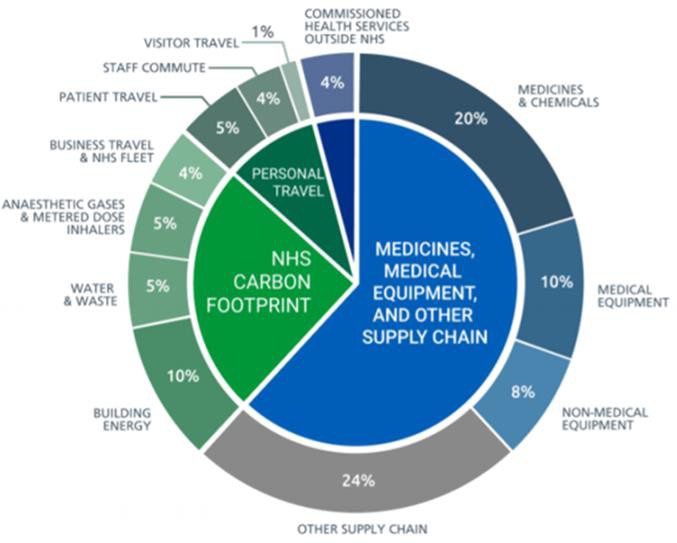


Figure 2: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus



# ACCOUNTABILITY REPORT

## Corporate Governance Report

**Members Report**

##### Member profiles

CCGs are clinically-led membership organisations made up of general practices. As of 31 March 2022, the following 39 NHS practices are members of Mid Essex CCG:

|  |  |  |
| --- | --- | --- |
| **Practice** | **Area served** | **Primary Care Network** |
| **Baddow Village Surgery** | Great Baddow | Chelmsford City Health |
| **Beacon Health Group** | Chelmsford and Danbury | Phoenix (Mid Essex) |
| **Beauchamp House Surgery** | Chelmsford | Chelmsford City Health |
| **Blackwater Medical Centre** | Maldon | Witham and Maldon |
| **Blandford Medical Centre** | Braintree | Braintree |
| **Blyth’s Meadow Surgery** | Braintree | Braintree |
| **Burnham Surgery** | Burnham-on-Crouch | Dengie and SWF |
| **Chelmer Medical Partnership** | Western Chelmsford | Chelmsford West |
| **Chelmer Village Surgery** | Chelmsford | Chelmer |
| **Church Lane Surgery** | Braintree | Braintree |
| **Coggeshall Surgery** | Coggeshall | Colne Valley |
| **Collingwood Road Surgery** | Witham | Witham and Maldon |
| **Dengie Medical Partnership** | Tillingham, the Maylands | Dengie and SWF |
| **Dickens Place Surgery** | Chelmsford | Chelmsford West |
| **Douglas Grove Surgery** | Witham | Aegros |
| **Elizabeth Courtauld Surgery** | Halstead | Colne Valley |
| **Fern House Surgery** | Witham | Witham and Maldon |
| **Freshford Practice** | Finchingfield | Colne Valley |
| **Greenwood Surgery** | South Woodham Ferrers | Dengie and SWF |
| **Hedingham Medical Centre** | Castle Hedingham, Sible Hedingham,  Yeldham | Colne Valley |
| **Kelvedon and Feering Health Centre** | Kelvedon | Colne Valley |
| **Kingsway Surgery** | South Woodham Ferrers | Dengie and SWF |
| **Little Waltham and Great Notley Surgeries** | Little Waltham | Aegros |
| **Longfield Medical Centre** | Maldon | Phoenix (Mid Essex) |
| **Mount Chambers Surgery** | Braintree | Braintree |

|  |  |  |
| --- | --- | --- |
| **North Chelmsford Healthcare Centre** | Chelmsford | Chelmer |
| **Pump House Surgery** | Earls Colne | Colne Valley |
| **Rivermead Gate Medical Centre** | Chelmsford | Chelmer |
| **Sidney House & The Laurels Surgeries** | Hatfield Peverel, Boreham | Aegros |
| **Silver End Surgery** | Witham | Braintree |
| **Stock Surgery** | Stock | Chelmsford City Health |
| **Sutherland Lodge Surgery** | Chelmsford | Chelmer |
| **Tollesbury Surgery** | Tollesbury | Phoenix (Mid Essex) |
| **Trinity Medical Practice** | The Maylands | Dengie and SWF |
| **Whitley House Surgery** | Chelmsford | Chelmsford City Health |
| **William Fisher Medical Centre** | Southminster | Dengie and SWF |
| **Witham Health Centre** | Witham | Witham and Maldon |
| **Writtle Surgery** | Writtle | Chelmsford West |
| **Wyncroft Surgery** | Bicknacre, East Hanningfield | Dengie and SWF |

##### Composition of Governing Body

The CCG’s board is the accountable body for the performance of the CCG. It has four members elected by their fellow GPs to lead the organisation alongside the Executive membership. One of these elected GPs, Dr Anna Davey, chairs the board.

The board also has three lay members and a secondary care member.

The role of lay members includes ensuring views and suggestions from patients and the public are properly considered by the CCG, providing independent judgement and sound commercial knowledge, and helping to ensure the CCG is well run and uses public funds properly.

The role of the secondary care member ensures that the views of secondary care providers, which includes acute and mental health services, are considered by the Board.

As of 31 March 2022, the board consisted of 12 members. Of these, 7 are female, and 5 are male.

Membership of the board, together with information on which of the main CCG committees each board member attends, is set out below and in the Governance Statement.

In February 2022 the Basildon and Brentwood, Castle Point and Rochford, Mid Essex, Southend and Thurrock CCG Boards, collectively referred to as Mid and South Essex (MSE) CCG Boards, agreed to ‘meet in common’ until establishment of the MSE Integrated Care Board. This means that each Board will meet in the same place (currently virtually via MS Teams), at the same time, although they still act and make decisions as separate Boards. These arrangements will enable decisions affecting the whole MSE population to be made collectively

The following people have been CCG Board Members during 2021/22:

* + **Mark Barker, Joint Chief Finance Officer**

Prior to joining the NHS over 20 years ago, Mark was a Senior Manager at KPMG, Director of Finance in various housing associations and business controller at Transport for London. Mark has worked in a number of NHS organisations, most recently as the Chief Finance Officer for Castle Point and Rochford and Southend CCGs and, from 1 January 2021, he was appointed as Joint Chief Finance Officer for the five mid and south Essex CCGs.

* + **Dr Anna Davey, Elected GP and Chair**

Dr Anna Davey qualified from the Guy’s and St. Thomas’ Medical School in 1999, going on to train at The Ipswich Hospital NHS Trust and Colchester Hospital University NHS Trust in junior doctor posts.

Anna worked as a GP in Halstead for 12 years before moving to Coggeshall Surgery in 2017. She became a clinical lead for out-of-hospital care at Mid Essex CCG in 2016 and became Chair in October 2018. Her clinical interests are women’s health, dermatology and the complex care of frail elderly patients.

* + **Dan Doherty, Alliance Director for Mid Essex and Deputy Accountable Officer for Mid and South Essex CCGs**

Dan was previously Director of Clinical Commissioning and from 15 January 2018 was appointed Director of Clinical Transformation and Deputy Accountable Officer. In March 2016 Dan was seconded to the Mid and South Essex Success Regime (Locality Health and Care) for 18 months, working on system transformation with a particular focus on innovation in health and care. Dan was appointed as the Alliance Director for Mid Essex on 2 November 2020 and also acts as Deputy Accountable Officer for the mid and south Essex CCGs.

Dan is a practising physiotherapist who previously worked at St Peter's Hospital in Maldon.

* + **John Gilham, Lay Board Member (Governance) and Deputy Chair**

John Gilham was appointed as Lay Member for Governance in July 2018. He was formerly chief executive of two NHS hospital trusts in Essex covering a period of almost nine years.

John has over 35 years’ management experience across a range of functions in the NHS. Prior to joining Mid Essex CCG, he served as a public sector non- executive director with the NHS, including undertaking the role as Chair of the Risk and Quality Committee at East and North Hertfordshire NHS Trust.

John also has experience of working with the private sector over the last nine years as a management consultant, focusing on how their services can best be matched to the needs of the NHS and to give patients an improved service experience.

* + **Dr Julia Hale, Secondary Care Specialist from 1 August 2021**

Dr Hale has been a consultant paediatrician for 21 years, specialising in neuro- disability, safeguarding and adoption. She has an MSc in Community Child Health and was a member of the CoramBAAF Health Advisory Committee for 7 years. She has experience in clinical governance, patient experience and service reconfiguration in community services. Dr Hale also serves as the Secondary Care Specialist member of Basildon and Brentwood CCG.

* + **Rachel Hearn, Executive Director of Nursing and Quality**

Rachel is a Registered Nurse and Executive Director of Nursing and Quality across the five Mid and South Essex CCGs. Rachel has over 20 years’ clinical experience as a nurse within the NHS. Having worked predominantly in emergency and general medicine, Rachel has clinically led work on the changing face of emergency care. Rachel’s role in commissioning focuses on quality improvement, safeguarding adults and children and continuing health care provision.

* + **Dr Julie McGeachy, Elected GP and Clinical Vice Chair**

Dr Julie McGeachy qualified from Nottingham University medical school in 1987 and trained as a GP in Derby. She has been a GP at the Tillingham Medical Centre for more than 20 years.

Julie also spent five years experiencing primary care in different settlings – New Zealand and the South Pacific – and has an interest in change and innovation in a challenging NHS environment.

Julie completed the Future Clinical Commissioning Leadership course run by the NHS Leadership Academy in 2018. Her clinical interests are dermatology, care of the elderly and mental health.

* + **Anthony (Mac) McKeever, Joint Accountable Officer, Mid and South Essex CCGs and Executive Lead, Mid and South Essex Health and Care Partnership**

Anthony, known to all as Mac, has more than 40 years’ experience in the NHS and other healthcare organisations. Before joining the mid and south Essex CCGs he served as Director General for Health and Community Services for the States of Jersey.

Originally a “fast stream” civil servant, Mac joined the NHS in 1987, operating for 25 years as a CEO, helping to turn around performance at several hospitals and commissioning organisations. Having established his own business, he served on the Future Forum in 2010, and returned to work in the NHS in 2015.

Mac has been appointed Chief Executive Officer Designate for the Mid and South Essex Integrated Care Board and System.

* + **Dr Fatai Salau, Elected GP**

Dr Fatai Salau qualified from the College of Medicine, University of Lagos, Nigeria in 1992 and has been a GP at the Douglas Grove Surgery in Witham since 2006.

Fatai is a member of the Royal College of Physicians and has been involved with developing changes to primary care in the Witham area. His clinical interests are acute medicine and gastroenterology.

* + **Pauline Stratford, Third Lay Member**

Before joining the NHS, Pauline was a senior commissioner for social care mental health services. Prior to that Pauline was a human resources and change manager with a lead in equalities in central government. Pauline also serves as the Lay Member for Primary Care of the Castle Point and Rochford and Southend CCGs.

* + **Dr Elizabeth Towers, Elected GP**

Dr Liz Towers was a GP at Whitley House Surgery for more than 30 years, having spent three years as a junior doctor in the Chelmsford area. Her interests were particularly cancer and end of life care. Liz became a Macmillan GP in 2010.

* + **Nathalie Wright, Lay Member (Patient and Public Engagement)**

Nathalie joined the CCG in 2018 as Lay Member for Patient and Public Engagement.

Following a career in Senior Management within Financial Services Nathalie joined the NHS within the Oncology Services team for Mid Anglia Cancer Network.

Nathalie has experience in both the private and public sector and is a qualified counsellor. Since 2016 Nathalie has undertaken voluntary roles working as a mental health therapist in local education settings and is a Young Minds ambassador.

##### Committees, including Audit Committee

A full list of the committees supporting the Board, including the Audit Committee, and membership of those committees is provided within the Governance Statement from page 38 onwards.

##### Register of Interests

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

The CCG maintains a register of interests declared by board members. The register of board members’ interests is regularly updated and included within the papers for publicly held board meetings available on the [CCG’s website](https://midessexccg.nhs.uk/about-us/ccg-board-meetings/board-papers).

##### Personal data related incidents

There were no serious incidents requiring investigation and involving personal data reported 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.

##### Donations to political parties and charitable organisations

The CCG does not make donations to political parties.

The CCG has made payments to a number of charitable organisations. The majority of these payments are in relation to Service Level Agreements (particularly to local hospices) or as a result of successful grant applications.

##### Modern Slavery Act

Mid Essex CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on our website at [Modern Slavery Statement](https://midessexccg.nhs.uk/about-us/our-key-documents/4100-modern-slavery-statement-2022/file).

##### Complaints to Parliamentary and Health Service Ombudsman

The CCG receives complaints from patients, carers, family members and Members of Parliament. Where the complaint relates directly to a provider the permission of the individual is sought to refer to the relevant provider. The CCG will analyse any trends and themes arising from complaints and works with providers to address these.

Complaints relating to primary care services are managed by NHS England.

During 2021/22, there were 61 complaints opened and 54 complaints closed, with 7 complaints still under investigation at the year end. Themes and trends included difficulty accessing face to face GP appointments, Covid vaccination queries and funding requests, including funding for ADHD referrals and IVF.

The investigation of two complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) were concluded in 2021/22. These two complaints were not upheld. Two new cases were referred to the PHSO in 2021/22 and the outcome of these is still awaited.

#### 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 England). NHS England has appointed the [inset post holder title] to be the Accountable Officer of [Name of 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 England 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 England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
  + Make judgements and estimates on a reasonable basis.
  + State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures in the accounts.
  + Prepare the accounts on a going concern basis.
  + 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 Mid Essex CCG’s auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

**Governance Statement**

**Introduction and Context**

Mid Essex CCG (the CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The CCG’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 31 March 2022, the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The CCG is part of the Mid and South Essex Health and Care Partnership (the HCP) covering the geographic areas of mid Essex, Basildon and Brentwood, Castle Point and Rochford, Southend, and Thurrock CCGs (the MSE CCGs). The HCP has been created to bring local health and care leaders together to plan for the long-term needs of local communities.

In July 2017 the five MSE CCGs formally established a CCG Joint Committee (JC) to act collectively in the planning, securing and monitoring of services to meet the needs of their 1.2 million population, as well as representing the HCP footprint for services commissioned over a larger area.

Specifically, the JC commissions and manages the contracts for acute hospital services (NHS and independent sector), NHS 111 and out-of-hours services, ambulance services, patient transport services, community services and mental health services.

The JC also played a role in decision-making about Learning Disability services within the existing pan-Essex arrangements.

Due to business continuity arrangements implemented by the CCG from mid-December 2021 to the end of February 2022 as a result of the ongoing COVID-19 pandemic (Omicron variant) and the need to support the vaccination booster programme, the JC did not meet from December 2021. Alternative committee/Board meeting arrangements were implemented to deal with issues within the JC’s remit as detailed in the following paragraph and the individual committee headings below.

The five MSE CCG Boards met in common on 24 February 2022 and agreed to hold all future CCG Board meetings in common until the MSE Integrated Care Board (ICB) is established. During this transition period, the Boards meeting in common conducted all business delegated to the JC and consequently the JC did not meet again.

All other decisions about healthcare continued to be taken locally by the relevant CCG.

**Scope of responsibility**

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG’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 CCG 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 governing body (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.

CCGs are clinically-led membership organisations made up of general practices. The members of the Mid Essex CCG have determined the governing arrangements for the CCG as set out in its constitution, which was based on the Model Constitution Framework for CCGs and originally approved on 28 March 2013. The CCG undertook a thorough review of its constitution, in line with the NHS CCG New Model Constitution, to enable the CCG to take on fully delegated primary care commissioning with effect from 1 April 2021 and to align its constitution with the other mid and south Essex CCGs in preparation for the development of an Integrated Care System.

The revised constitution was approved by the Board at its meeting on 25 March 2021.

There are 39 member practices within Mid Essex CCG, serving a registered population of 404,168 patients as of 1 January 2022. The practices were formed into nine Primary Care Networks (PCNs) across mid Essex from 1 July 2019. Details of the nine PCNs are shown in the table below:

|  |  |  |
| --- | --- | --- |
| **Primary Care Network** | **Number of Practices** | **Registered Patient Population as at**  **1 April 2022** |
| Braintree | 5 | **56,436** |
| Colne Valley | 6 | **55,015** |
| Aegros | 3 | **37,514** |
| Witham and Maldon | 4 | **37,496** |
| Phoenix | 3 | **45,895** |
| Dengie and South Woodham Ferrers | 7 | **48,951** |

|  |  |  |
| --- | --- | --- |
| Chelmer | 4 | **40,504** |
| Chelmsford West | 3 | **41,082** |
| Chelmsford City | 4 | **42,451** |

Each of the PCNs is led by Clinical Directors who have standing membership of the CCG’s Clinical Cabinet and are accountable to their constituent practices under the Terms of Reference. The CCG Clinical Cabinet is responsible for engagement with member practices and other stakeholders in respect of primary care matters.

The Clinical Cabinet provides a forum through which member practices as representatives of primary care can share their views, concerns, ideas and be involved in the service planning, provision and decision-making processes of the CCG.

Practices work together within their PCNs to collaborate on the effective provision of primary care in their local areas and to engage in the commissioning of services on behalf of their populations.

In some PCNs these working together arrangements are facilitated through the sharing of workforce, sharing back office functions, and collaborative working in certain chosen clinical areas. Practices are gradually working towards developing standardised policies, processes and agreed governance structures.

**Governing Body (the Board)**

The CCG’s constitution sets out the governance arrangements, roles and responsibilities of the Board and its membership.

Publicly held Board meetings are held on a bi-monthly basis. The CCG Board meeting due to be held in January was cancelled as part of the business continuity arrangements implemented from mid-December to the end of February 2022 detailed above. However, appropriate arrangements were implemented to ensure that any key decisions were taken forward. Any decisions taken by the Central Incident Management Team (CIMT) were logged on the CIMT decisions log which was then reported to the Board.

In February 2022 the CCG Board met in common with the other MSE CCG Boards and agreed that they would continue to meet in common until the MSE Integrated Care Board (ICB) is established.

Board meetings are broadcast via ‘MS Teams’ which enables members of the public to listen to discussions held and submit questions.

Board meetings were quorate on the majority of occasions. If a Board meeting was inquorate due to one or more members being unavailable, their support for recommendations made was sought following the meeting to ensure that decisions were quorate. There are also arrangements in place to maintain a clinical majority and manage conflicts of interest to achieve quorum where voting members of the Board are able to recuse themselves from a relevant vote.

As at 31 March 2022, the Board membership comprised of the following voting members:

The Chair (a GP member), Joint Accountable Officer, NHS Alliance Director for Mid Essex, Executive Chief Finance Officer, Executive Director of Nursing and Quality (Registered Nurse), three other GP members, Secondary Care Board member and three Lay Members.

Anthony McKeever was appointed Interim Joint Accountable Officer for the Mid and South Essex CCGs from 1 March 2020 and was subsequently appointed to this role on a permanent basis from 3 October 2020. Mr McKeever has since been appointed to the role of Chief Executive Officer Designate for the Mid and South Essex Integrated Care System.

Board representation also includes a Public Health Consultant from Essex County Council (ECC). An elected ECC councillor is also entitled to attend Board meetings as an observer with speaking rights.

The Board undertakes an annual review of its effectiveness and has determined that it fulfils its role effectively either all or most of the time and that there is good engagement of members.

To support the Board in carrying out its duties effectively, committees reporting to the Board are formally established. The current committee structure was approved at the Board meeting held on 29 March 2018 and took effect from 1 April 2018. In line with NHS guidance to reduce the burden on NHS staff during the pandemic, some formal committee meetings were stood down during April 2021 and again from mid-December 2021 to February 2022, with any urgent business being conducted virtually.

From Quarter 1 of 2020/21, the five MSE CCGs held their Remuneration Committee, Patient Safety & Quality Committee (or equivalent) and Finance & Performance Committee meetings in common.

From Quarter 1 of 2021/22, meetings in common arrangements were extended to include the five MSE CCGs’ Audit Committees and Primary Care Commissioning Committees.

The Mid and South Essex Health and Care Partnership Board, which includes representation from the CCG, local authorities, Healthwatch Essex, the voluntary sector, Anglian Ruskin University and the CCG’s main providers, met in private throughout 2021/22. The minutes of these meetings were submitted to the CCG’s Part II Board meetings.

Each committee submits its minutes to Board meetings. The main committees providing assurance to the Board are set out below.

**Audit Committee**

This Committee provides the CCG Board with an independent and objective view of the CCG’s financial systems, financial information and compliance with laws, regulations and directions governing the CCG insofar as they relate to finance, good corporate governance, information governance, cyber-security, emergency planning, response and resilience (EPRR), business continuity management (BCM) and the CCG’s responsibility to act effectively, efficiently and economically.

The Audit Committee is chaired by the Lay Member (Governance) and Deputy Chair of the CCG, John Gilham. As at 31 March 2022, the Committee’s other members were Dr Elizabeth Towers, elected GP Board member, and Nathalie Wright, Lay Member (Patient and Public Engagement).

From Quarter 1 of 2021/22, the Committee met in common with the other MSE CCG Audit Committees on 5 occasions, plus 2 extraordinary meetings to review draft policies developed for the MSE ICB. Attendance has been quorate in line with its Terms of Reference (minimum of two core members) on all occasions.

During 2021/22 the Audit Committee continued to focus upon ensuring the development and review of the systems, policies, procedures and processes fundamental to the governance of the organisation. During Quarter 4, the committee undertook a review of policies being developed for the MSE ICB relating to areas within the committee’s remit.

The Committee has received assurance from internal audit of key systems and processes and, in addition to routine reporting, has received updates on counter-fraud initiatives and investigations and implementation of audit recommendations. The Committee reviewed the CCG’s draft accounts and approved the final accounts and management response to the auditor on behalf of the Board.

The Committee also reviews the CCG’s risk register/Board Assurance Framework (BAF) and associated risk management processes and procedures. The Committee supported an aligned MSE CCG Risk Management Policy which was adopted by the CCG Boards in November 2021.

During the Level 4 incident from mid-December to February 2022, the committee received a copy of the CIMT Risk Register which focused on key risks whilst normal risk register reporting arrangements were paused. During this period, the committee also received a copy of the CIMT Decisions Log recording all decisions taken by CIMT.

The Committee also received the minutes of other main CCG committees, namely the minutes of the Primary Care Commissioning Committee, the Patient Safety and Quality and the Finance & Performance Committee meetings held in common with the other M&SE CCG committees.

In line with NHS England guidance on the management of Conflicts of Interest, the Chair of the Audit Committee acts as the CCG’s Conflicts of Interest Guardian.

The Committee and Board approved an extension of the expiry date of relevant CCG policies, including the Conflicts of Interest, Gifts and Hospitality and Standards of Business Conduct policies, to March 2022 to enable the M&SE CCGs to focus on developing new aligned policies in preparation for the formation of a new Integrated Care System (ICS) NHS Body. In March 2022, these policies were subsequently extended by the Board until 30 June 2022 as a result of the national decision to delay the establishment of ICBs by three months.

The Audit Committee Chair received assurance that the CCG was adhering to NHS England mandatory guidance on the management of conflicts of interest via the annual internal audit of conflicts of interest which identified ‘reasonable’ assurance. The

requirement to submit quarterly returns to NHS England regarding the CCG’s adherence to the mandatory guidance was suspended during 2021/22.

**Remuneration Committee**

The Remuneration and Terms of Service Committee is a committee of the CCG Board with delegated responsibility for making recommendations to the Board on all aspects of remuneration and terms of service of employees, including the Accountable Officer, Directors and Lay Members.

In addition, the Committee is responsible for making recommendations to the Board concerning the remuneration and terms of service for Elected GP members and other people who provide services to the CCG (all of whom are not employees of the CCG), taking in to account any national or local guidance as appropriate, so as to ensure that individuals are fairly rewarded for their contribution to the CCG.

As at 31 March 2022, the membership of the Remuneration Committee comprised of two lay members. The committee is chaired by the Lay Member (Patient and Public Engagement).

The Remuneration Committee met in common with the other M&SE CCG Remuneration Committees on 10 occasions, either via MS Teams or by conducting business ‘virtually’ by email, during 2021/22.

**Patient Safety and Quality Committee**

This Committee provides assurance regarding the safety and quality of services directly commissioned by the CCG, i.e. acute, community, learning disability and mental health services, as well as the quality of services within primary care and the care home sector.

The committee also maintains oversight of safeguarding (adults and children) and medicines optimisation.

At the start of the year the Committee was chaired by the Lay Member for Patient and Public Engagement and its core decision making membership comprised a GP Representative (Vice Chair), Director of Nursing and Quality and the NHS Alliance Director for Mid Essex. Committee meetings were also attended by other senior managers with specific responsibility for areas within the remit of the committee.

In May 2020 the Committee commenced meeting in common with the other four MSE CCGs’ Patient Safety and Quality (or equivalent) Committees to review the safety and quality of all health care services.

The Committees meeting in common focused on arrangements to provide care for patients diagnosed with COVID-19 within acute, community and care home settings, the safety of staff and workforce capacity issues, and the effect that the pandemic was having on patients requiring routine and elective care.

Other key areas discussed included arrangements for monitoring the quality of provider contracts; review of NHS Patient Safety Updates; review of the Quality Accounts 2020/21 from Mid and South Essex Hospital NHS Foundation Trust, Essex Partnership University NHS Foundation Trust (EPUT); North East London NHS Foundation Trust;

Barking, Havering and Redbridge NHS Foundation Trust; Provide Community Interest Company and Farleigh Hospice; and agreeing the CCGs’ responses to the Quality Accounts; serious incidents and never events; review of arrangements for the implementation of the Patient Safety Incident Response Framework; update on Special Educational Needs and Disabilities services; updates on Learning Disabilities Mortality Review (LeDeR) Programme; System Quality Strategy; Infection Prevention and Control Strategy; approval of policies; all age continuing care; personal health budgets; review of patient safety and quality risks; quality and equality impact assessments; complaints and a review of any virtual decisions taken since the last committee meeting.

These meetings were attended by the minimum number of members required for each CCG committee to be considered quorate. Attendance was generally quorate in line with the Committees’ Terms of Reference. If a committee was inquorate due to one or more members being unavailable, their support for any decisions made was sought following the meeting.

Three ‘virtual’ meetings were held by email with update reports being circulated to members for information.

**Finance and Performance Committee**

This Committee scrutinises and provides the CCG Board with assurance on the delivery of the CCG’s remit in respect of the CCG’s overall financial position (including running costs) and for service performance for commissioned services not delegated to the JC.

The Committee also maintains local oversight of information management and technology, estates developments and the Savings Programme Board’s scrutiny and challenge role to ensure the delivery of the CCG’s programme of financial savings. The Committee acts as a point of approval for major changes to existing projects and plans, where these are based on considerations related to the achievement of financial or other benefits. The Committee also assesses whether there is continued business justification for existing projects and programmes where the financial or other benefits have changed.

At the start of the year the Committee was chaired by the Lay Member (Governance) and its core membership comprised a GP Representative (Vice Chair), Executive Chief Finance Officer, NHS Alliance Director for Mid Essex (or nominated deputy), and Executive Director of Nursing and Quality (or nominated deputy nurse).

In May 2020, the Committee commenced meeting in common with the other four M&SE CCGs’ Finance and Performance (or equivalent) Committees. During 2021/22 it met on 8 occasions to review finance and performance issues across all health care services, including those ordinarily within the remit of the Mid and South Essex STP CCG Joint Commissioning Committee (JC).

The quoracy arrangements for meetings held in common with the other CCG committees, mirrored those described under the ‘Patient Safety and Quality Committee’ section.

During 2021/22 the Committee particularly focused upon review of finance and performance risks, receipt of monthly finance reports, Joint Committee finance reports,

Elective Recovery Framework updates, Hospital Discharge Programme 2021/22, contract planning, awards and procurement decisions, performance reports from System Oversight and Assurance Group (SOAG), Adult Mental Health Transformation Plan contracts, system financial sustainability, 2021/22 Business Plan and CCG budgets, approval of terms of reference/frequency of meetings, receipt of System Finance Leaders Group (SFLG) minutes.

**Mid Essex Live Well Partnership**

The aim of the Mid Essex Alliance is to bring all key partners from across mid Essex together to provide the localism needed within the Mid and South Essex system to create opportunities for people to live well in mid Essex.

Its membership comprises Director level representation from the CCG, PCN Clinical Directors, the CCG Chair, representation from Essex County Council and Braintree, Chelmsford and Maldon District Councils, Provide Community Interest Company, Essex Partnership University NHSFT, North East London NHSFT, Mid and South Essex Foundation Trust, Farleigh Hospice, Chelmsford and Maldon CVS, Community 360 and Virgin Healthcare.

The Alliance met monthly during 2021/22 with good representation from all partners. An Alliance plan was developed with all mid Essex system partners for 2021/22 which determined the priorities, vision, outcomes and measures for improving health and wellbeing of the population of Mid Essex.

The Alliance is involved in a three month Place Development Programme, led by NHS England, to support the development of priorities and plans, governance and the Alliance approach to population health management for 2022/23 and beyond.

**Primary Care Commissioning Committee**

This Committee was established from 1 April 2021 following the CCG being approved fully delegated Primary Care commissioning and is chaired by the Lay Member for Patient and Public Engagement.

The Committee did not meet in the first couple of months of 2021/22 and from June 2021 the Committee met in common with the other MSE CCGs Primary Care Commissioning Committees.

There were five meetings held, with three further virtual meetings held to conduct urgent business that could not wait until the next scheduled meeting.

A review of committee effectiveness confirmed that the committee was quorate in line with the Committee’s Terms of Reference on all occasions.

During 2021/22 the Committee focused on contractual updates/breaches/requests for contractual changes from general practices; local contract decisions, e.g. Designated Enhanced Services; GP primary care quality and safety reports; budget reports; information technology and digital updates; estates issues; primary care workforce; review of Primary Care Risk Group minutes; review of primary care risks; and GP Business Continuity and resilience arrangements.

**Better Care Fund (including Improved Better Care Fund) Governance**

A Better Care Fund (BCF) Partnership Board meets to fulfil the governance requirements with Essex County Council.

In line with the terms of the Section 75 Better Care Fund Agreement, decision-making relating to the BCF is delegated to two nominated representatives of the CCG and two representatives of Essex County Council. Utilisation of the BCF funds was agreed in the Section 75 Agreement and in-year reporting focused upon expenditure on the approved services and monitoring against agreed performance targets.

**Mid and South Essex CCG Joint Commissioning Committee**

As outlined in the introduction, the five mid and south Essex CCGs formally established a CCG Joint Committee (JC) to act collectively in the planning, securing and monitoring of services to meet the needs of their 1.2million population. The JC was established as a committee of each CCG, not of the CCG’s governing bodies, and therefore sits alongside the CCG governing bodies, rather than being accountable to them.

During 2021/22 the committee met three times to consider: risks within the remit of the committee; planning guidance; the Vanguard Theatre contract; MSEFT Legal Undertakings; Adult Mental Health Transformation Plan; review of Medicines Optimisation Terms of Reference; patient safety, finance and performance reports; receipt of minutes from Patient Safety & Quality Committees in common and Finance & Performance Committees in common; provider Quality Accounts and the CCGs’ responses to these; non-emergency patient transport procurement; and a review of community beds.

The JC did not meet during December to February due to implementation of pandemic business continuity arrangements and, following a decision by the MSE CCGs to meet in common from February until the establishment of the MSE ICB, the JC did not meet again.

**UK Corporate Governance Code**

The CCG is not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

As part of its annual review of effectiveness, the CCG Board undertook an assessment which encompassed the relevant principles of the UK Corporate Governance Code.

The Board concluded from this assessment that it was generally following best practice in relation to providing effective leadership, having an appropriate balance of skills, experience, independence and knowledge to enable Board members to discharge their duties and responsibilities effectively, presenting a balanced and understandable assessment of the CCG’s position in its financial and other reporting and ensuring that remuneration is set appropriately.

**Discharge of Statutory Functions**

In light of the recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. The CCG’s current Scheme of Reservation and Delegation (SoRD) was approved by the Board in March 2021. The CCG is working with the other MSE CCGs to develop a new SoRD for the MSE ICB.

**Risk management arrangements and effectiveness**

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

An aligned MSE CCG Risk Management Policy, which encompasses both clinical and non-clinical risks and the CCGs’ agreed risk appetite statement, was approved by all MSE CCGs in November 2021. The Policy is based on the Australia/New Zealand risk management model and sets out the risk management system, supporting processes and reporting arrangements which aim to protect patients, the public, staff and the CCG’s assets and reputation.

In line with NHS guidance to reduce the burden on staff during the pandemic, the usual risk management processes were paused during April 2021 and again in December to February 2022. During these periods, the CIMT Risk Register was in use.

The overarching M&SE Board Assurance Framework (BAF) originally implemented in June 2020, has been further developed. Risks are mapped against the MSE CCGs common strategic objectives and key workstreams, these being:

* + Cancer and End of Life
  + Children and Young People
  + Community
  + Digital and Business Intelligence
  + Estates
  + Finance
  + Health Inequalities
  + Integrated Care System
  + Maternity
  + Medicines Optimisation
  + Mental Health and Learning Disability
  + People
  + Planned Care
  + Population Health Management
  + Primary Care
  + Stewardship
  + Urgent Emergency Care
  + Vaccination

The risk appetite statement assists managers to identify when risk levels are tolerable or where further action is required to reduce risk ratings to an acceptable level. The Board reviews the BAF at each Part I Board meeting. During 2021/22 a review was undertaken to review risk descriptions and consolidate risks where possible to ensure that the BAF reflected risks facing the organisation as it emerged from the pandemic.

**Capacity to Handle Risk**

During 2021/22 the CCG had the following arrangements in place:

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

The CCG’s Whistleblowing Policy and arrangements, including the appointment of a Freedom To Speak Up Guardian, also support risk management by providing a framework for employees to raise concerns, in line with the Public Interest Disclosure Act 1998, without the perception of being disloyal to colleagues, managers or the organisation. The Whistleblowing Policy was last updated in March 2020 and, as no amendments were required, its expiry date has been extended to June 2022.

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 failures.

Stakeholders, including staff, patients and the public have been involved in the risk management process, for example by ensuring that relevant staff were identified to input into any risk assessments in their function or area of work; that CCG staff and contractors were made aware of agreed risk reporting procedures including risks associated with COVID-19; that contracts clearly stated the responsibilities of contracted personnel with regard to risk identification, reduction, mitigation and reporting; that feedback on risk issues was encouraged via the CCG’s complaints and enquiries services and through its public engagement and consultation mechanisms,

e.g. patient stories at Board meetings, engagement with the public and other stakeholders on future plans for services.

The effectiveness of these risk management arrangements are summarised under the ‘Review of the Effectiveness of Governance, Risk Management and Internal Control’

section, which includes the monitoring, review and management of the Assurance Framework by the Audit Committee and Board.

The annual audit of risk and governance was finalised by the CCG’s Internal Auditor in March 2021 and identified ‘reasonable’ assurance.

**Prevention of Risk**

The application of this framework enables the prevention of risk through:

* Commitment to identifying the underlying or root causes of incidents, complaints and claims (should they arise)
* Promoting an open, just and non-punitive culture
* Driving an ongoing information and education programme which empowers and supports Board members and staff in the risk management process generally and in relation to specific areas of risk
* All staff being familiar with the Anti-fraud, Anti-bribery and Security policies’ terms through promotion and training and the issuing of fraud alerts, with the help of counter-fraud services
* All staff being familiar with the terms of the Conflicts of Interest, Gifts and Hospitality and Standards of Conduct Policies.
* Registers of Interests being produced for Board and Committee meetings and those Sub-committees with decision-making powers, or capacity to influence decisions made by the CCG, so that the relevant Chair can ensure that potential conflicts are managed appropriately.

**Other sources of assurance Internal Control Framework**

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

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

The system of control in place is set out within the Board, Committee and Risk Management sections of this statement.

**Financial arrangements**

The CCG’s key financial systems are operated by third party providers. The CCG Finance team oversee the operation of internal financial control arrangements and the dissemination of good financial management and professional standards. The CCG’s financial arrangements are assessed annually by external parties as part of the internal and external audit functions.

The Finance and Performance Committee, which held local meetings and also met in common with the other M&SE CCGs during 2021/22, exercises the Board’s functions in respect of the oversight of financial control.

**Risk Assessment**

Risk assessments have been carried for each workstream identified in Section 2.2.3 above. Each risk recorded on the BAF is scored on the basis of inherent and residual risk. Continued efforts are made to strengthen controls where residual risk scores remain above the CCG Risk Appetite.

The CCG also undertakes other risk assessments, for example, health and safety/fire workplace risk assessment of its premises and COVID-19 risk assessment to ensure that its premises are COVID-19 secure. These risk assessments have associated action plans, policies and procedures to ensure that risks identified are managed on an ongoing basis.

**Annual Audit of Conflicts of Interest Management**

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management.

To support CCGs to undertake this task, NHS England has published a template audit framework. The annual internal audit of conflicts of interest 2022/22, which was undertaken as part of the wider audit of the CCG’s risk management and governance arrangements, identified ‘reasonable’ assurance.

**Data quality**

Due to the pandemic, NHS contracts were nationally suspended in 2021/22 and nationally calculated mandatory payments were made to NHS providers to ensure cashflow remained in place. As such, there was no requirement for detailed data quality monitoring during 2021/22.

Independent Sector Providers were contracted under national frameworks and guidance and so similarly there was no requirement for local data quality monitoring during 2021/22.

Non-NHS providers were contracted on a ‘light-touch’ basis to support the pandemic response as instructed under national contracting and payment guidance. As such, there was again no requirement for detailed data quality monitoring during 2021/22.

**Information Governance**

The NHS Information Governance (IG) Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a data security and protection toolkit and the annual submission process provides assurances to the 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 information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure members of staff are aware of their information governance roles and responsibilities, and how to access information or assistance.

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 new data flow mapping and information asset registers to ensure compliance with the General Data Protection Regulations (GDPR). This was undertaken with support from the IG Team to ensure consistency of approach.

The CCG submitted a “Standards Met” Data Security and Protection Toolkit for 2021/22 on 22 June 2022.

**Business-critical models**

The CCG supports the principles of the Macpherson Report and is committed to embedding best practice in relation to quality assuring our prioritised business critical models and other functions.

The Essex CCGs each have a Business Continuity Plan supported by an overarching Essex-wide Business Continuity Policy, all of which have been approved by the CCGs' Audit Committee. The documents are updated when a material change occurs, and usually a comprehensive annual review takes place each year, although during the last two years events have curtailed this process.

A memorandum of understanding has been signed by the Essex CCGs which sets out the intentions of the CCGs to provide mutual aid and assistance to each other during a business continuity incident which cannot be managed internally within each CCG’s own business continuity arrangements and which involves one or more of the following: critical loss of key staff, temporary loss of premises or loss of a significant amount of IT hardware. The CCGs have worked jointly since March 2020 on the response to the Covid-19 pandemic.

Since March 2020, the CCGs have reviewed, tested and updated their internal business continuity arrangements as a result of the COVID-19 pandemic and continued to update these throughout 2021-22 in line with operational and Government requirements.

**Third-party assurances**

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

The CCG relies on a third party provider for payroll and pension services. This service is provided by Whittington Health NHS Trust which is based in North London. The CCG continues in a positive relationship with Whittington Health and regular virtual MS Teams meetings are held between Whittington and the HR Managers at the CCG. The annual audit of payroll identified ‘substantial’ assurance.

Human Resources transactional, recruitment and workforce services are now provided in house directly by the CCG. This service, including Occupational Health was provided by Anglian Community Enterprise (ACE) up to 30 June 2021. There were no concerns with the service provided, however due to this organisation ceasing to trade an alternative provider was sourced. From 1 July 2021 until 21 January 2022 Essex Partnership University Hospital Trust (EPUT) provided the Human Resources transactional services. From 1 July 2021, Occupational Health support has been provided by Optima Health.

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

The MSE CCGs hold a monthly contract review meeting with Arden and Greater East Midlands (AGEM) Central Support Unit (CSU) to monitor all aspects of the contract and review performance against service level agreements and key performance indicators. This includes extended services such as back-ups and business continuity planning.

Exceptions or escalations are reported to the Primary Care Digital Board. The CCGs receive copies of all NHS Digital CareCert alerts and confirmation when AGEM has updated against them.

**Control Issues**

The NHS declared Coronavirus (Omicron variant) as a ‘level 4 incident’ (the highest category of emergency) on 13 December 2021. Organising the local response to limit the spread of the virus and treat its effects, including providing support to the vaccination booster programme, therefore became a key focus for the CCG and partner organisations and the system-wide incident management structure that was set up during the first wave of the pandemic coordinated this work. In accordance with the CCG’s Business Continuity Plan, several of its functions were either paused or scaled down during mid-December to February 2022 to enable resources to be directed to the management of this latest outbreak.

The CCG implemented good practice guidance issued by organisations such as the Internal Audit Network and the Healthcare Financial Management Association to ensure that it continued to comply with its statutory duties and that its governance arrangements remained effective throughout the pandemic.

EPUT have developed a Quality Strategy ‘Safety First, Safety Always’ which aims to ensure that EPUT provide safe and high quality care. The Essex mental health system is one of the first areas in the country to roll out the new Patient Safety Incident Response Framework. The CCG continues to monitor safety via the CQRG mechanism. In September 2020 the CCGs began an independent review (known as the Taskforce) of the systems and processes within CCGs covering Essex footprint for the

commissioning of mental health services as provided by Essex Partnership University NHS Trust. The Mental Health Taskforce has completed its review and the final report has been produced. The ongoing work to fully deliver the taskforce recommendations is being mapped against the Mental Health Partnership Board governance to ensure that the delivery and progress is maintained going forward.

As detailed within the Head of Internal Audit Opinion section below, Mid Essex CCG received two Internal Audit reports during 2021/22 which identified ‘Requires Improvement’. There were no Internal Audit reports that identified ‘Insufficient’ assurance. The Audit Committee will maintain oversight of implementation of all recommendations made.

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

As described in the Financial Overview section, many of the amendments made to the financial regime during 2020/21 remained in place during 2021/22 in response to the ongoing challenges of the Covid-19 pandemic. The CCG has reported a £0.3m deficit at the end of 2021/22. The CCG has repaid over £20m towards its accumulated deficit across the last five financial years, however we continue to carry forward a historic deficit of £4 million.

The MSE CCGs’ Finance and Performance Committees meeting in common (F&P CiC) and the Board have each received regular financial reporting and had the opportunity for detailed review of the CCG’s position.

The F&P CiC continued to monitor the CCG’s procurement and planning arrangements in order to ensure value for money from commissioned services.

The CCG’s 2021/22 running (management) costs were marginally below permitted expenditure.

The Internal Auditor has reviewed the CCG’s financial systems and processes, including the arrangements for financial reporting and confirmed that the CCG has reasonable arrangements in place. The external auditor’s comments on our arrangements for securing economy, efficiency and effectiveness in use of resources in 2021/22 are included in their report immediately preceding the Annual Accounts (page x onwards).

**Delegation of functions**

Acute services are commissioned by a central Mid and South Essex Acute Commissioning Team, which is hosted by Mid Essex CCG.

Acute adult and older adult mental health services are commissioned by a central mental health commissioning team hosted for Mid and South Essex by Thurrock CCG. The individual placements team, which commissions placements for individuals with Section 117 after-care rights as well as specialist placements for children and for adults requiring tertiary care, is hosted by North East Essex CCG, which provides this function on a pan-Essex basis.

Early intervention (Tier 2- Local Authority) and Specialist Community Mental Health Services (Tier 3- CCGs) for Children is known as Southend, Essex and Thurrock

Children and Adolescent Mental Health Services (SET CAMHS). This has been procured on a pan-Essex basis with a Commissioning Collaborative Agreement in place for all 10 partner organisations. West Essex CCG is the Host commissioner for this service. Children’s in-patient services continue to be commissioned by NHS England and managed through the establishment of the Provider Collaborative for Children’s Mental Health.

Learning Disability (LD) services are commissioned by Essex County Council, with Castle Point and Rochford and Southend CCGs leading on this for health for Mid and South Essex.

In common with other CCGs, the Executive Director of Nursing and Quality was a member of the Quality Surveillance Group which allows quality intelligence to be shared across Essex with other commissioners and with the CQC.

No adverse information has been received from third party assurance reports relating to West Essex’s host commissioner role for EWMHS or North East Essex CCG’s host commissioner role for section 117 services.

**Counter fraud arrangements**

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

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

The 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.

At the end of each financial year, the CCG submits a self-assessment to the NHS Counter Fraud Authority against the Counter Fraud Functional Standards for Commissioners. The Executive Chief Finance Officer and Chair of the Audit Committee authorise the assessment which is part of the NHS Protect Standards for Commissioners prior to submission. The CCG has achieved a Green rating for the 2021/22 Counter Fraud Functional Standard Return.

**Head of Internal Audit Opinion**

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group’s system of risk management, governance and internal control.

During 2021/22 Internal Audit issued the following audit reports:

|  |  |
| --- | --- |
| **Assignment** | **Assurance Opinion** |
| Cyber Security | Requires Improvement |
| Data Security and Protection Toolkit pt1 | Reasonable |
| Personal Health Budgets | Requires Improvement |
| Key Financial Systems | Substantial |
| Primary Care Governance | Reasonable |
| Payroll | Substantial |
| Adult Safeguarding | Reasonable |
| BAF Risk Management and Conflicts of Interest | Reasonable |
| Transformation Due Diligence Assurance (Part I) | Reasonable |

The result of the audits on cyber security and Personal Health Budgets (PHBs) was ‘requires improvement’.

In relation to cyber security, there were 10 ‘high’ priority recommendations made. The Primary Care IT and Digital Board and Audit Committee monitored progress on implementation of recommendations made by internal audit. The MSE CCGs’ Associate Director of IT and Digital attended the Audit Committee on 11 March 2022 to present his comprehensive report on action being taken to address all outstanding recommendations. As of 31 March 2022, there were 7 high priority agreed management actions to be completed.

In relation to PHBs, there were 2 ‘high’ priority recommendations made in relation to Mid Essex CCG. The MSE Programme Lead for Personalised Care (which incorporates PHBs) attended the Audit Committees meeting in common on 15 October 2021 and the Patient Safety and Quality Committees meeting in common on 8 March 2022 to provide an update on implementation of internal audit recommendations. As of 31 March 2022, 1 high priority management action remained to be completed.

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

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group and the Acute Commissioning Team 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
* Remuneration Committee
* Quality and Governance Committee
* Finance and Performance Committee
* Primary Care Commissioning Committee
* The Joint Committee
* Internal audit
* Other explicit review/assurance mechanisms.

**Conclusion**

I concur with the Head of Internal Audit Opinion that during the 2021/22 financial year there has been a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls have been generally applied consistently.

Action plans to implement any outstanding recommendations from audits are in place and will continue to be monitored during the 2022/23 financial year.

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

Anthony McKeever Accountable Officer 30 June 2022

## Remuneration and Staff Report

**Remuneration Report**

**Remuneration Committee**

During 2021/22 the membership of the remuneration committee was as follows:

* Nathalie Wright, Lay Member (Patient and Public Engagement) - Chair
* John Gilham, Lay Board Member (Governance)
* Pauline Stratford, Third Lay Member

This committee met on 10 occasions during 2021/22, during which the Committee Chair was present and the meeting was quorate. The Accountable Officer withdrew at any time during discussion of their own remuneration.

HR and remuneration advice was provided by Victoria Robertson, Interim Director of Human Resources, and the committee was informed by local and national guidance on remuneration matters.

**Policy on the remuneration of senior managers**

Senior managers are subject to Agenda for Change terms and conditions, with the exception of those roles that are subject to the VSM (Very Senior Managers) framework. The salaries of governing body members are determined by Remuneration Committee with national and local guidance (provided by the Chief Finance Officer and Interim Director of Human Resources) being considered in all decisions.

**Remuneration of Very Senior Managers**

The Accountable Officer’s salary is set within national salary boundaries for the Accountable Officer of CCG and Chief Executive of an ICS. The determination within this broad salary boundary is set by NHS England and the CCG Remuneration Committee.

**Senior managers’ performance-related pay**

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

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

Under the VSM pay framework, there is the potential for performance-related pay under the terms and conditions of the contract. No proportion of remuneration for any staff member has been subject to performance conditions at the CCG during 2021/22.

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

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

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

**Senior manager remuneration (including salary and pension entitlements)**

The remuneration of Very Senior Managers for 2021/22 is shown in three sections, representing the senior leadership structure of the five CCGs within the Mid & South Essex Health & Care Partnership. These show the following information:

**Salaries and allowances CCG Table:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name and Title** | **Note** | **Date served** | |  |  | **2021/22** |  |  |  |  | **2020/21** |  |  |  |
| **Commenced** | | **Ceased** | **Salary (bands of**  **£5,000)** | **Expense Payments (taxable) (total to nearest**  **£100)** | **Other Remun- eration (bands of**  **£5,000)** | **All Pension Related Benefits (bands of**  **£2,500)** | **Total (bands of**  **£5,000)** | **Salary (bands of**  **£5,000)** | **Expense Payments (taxable) (total to nearest**  **£100)** | **Other Remun- eration (bands of**  **£5,000)** | **All Pension Related Benefits (bands of**  **£2,500)** | **Total (bands of**  **£5,000)** | |
|  | | **£000** | | **£** | **£000** | **£000** | **£000** | **£000** | **£** | **£000** | **£000** | | **£000** |
| **Anthony McKeever Joint Accountable Officer – Joint Executive Team** | 1 & 8 | 03-Oct-20 | **50-55** | | 0 | 0 | 7.5-10 | 60-65 | **50-55** | 1,400 | 0 | 0 | | 55-60 |
| **Mark Barker**  **Joint Chief Finance Officer - Joint Executive Team** | 1 & 9 | 01-Jan-21 | 40-45 | | 0 | 0 | 0 | 40-45 | 10-15 | 0 | 0 | 0-2.5 | | 10-15 |
| **Rachel Hearn Director of Nursing, CCG 0.5wte** |  | 13-Feb-19 | 01-Nov-20 |  |  |  |  |  | 30-35 | 0 | 0 | 22.5-25 | | 55-60 |
| **Executive Director of Nursing and Quality - Joint Executive Team** | 1 | 02-Nov-20 |  | 40-45 | 0 | 0 | 62.5-65 | 105-110 | 15-20 | 0 | 0 | 10-12.5 | | 25-30 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Daniel Doherty Director of Clinical Transformation and Deputy Accountable Officer** |  | 01-Apr-13 | 01-Nov-20 |  |  |  |  |  | 60-65 | 0 | 0 | 55-57.5 | 170-175 |
| **NHS Alliance Director, Mid Essex - Joint Executive Team and Deputy Accountable Officer** | 2 | 02-Nov-20 |  | 125-130 | 0 | 0 | 72.5-75 | 195-200 | 50-55 | 0 | 0 |  |  |
| **John Gilham Lay Member,**  **Governance and Audit Chair** |  | 01-Jul-18 |  | 15-20 | 0 | 0 | 0 | 15-20 | 15-20 | 0 | 0 | 0 | 15-20 |
| **Nathalie Wright**  **Lay Member, Patient & Public Participation** | 4 | 01-Apr-18 |  | 10-15 | 0 | 0 | 0 | 10-15 | 10-15 | 0 | 0 | 0 | 10-15 |
| **Pauline Stratford Lay Member** | 6 | 01-Aug-21 |  | 0-5 | 0 | 0 | 0 | 0-5 | 0 | 0 | 0 | 0 | 0 |
| **Dr Anna Davey Elected GP – Governing Body Member and**  **CCG Chair (Clinical)** | 5 | 01-Apr-18  01-Oct-18 |  | 65-70 | 0 | 0 | 0 | 65-70 | 60-65 | 0 | 0 | 0 | 60-65 |
| **Dr Elizabeth Towers Elected GP - Governing Body Member** | 3 | 01-Apr-15 |  | 65-70 | 0 | 0 |  | 65-70 | 65-70 | 0 | 0 | 0 | 65-70 |
| **Dr Julie McGeachy Elected GP – Governing Body Member** | 5 | 01-Apr-18 |  | 10-15 | 0 | 0 | 0 | 10-15 | 10-15 | 0 | 0 | 0 | 10-15 |
| **Dr Fatai Salau Elected GP – Governing Body Member** | 5 | 01-Apr-18 |  | 10-15 | 0 | 0 | 0 | 10-15 | 10-15 | 0 | 0 | 0 | 10-15 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dr Julia Hale Secondary Care Consultant** | 7 | 01-Aug-21 |  | 0-5 | 0 | 0 | 0 | 0-5 | 0 | 0 | 0 | 0 | 0 |

**Notes**:

1. Anthony McKeever, employed by Basildon and Brentwood CCG, Mark Barker, employed by Castle Point & Rochford CCG, and Rachel Hearn, employed by Mid Essex CCG are members of the Joint Executive Team, a single executive body covering the five CCGs in mid and south Essex. Their remuneration is shared across the five CCGs and our share is shown in the table above. The total remuneration (inclusive of pension benefits and taxable expense payments) for Rachel Hearn was in the range £185k-

£190k, for Mark Barker in the range £165k-£170k, and for Anthony McKeever in the range £185k-£190k..

1. Daniel Doherty is a member of the Joint Executive Team as a NHS Alliance Director supporting the mid Essex locality and leading on Community services across the five CCGs in mid and south Essex. Daniel Doherty’s total remuneration is shown in the Salaries and Allowances table above.
2. The Salary Band for Elizabeth Towers includes work undertaken for the CCG under separate contracts. These are: Macmillan GP Facilitator and Clinical Lead - Rapid Diagnostic Centre initiative. The Macmillan GP Facilitator role is partly funded by Macmillan Cancer Support, with the Clinical Lead – Rapid Diagnostic Centre being funded by NHS England. The remuneration band for this additional work was £50k-£55k.
3. The Salary Band for Nathalie Wright includes bank work for Essex Partnership University Hospital Trust in support of the Covid- 19 response. This remuneration is recharged back to Essex Partnership University Hospital Trust. The remuneration band for this additional work was £0k-£5k.
4. Drs Anna Davey, Julie McGeachy and Fatai Salau, GP Elected members of the Governing Body, are employed as ‘Off Payroll Workers’ but processed through the CCG’s payroll to ensure the statutory HMRC deductions are made. The salary disclosure includes employer pension contributions (where applicable). They are not reported in the ‘Off-Payroll’ section of the Remuneration Report.
5. Pauline Stratford, Lay Member is also a member of NHS Southend CCG, NHS Castle Point & Rochford CCG and NHS Thurrock CCG Boards. The agreed remuneration as shown in the table above is recharged to NHS Mid Essex CCG. The total remuneration for Pauline Stratford was in the range £15k-£20k.
6. Dr Julia Hale, Secondary Care Specialist, is also a member of NHS Basildon and Brentwood CCG Board. The agreed remuneration as shown in the table above is recharged to NHS Mid Essex CCG. The total remuneration for Dr Julia Hale was in the range £15k-£20k.
7. The Employers contribution to stakeholder pension has been show in line with the proportion funded by each CCG.
8. The pension figures for staff who are also included in CCG remuneration reports are shown in full in their employing CCG's remuneration report and have not been apportioned to more than one organisation.

Dr Maggie Pacini, Consultant in Public Health and Councillor Mike Steel attend the board in a non-voting capacity as Essex County Council representatives. No remuneration is paid to Essex County Council and they are therefore not included in the above table.

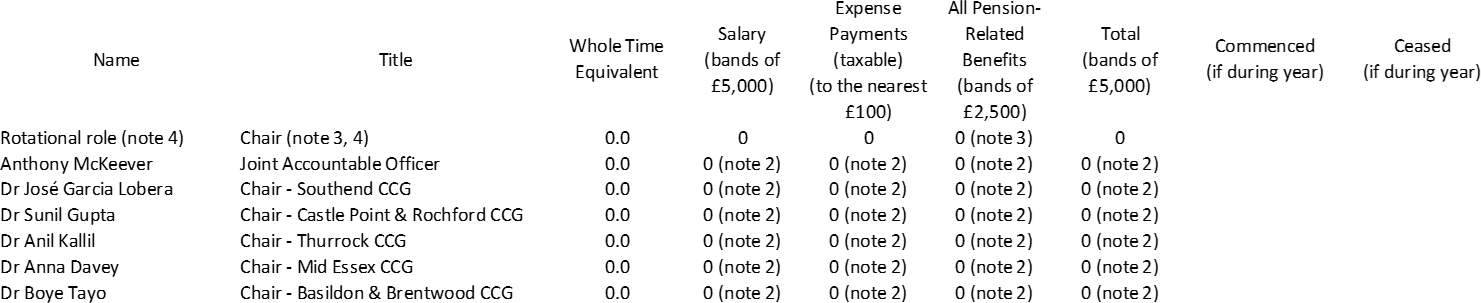
Performance pay and bonuses and Long Term performance pay and bonuses are not paid by the CCG.

**Joint Committee Table:**

During 2017, the five CCGs in mid and south Essex formed a Joint Committee to enable commissioners to act collectively in the planning, commissioning and monitoring of services to meet the needs of the whole population of the area they cover between them. To enable the Joint Committee to discharge its functions, and following a staff consultation process, relevant staff across the five CCGs have now formed combined teams such as the Acute Commissioning team.

The Joint Committee comprises the Chairs and Joint Accountable Officer of the five CCGs, with the Executive Director of Nursing, Joint Chief Finance Officer, Medical Director and Director of Commissioning for the Joint Commissioning Team in attendance. The committee is chaired by one of the CCG Chairs on a 6-monthly rotation.

Joint Committee Members

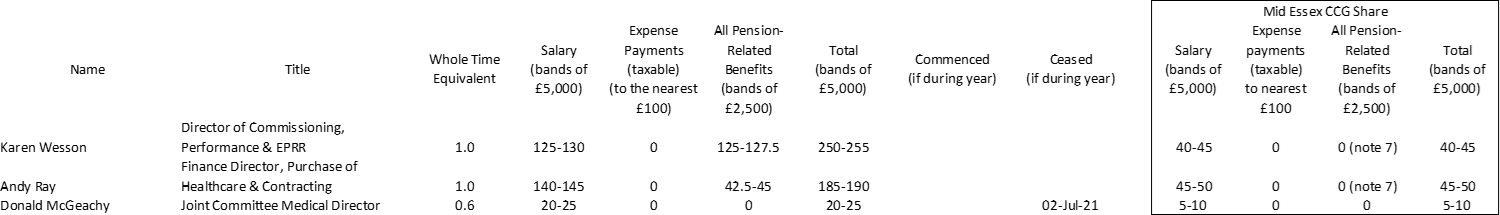


**Notes:**

* 1. The members of the Joint Committee comprise the Joint Accountable Officer and Chairs of the five Mid & South Essex CCGs (Basildon & Brentwood CCG, Castle Point & Rochford CCG, Mid Essex CCG, Southend CCG and Thurrock CCG).
  2. No remuneration is paid to Joint Committee members as a result of them being a CCG Chair or Accountable Officer above the remuneration paid to them by that CCG.
  3. The Chair role is not a pensionable role.
  4. The Chair role is fulfilled by existing CCG Chairs on a rotational basis. No additional remuneration is paid for this role above that paid directly by the CCGs.

The Joint Committee table shows those staff employed to discharge these commissioning functions across the five CCGs. From the 1st October 2020, some of these staff have transferred to the new Joint Executive Team (see below)

Joint Committee Executive



**Notes:**

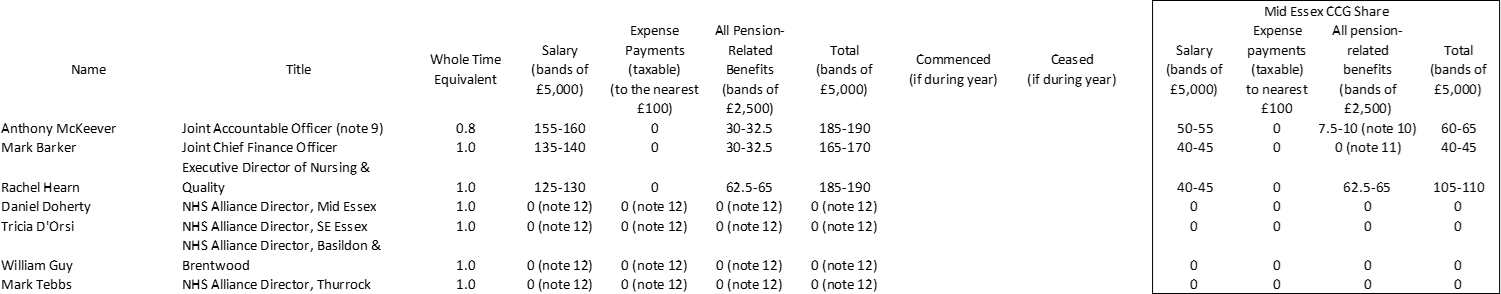
* 1. Payments include salaries, expenses and bonus payments made to staff, and do not include employer's NI or pension contributions. Pension related benefits reflect the increase in the theoretical value of the pension fund for the relevant staff member calculated in line with NHS guidance for the purposes of the remuneration report and do not reflect payments actually made in-year to the member of staff.
  2. Andrew Ray is on secondment to the Finance Director role. The costs included under salary payments reflect the payment made to his employing NHS organisation.
  3. The pension figures for staff who are also CCG directors are shown in full in that CCG's remuneration report and have not been apportioned to more than one organisation. Donald McGeachy is not a CCG Director and does not contribute to the NHS Pension Scheme.

Joint Executive Committee Table

From 1st October 2020, the Joint Executive Team has been established across the five CCGs. This replaces the executive structure of the existing CCG Governing Bodies. The GP representation remains on a CCG specific basis and there are no other members therefore included in the Joint Executive Team table.

The NHS Alliance director roles are specific to Place and as such continue to be shown in the Remuneration Report table specific to the CCG that they support.

The other executive roles are included in the Joint Executive Table.



**Notes:**

* 1. There are currently no Joint Executive Team appointed GP or Chair roles. The existing five CCG Governing Body members and Chairs remain in place for the 2021/22 financial year.
  2. 0.8 wte of this role is funded by the CCGs as the Joint Accountable Officer.
  3. The Employers contribution to stakeholder pension has been show in line with the proportion funded by each CCG.
  4. The pension figures for staff who are also included in CCG remuneration reports are shown in full in their employing CCG's remuneration report and have not been apportioned to more than one organisation.
  5. The NHS Alliance Director roles are part of the Joint Executive Team. The costs for these roles are paid directly by the CCGs that their geographic roles cover - Daniel Doherty, Mid Essex CCG; Tricia D'Orsi, Castle Point & Rochford and Southend CCGs; William Guy, Basildon & Brentwood CCG; Mark Tebbs, Thurrock CCG.

**Pension benefits as at 31 March 2022**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name and Title | (a)  Real increase in pension at pension age (bands of  £2,500) | (b)  Real increase in pension lump sum at pension age (bands of  £2,500) | (c) Total accrued  pension at pension age at 31 March 2022  (bands of  £5,000) | (d)  Lump sum at pension age related to accrued pension at 31 March  2022  (bands of  £5,000) | (e) Cash  Equivalent Transfer Value at 1  April 2021 | (f) Real  Increase in Cash Equivalent Transfer Value | (g) Cash  Equivalent Transfer Value at 31 March 2022 | (h) Employers Contribution to partnership pension |
|  | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Rachel Hearn Executive Director of Nursing and Quality – Joint Executive  Team | 2.5-5 | 2.5-5 | 35-40 | 65-70 | 484 | 48 | 553 | 0 |
| Daniel Doherty  NHS Alliance Director, Mid Essex – Joint Executive Team and Deputy Accountable  Officer | 2.5-5 | 5-7.5 | 30-35 | 60-65 | 452 | 52 | 524 | 0 |
| Elizabeth Towers Elected GP - Governing Body Member | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Anthony McKeever Joint Accountable Officer – Joint Executive  Team | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 |
| Mark Barker Joint Chief Finance Officer – Joint Executive  Team | 2.5-5 | 0 | 0-5 | 0 | 9 | 19 | 48 | 0 |
| Andy Ray Finance Director, Purchase of  Healthcare & Contracting | 2.5-5 | 0-2.5 | 50-55 | 105-110 | 929 | 49 | 998 | 0 |
| Karen Wesson Director of Commissioning, Performance & EPRR | 5-7.5 | 10-12.5 | 45-50 | 95-100 | 680 | 108 | 808 | 0 |

GP Board Members are classified as Off Payroll workers, and no pension disclosure is therefore required.

**Cash equivalent transfer values**

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

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

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

**Real increase in CETV**

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

**Compensation on early retirement or for loss of office**

There have been 0 compensation payments on early retirement or for loss of office.

**Payments to past directors**

There have been 0 payments to past directors.

**Fair Pay Disclosure**

Additional and new in 2021/22:

**Percentage Change in Remuneration of Highest Paid Director**

|  |  |  |
| --- | --- | --- |
|  | **% Change from previous financial year in Salary and Allowances** | **% Change from previous financial year in Performance Pay and Bonuses** |
| The percentage change from the previous financial  year in respect of the highest paid director | 0% | N/A\* |
| The average percentage change from the previous | +1.3% | N/A\* |

|  |  |  |
| --- | --- | --- |
| financial year in respect of employees of the entity, taken as a whole. |  |  |

\* No Performance Pay and Bonus payments are made by the CCG.

**Pay ratio information**

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

The banded remuneration of the highest paid director/member in Mid Essex CCG in the financial year 2021-22 was £120k-125k (0%+/- against 2020-21: £120k-125k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

**Pay Ratio information table**

|  |  |  |  |
| --- | --- | --- | --- |
| 2021-22 | 25th percentile | Median | 75th percentile |
| Total remuneration (£) | £26,721 | £41,890 | £54,904 |
| \*Salary component of total remuneration (£) | £26,721 | £41,890 | £54,904 |
| Pay ratio information | 4.8**:**1 | 3.0**:**1 | 2.3**:**1 |
| 2020-21 | | | |
| Total remuneration (£) | £26,454 | £38,890 | £51,668 |
| \*Salary component of total remuneration (£) | £26,454 | £38,890 | £51,668 |
| Pay ratio information | 4.7**:**1 | 3.2**:**1 | 2.4**:**1 |

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

During 2021/22, a decision was made to use the Mid Essex CCG payroll for all new members of staff recruited across the five CCGs. This was to aid the transition to the ICB payroll due in 2022/23. As a result the number of staff on the Mid Essex CCG payroll has increased substantially and include a number of staff recompensed to transition the CCGs to the new ICB.

In 2021/22, 0 (2020/21, 0) employees received remuneration in excess of the highest- paid director/member.

As at 31 March 2022, remuneration ranged from £3k to £125k (2020/21: £7k-125k) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

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

**Staff Report**

**Number of staff including senior managers**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pay Band** | **2** | **3** | **4** | **5** | **6** | **7** | **8a** | **8b** | **8c** | **8d** | **9** | **Other** | ***Sub- total*** | **Grand Total** |
|  |  |  |  |  |  |  |  |  | **Senior Managers** | | | | |  |
| Female | 0 | 14 | 23 | 16 | 26 | 26 | 22 | 15 | 10 | 9 | 1 | 4 | *24* | **166** |
| Male | 1 | 1 | 3 | 3 | 2 | 7 | 2 | 7 | 5 | 0 | 4 | 6 | *15* | **41** |
| **TOTAL** | **1** | **15** | **26** | **19** | **28** | **33** | **24** | **22** | **15** | **9** | **5** | **10** | ***39*** | **207** |

**Staff numbers and costs**

Mid Essex CCG hosts the acute commissioning team (ACT) and holds the majority of these employees’ contracts of employment, although the five mid and south Essex CCGs share the ACT costs. As a result, Mid Essex CCG accounts only for its share of the ACT costs. The number of staff and related costs, disclosed in Notes 4.2 and 4.1 respectively of the Annual Accounts, reflect this share of those staff.

Staffing numbers, split by WTE and headcount are given below and are based on information recorded in the Electronic Staff Record (ESR) as of 31 March 2022.

|  |  |  |
| --- | --- | --- |
| **EMPLOYED STAFF** | | |
| **Employee category** | **Headcount** | **WTE** |
| Permanent | 176 | 160.55 |
| Fixed-term | 24 | 24.11 |
| TOTAL |  |  |
| **AGENCY AND INTERIM** | | |
| TOTAL | 7 | 0.40 |
| **GRAND TOTAL** | **207** | **185.06** |

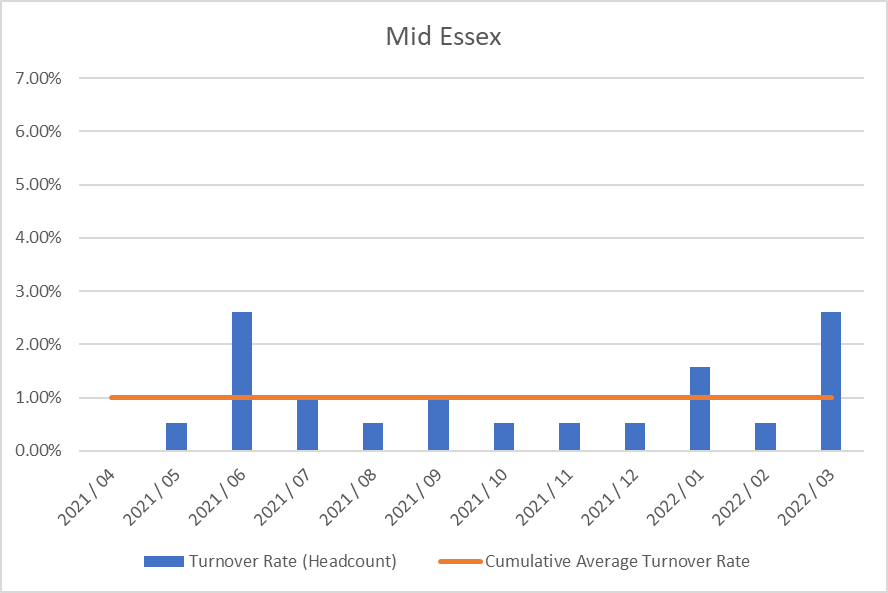
|  |  |  |  |
| --- | --- | --- | --- |
|  | **Female** | **Male** | **Grand Total** |
| Governing Body | 1 | 1 | **2** |
| All other staff | 165 | 40 | **205** |
| **TOTAL** | **166** | **41** | **207** |

**Sickness absence data**

Details of the CCG’s sickness absence data can be found here: [https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates) [rates](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates)

**Staff turnover percentages**

The graph below shows the CCG’s staff turnover rate during 2021/22.



**Staff engagement**

In 2021/22 all of the 5 CCGs in Mid and South Essex participated in the NHS Staff Survey on a combined basis and the results have been presented across joint Directorates and teams. The CCGs chose Picker to run the survey and results were published nationally on 30 March 2022.

The CCGs achieved an excellent response rate of 78%. Key themes have been shared with the CCGs’ Executive Team and they have been asked to work with their teams to write action plans in response to the staff survey results. In addition to this, the 5 CCGs formed a staff engagement group in January 2022 and this group is also developing an organisational action plan to look at key themes such as health and wellbeing and diversity and inclusion. This group has representation of staff from across the 5 CCGs and will be tasked with feeding into the organisational development work required as the CCGs transition into an ICB.

There are regular all-staff briefings across the 5 CCGs to communicate key messages around organisational change, as well as operational updates and regular updates on system priorities, for example Covid response updates.

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

All of the 5 CCGs in Mid and South Essex have participated in the NHS Staff Survey on a combined basis and the results have been presented across joint Directorates and teams. The CCGs chose Picker to run the survey and the results were published nationally on 30 March 2022.

**Staff Policies**

The CCG has given full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.

The CCG has continued the employment of and arranged appropriate training for employees who have become disabled persons during their period of employment.

It is the policy of the CCG to ensure that any member of the CCG Board, its staff and its member practices are able to raise concerns about unlawful conduct, financial malpractice/fraud and risks to the environment and to patient care in line with legislation and good practice. This is covered under our whistleblowing policy.

**Equality, Diversity and Inclusion**

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

All CCG staff will be offered further equality, diversity and inclusion training as part of the transition into the ICB - the offering will include unconscious bias training, awareness of protected characteristics, allyship and also a complete review of policies, procedures and practices to eliminate bias. This will be offered in line with the recommendations of the No More Tick boxes report.

The CCGs will also be working with the Mid and South Essex Health and Care Partnership to develop an organisational and system response to the regional Anti- Racism Strategy and this will be implemented through the Equality, Diversity and Inclusion Sub Group that is accountable to the Mid and South Essex People Board. In addition, an Equality, Diversity and Inclusion dashboard is in development for the MSE Partnerships which the CCGs will feed into.

As the CCGs transition into an ICB, single Workforce Race Equality Scheme and Workforce Disability Equality Scheme reports and action plans will be co-produced and regularly monitored to ensure progress against agreed objectives.

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

**Trade Union Facility Time Reporting Requirements**

There was no Trade Union Facility Time in 2020/21.

**Health and Wellbeing**

The CCGs have benefitted from a comprehensive staff health and wellbeing offer through the Live Life Connected programme, which offers a vast array of health and wellbeing interventions such as online talks around health topics, online exercise classes, mindfulness and gratitude practice.

In addition, there is also an employee assistance programme available to all staff which provides a telephone support line and counselling as well as a comprehensive occupational health provision.

During the Covid pandemic, there have also been enhanced national, regional and local offers available to staff, including the regional mental health hubs and the Here For You service is available to all CCG employees.

The CCGs also have a trained network of mental health first aiders and have also provided bespoke Change and Resilience workshops for staff, as well as benefitting from ICS offers such as Kindness masterclasses.

The CCGs are committed to supporting disabled colleagues within the workplace through making reasonable adjustments as well as the use of regular risk assessments and also supporting colleagues’ mental health through the use of stress risk assessments and other support tools.

**Health and Safety**

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

Risk assessment and inspections identify health and safety issues to enable appropriate action to be taken to reduce risks to staff and other users of CCG premises. Although CCG staff have worked from home since the beginning of the pandemic, regular health and safety inspections, building system tests and maintenance continued throughout the year.

All CCG staff were asked to complete an individual risk assessment to identify their personal level of risk in relation to Covid-19. In addition, the CCG undertook a Covid-19 risk assessment of its premises and developed an associated procedure based on Government, NHS England and Health and Safety Executive guidance and advice from CCG Infection Prevention and Control staff, to ensure that the building was Covid-19 secure. These documents also received input from staff and union representatives.

During the pandemic access to the CCG’s premises was restricted by application of a strict criteria and approval process.

A number of CCG staff were redeployed to provider organisations to assist with the frontline response to COVID-19. Where this was the case, a formal cross-organisational agreement was in place to ensure that all health, safety and wellbeing needs of employees were met throughout their period of redeployment.

**Expenditure on consultancy**

|  |  |  |
| --- | --- | --- |
| **Year** | **Administrative** | **Programme** |
| 2021/22 | £77k | £392k |
| 2020/21 | £260k | £165k |
| 2019/20 | £150k | £78k |

**Off-payroll engagements**

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

For all off-payroll engagements as at 31 March 2022 for more than £245\* per day

|  |  |
| --- | --- |
|  | Number |
| Number of existing engagements as of 31 March 2022 | 15 |
| Of which, the number that have existed: | |
| for less than one year at the time of reporting | 7 |
| for between one and two years at the time of reporting | 4 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 4 |
| for 4 or more years at the time of reporting | 0 |

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

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

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than

£245(1) per day:

|  |  |
| --- | --- |
|  | Number |
| No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022 | 26 |
| Of which: | |
| No. not subject to off-payroll legislation(2) | 9 |
| No. subject to off-payroll legislation and determined as in-scope of IR35(2) | 7 |
| No. subject to off-payroll legislation and determined as out of scope of IR35(2) | 10 |
| the number of engagements reassessed for compliance or assurance purposes during the year | 3 |
| Of which: no. of engagements that saw a change to IR35 status following review | 3 |

(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.

All off-payroll contractors are assessed before engagement to determine IR35 status. For contractors in-scope of IR35, invoices are submitted and paid through payroll, where tax and NI payments are deducted at source

**Table 3: Off-payroll engagements / senior official engagements**

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2021 and 31 March 2022:

|  |  |
| --- | --- |
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year. | 0 |
| Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. | 12 |

**Exit packages, including special (non-contractual) payments**

There have been 0 Exit Packages.

### Parliamentary Accountability and Audit Report

Mid Essex CCG is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report at pages 87, 98, 100 and 110. An audit certificate and report is also included in this Annual Report at page 78.

# INDEPENDENT AUDITOR’S REPORT

**INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS MID ESSEX CLINICAL COMMISSIONING GROUP**

**REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS**

**Opinion**

We have audited the financial statements of NHS Mid 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 1.1 to the financial statements which explains that on 1 July 2022, NHS Mid Essex CCG will be dissolved and its services transferred to Mid and South Essex Integrated Health and 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, journals entries in period 12 where one side posts to expenditure and the other side posts to an unusual account, and Journals entries containing key words being: fraud, litigation, error
* 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 38, 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](http://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 38, 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 Mid 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 Mid 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.

Emma Larcombe

**for and on behalf of KPMG LLP** *Chartered Accountants* Cambridge

30 June 2022

# ANNUAL ACCOUNTS

See overleaf

NHS Mid Essex CCG - Annual Accounts 2021-22

**CONTENTS Page Number**

**The Primary Statements:**

Statement of Comprehensive Net Expenditure for the year ended 31st March 2022 86

Statement of Financial Position as at 31st March 2022 87

Statement of Changes in Taxpayers' Equity for the year ended 31st March 2022 88

Statement of Cash Flows for the year ended 31st March 2022 89

**Notes to the Accounts**

Accounting policies 90-93

Other operating revenue 94

Revenue 94

Employee benefits and staff numbers 95-97

Operating expenses 98

Better payment practice code 99

Operating leases 100

Property, plant and equipment 101

Trade and other receivables 102

Cash and cash equivalents 103

Trade and other payables 103

Borrowings 104

Provisions 105

Financial instruments 106-107

Operating segments 107

Joint arrangements - interests in joint operations 108

Related party transactions 109

Events after the end of the reporting period

110

Loses and Special Payments 110

Financial performance targets 110

Please note that occassionally £1k differences occur between the primary statements and the notes to the accounts and within individual lines which is unavoidable due to rounding discrepancies.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22 |  | | | |
| **Statement of Comprehensive Net Expenditure for the year ended 31 March 2022** |
|  | **Note** | **2021-22**  **£'000** |  | 2020-21  £'000 |
| Income from sale of goods and services | 2 | (720) |  | (482) |
| **Total operating income** |  | **(720)** |  | **(482)** |
| Staff costs | 4 | 9,443 |  | 8,971 |
| Purchase of goods and services | 5 | 917,925 |  | 623,252 |
| Provision expense | 5 | 973 |  | 1,990 |
| Other Operating Expenditure | 5 | 675 |  | 262 |
| **Total operating expenditure** |  | **929,017** |  | **634,475** |
| **Net Operating Expenditure** |  | **928,297** |  | **633,993** |
| **Net expenditure for the Year** |  | **928,297** |  | **633,993** |
| **Comprehensive Expenditure for the year** |  | **928,297** |  | **633,993** |
| The accompanying notes form part of the financial statements |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22 |  |  |  |  |
| **Statement of Financial Position as at 31 March 2022** |  | **2021-22** |  | 2020-21 |
| **Current assets:** | **Note** | **£'000** |  | £'000 |
| Trade and other receivables | 9 | 1,653 |  | 8,724 |
| Cash and cash equivalents | 10 | 0 |  | 0 |
| **Total current assets** |  | **1,653** |  | 8,724 |
| **Total assets** |  | **1,653** |  | 8,724 |
| **Current liabilities**  Trade and other payables | 11 | (46,420) |  | (43,449) |
| Borrowings | 12 | (4,300) |  | (548) |
| Provisions | 13 | (1,568) |  | (705) |
| **Total current liabilities** |  | **(52,288)** |  | (44,702) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** |  | **(50,635)** |  | (35,978) |
| **Non-current liabilities**  Provisions | 13 | (2,549) |  | (2,549) |
| **Total non-current liabilities** |  | **(2,549)** |  | (2,549) |
| **Assets less Liabilities** |  | **(53,184)** |  | (38,527) |
| **Financed by Taxpayers’ Equity**  General fund |  | (53,184) |  | (38,527) |
| **Total taxpayers' equity:** |  | **(53,184)** |  | (38,527) |
| The accompanying notes form part of the financial statements |  |  |  |  |

The accompanying notes were approved by the Governing Body on 28 June 2022 and signed on its behalf by:

Anthony McKeever Accountable Officer 30 June 2022

|  |  |  |
| --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22 |  | |
| **Statement of Changes In Taxpayers Equity for the year ended** |
| **31 March 2022** |  | **Total** |
|  | **General fund** | **reserves** |
|  | **£'000** | **£'000** |
| **Changes in taxpayers’ equity for 2021-22** |  |  |
| **Balance at 01 April 2021** | (38,528) | **(38,528)** |
| **Adjusted NHS Clinical Commissioning Group balance at 31 March 2021** | **(38,528)** | **(38,528)** |
| **Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2021-22** |  |  |
| Net operating expenditure for the financial year | (928,297) | **(928,297)** |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year** | **(928,297)** | **(928,297)** |
| Net funding | 913,641 | **913,641** |
| **Balance at 31 March 2022** | **(53,184)** | **(53,184)** |
|  |  | **Total** |
|  | **General fund** | **reserves** |
|  | **£'000** | **£'000** |
| **Changes in taxpayers’ equity for 2020-21** |  |  |
| **Balance at 01 April 2020** | (33,631) | **(33,631)** |
| **Adjusted NHS Clinical Commissioning Group balance at 31 March 2021** | **(33,631)** | **(33,631)** |
| **Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2020-21** |  |  |
| Net operating costs for the financial year | (633,993) | (633,993) |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year** | **(633,993)** | **(633,993)** |
| Net funding | 629,097 | 629,097 |
| **Balance at 31 March 2021** | **(38,528)** | **(38,528)** |

The accompanying notes form part of the financial statement

The Net Funding for the CCG comprises of the Cash Drawn down from the agreed parliamentary funding within the current financial year (£913,641).

The expenditure position is that reported in Statement of Comprehensive Income for the financial year. The balance at the 31st March 22, includes the opening position reported above and the movement in balances as set out in the cashflow statement.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22 |  | | | |
| **Statement of Cash Flows for the year ended 31 March 2022** |  | **2021-22** |  | 2020-21 |
| **Cash Flows from Operating Activities** | Note | **£'000** |  | £'000 |
| Net operating expenditure for the financial year |  | (928,297) |  | (633,993) |
| (Increase)/decrease in trade & other receivables | 9 | 7,071 |  | (3,510) |
| Increase/(decrease) in trade & other payables | 11 | 2,971 |  | 6,542 |
| Provisions utilised | 13 | (111) |  | (24) |
| Increase/(decrease) in provisions | 13 | 973 |  | 1,990 |
| **Net Cash Inflow (Outflow) from Operating Activities** |  | **(917,392)** |  | (628,995) |
| **Net Cash Inflow (Outflow) before Financing** |  | **(917,392)** |  | (628,995) |
| **Cash Flows from Financing Activities**  Grant in Aid Funding Received |  | 913,641 |  | 629,097 |
| **Net Cash Inflow (Outflow) from Financing Activities** |  | **913,641** |  | 629,097 |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 10 | **(3,751)** |  | 102 |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** |  | **(548)** |  | (650) |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** |  | **(4,299)** |  | (548) |
| The accompanying notes form part of the financial statements |  |  |  |  |

NHS Mid Essex - Annual Accounts 2021-22

**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. **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 25 following the approval of the Health and Care Bill NHS Mid 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 the Mid and South Essex Integrated Health and 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. **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. **Movement of Assets within the Department of Health and Social Care Group**

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

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

* 1. **Pooled Budgets**

The clinical commissioning group has not been part of any pooled budget arrangements in 2021-22. Mid Essex clinical commissioning group and Essex County Council have continued to operate a Better Care Fund during 2021-22 under a Section 75 agreement. The arrangements under which the Better Care Fund has operated in 2021-22 do not constitute a pooled budget as the risks of each scheme have remained with the respective commissioners. Each scheme within the Better Care Fund has been reviewed and accounted for on an appropriate basis (see Note 16.

The clinical commissioning group (along with 6 other Essex CCGs and 3 local authorities) is party to a Section 75 agreement providing for the costs of discharged long-term in-patients with learning disabilities as identified by the Transforming Care programme. Essex County Council and the clinical commissioning groups have agreed that Joint Control does not exist within this arrangement as both health and community packages continue to be commissioned by the respective partners.

* 1. **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. **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.

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. **Employee Benefits**
     1. **Short-term Employee Benefits**

NHS Mid Essex - Annual Accounts 2021-22

**Notes to the financial statements**

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

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

* + 1. **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.](http://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. **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. **Property, Plant & Equipment**
     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. **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. **Subsequent Expenditure**

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

* 1. **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.

1.10.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group’s surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

NHS Mid Essex - Annual Accounts 2021-22

**Notes to the financial statements**

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

* 1. **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. **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.

* 1. **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.

* 1. **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. **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. **Financial Assets at Amortised cost**

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

* + 1. **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

* + 1. **Financial assets at fair value through profit and loss**

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

* + 1. **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. **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.

1.16.1 **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.

NHS Mid Essex - Annual Accounts 2021-22

**Notes to the financial statements**

* 1. **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. **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. **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). The clinical commissioning group's losses and special payments are disclosed in Note 20.

* 1. **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. **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.

Mid Essex clinical commissioning group and Essex County Council have continued to operate a Better Care Fund during 2021-22 under a section 75 agreement. The arrangements under which the Better Care Fund has operated during 2021-22 do not constitute a pooled budget as the risks of each scheme have remained with the respective commissioner. See Note 16 for further information.

The clinical commissioning group is part of a section 75 agreement with the members of the Essex Transforming Care Partnership. The arrangement is not considered to be one of Joint Control as both health and community packages continue to be commissioned by the respective partners. See Note 16 for further information.

* + 1. **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.

Where possible the value of year end transactions has been agreed with NHS counter parties on an estimated basis. Where information is not available, the clinical commissioning group has made estimates of the value of liabilities in respect of activity in the final weeks of the year. Asset life assumptions are based on standard assumptions for each category of non-current asset. The clinical commissioning group carries a number of provisions which are reflected in Note 13. A number of high value accruals have been made which include a prescribing accrual.

* 1. **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 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.

* 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.

The NHS clinical commissioning group does not anticipate any significant impact from Standards that have not yet been adopted.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22  **2 Other Operating Revenue** |  | | | | | | |
|  | **2021-22**  **Admin** |  | **2021-22**  **Programme** |  | **2021-22**  **Total** |  | 2020-21  Total |
|  | **£'000** |  | **£'000** |  | **£'000** |  | £'000 |
| **Income from sale of goods and services (contracts)**  Non-patient care services to other bodies | 50 |  | 660 |  | **710** |  | 162 |
| Other Contract income | - |  | 10 |  | **10** |  | 320 |
| **Total Income from sale of goods and services** | **50** |  | **670** |  | **720** |  | **482** |
| **Total Operating Income** | **50** |  | **670** |  | **720** |  | **482** |

Admin Revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Allocation funding received from NHS England is not included in this note as it is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

* 1. **Disaggregation of Income - Income from sale of good and services (contracts)**

**Non-patient care services to other**

**Other Contract income**

|  |  |  |
| --- | --- | --- |
|  | **bodies** |  |
| **£'000** | **£'000** |
| **Source of Revenue** |  |  |
| NHS | - | - |
| Non NHS | 710 | 10 |
| **Total** | **710** | **10** |

**Non-patient care services to other**

**Other Contract income**

|  |  |  |
| --- | --- | --- |
|  | **bodies** |  |
| **£'000** | **£'000** |
| **Timing of Revenue** |  |  |
| Point in time | - | - |
| Over time | 710 | 10 |
| **Total** | **710** | **10** |

* 1. **Transaction price to remaining contract performance obligations**

There is no contract revenue expected to be recognised in future periods related to contract performance obligations not yet completed at the reporting

The Clinical Commissioning Group's revenue is allocated for the supply of services, there is no revenue generated by the sale of goods.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22  **4. Employee benefits and staff numbers** |  | | | | |
| **4.1.1 Employee benefits** | **Total**  **Permanent** | | |  | **2021-22** |
| **Employee Benefits** | **Employees Other**  **£'000 £'000** | | |  | **Total**  **£'000** |
| Salaries and wages | **6,669 800** | | |  | **7,469** |
| Social security costs | **722 2** | | |  | **724** |
| Employer Contributions to NHS Pension scheme | **1,214 -** | | |  | **1,214** |
| Other pension costs | **9 -** | | |  | **9** |
| Apprenticeship Levy | **28 -** | | |  | **28** |
| **Gross employee benefits expenditure** | 8,642 802 | | |  | 9,444 |
|  |  | | |  |  |
| **Total Net employee benefits excluding capitalised costs** | 8,642 802 | | |  | 9,444 |
| **4.1.1 Employee benefits** | **Total**  **Permanent** | | |  | **2020-21** |
|  | **Employees Other**  **£'000 £'000** | | |  | **Total**  **£'000** |
| **Employee Benefits**  Salaries and wages | **6,171** |  | **894** |  | 7,065 |
| Social security costs | **565** |  | **0** |  | 565 |
| Employer Contributions to NHS Pension scheme | **1,132** |  | **-** |  | 1,132 |
| Other pension costs | **6** |  | **-** |  | 6 |
| Apprenticeship Levy | **25** |  | **-** |  | **25** |
| Termination benefits | **178** |  | **-** |  | **178** |
| **Gross employee benefits expenditure** | 8,077 |  | 894 |  | 8,971 |
|  |  |  |  |  |  |
| **Net employee benefits excluding capitalised costs** | 8,077 |  | 894 |  | 8,971 |
| **4.1.2 Recoveries in respect of employee benefits** |  |  |  |  |  |

In 2021-22 no employee benefits were recovered from third parties not capitalised (2020-21 = £NIL)

The Clinical Commisiioning Group hosts staff employed by the Acute Commissioning Team which supports the Joint Committee on behalf of the 5 CCGs in the Mid and South Essex system. An adjustment is made to reflect the Mis Essex share of these costs only.

The increase in salaries and wages in 2021-22 is predominantly due to the national Agenda for Change payaward uplift of 3%.

NHS Mid Essex CCG - Annual Accounts 2021-22

* 1. **Average number of people employed**

**Permanently**

**2021-22**

**Permanently**

**2020-21**

**employed Other Total employed Other Total**

**Number Number Number Number Number Number**

**Total 136.09 7.39 143 126 8 133.74**

Staff numbers disclosed in the above note are lower than those disclosed in the Annual Report as the above figures show only the proportion of the shared Acute Commissioning Team that m Essex CCG funds. The Annual Report discloses the number of staff who are employed by Mid Essex CCG.

* 1. **Ill Health Retirements**

There were no early retirements on health grounds in 2021-22 or 2020-21

* 1. **Exit packages agreed in the financial year**

There were no Exit Packages agreed during 2021-22.

NHS Mid Essex CCG - Annual Accounts 2021-22

* 1. **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.](http://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:

* + 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.

* + 1. **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.](http://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports)

|  |  |  |  |
| --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22  **5. Operating expenses** |  | | |
|  | **2021-22**  **Total**  **£'000** |  | 2020-21  Total  £'000 |
| **Purchase of goods and services**  Services from other CCGs and NHS England | 1,686 |  | 1,632 |
| Services from foundation trusts | 605,210 |  | 392,046 |
| Services from other NHS trusts | 25,771 |  | 25,002 |
| Services from Other WGA bodies | 1 |  | - |
| Purchase of healthcare from non-NHS bodies | 152,882 |  | 133,649 |
| Prescribing costs | 58,098 |  | 58,700 |
| General Ophthalmic services | 8 |  | 0 |
| GPMS/APMS and PCTMS | 64,395 |  | 5,969 |
| Supplies and services – clinical | 30 |  | - |
| Supplies and services – general | 3,836 |  | 578 |
| Consultancy services | 542 |  | 425 |
| Establishment | 836 |  | 1,063 |
| Transport | 2,864 |  | 2,106 |
| Premises | 1,368 |  | 1,553 |
| Audit fees  Other non statutory audit expenditure  · Internal audit services | 78  - |  | 63  - |
| · Other services | - |  | 8 |
| Other professional fees | 239 |  | 357 |
| Legal fees | 56 |  | 17 |
| Education, training and conferences | 25 |  | 81 |
| **Total Purchase of goods and services** | **917,925** |  | **623,249** |
| **Provision expense**  Provisions | 973 |  | 1,990 |
| **Total Provision expense** | **973** |  | **1,990** |
| **Other Operating Expenditure**  Chair and Non Executive Members | 104 |  | 102 |
| Grants to Other bodies | 566 |  | 155 |
| Other expenditure | 5 |  | 8 |
| **Total Other Operating Expenditure** | **675** |  | **265** |
| **Total operating expenditure** | **919,574** |  | **625,504** |

The clinical commissioning group's external auditors are KPMG. The external audit contract limits KPMG's liability for losses in connection with this engagement to a maximum aggregate of £1m. Any claim must be brought within 4 years. The fee for auditing the 2021-22 accounts was £78,226 net of VAT.

During 2021-22 the CCG continued to act as the banker for the Mid & South Essex System, as a result the expense associated with Services from Foundation Trusts and other NHS Trusts includes a significant element of 'Top-up', Covid and system growth funding (£127m), that has been passed through the clinical commissioning group. In addition the clinical commissioning group also hosted transformation and other system support funds (£28m).

During 2021-22 the CCG took on full delegation for GMS/APMS and PCTMS spend for our population. The CCG recievied the funding allocation for these Primary Care Services and has manged the payments and expenditure throughout the year. This can been seen in the increase in the GMS/APMS and PCTMS spend between years.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22 |  | | | |
| **6.1 Better Payment Practice Code** |
| **Measure of compliance**  **Non-NHS Payables** | **2021-22**  **Number** | **2021-22**  **£'000** | 2020-21  Number | 2020-21  £'000 |
| Total Non-NHS Trade invoices paid in the Year | 12,247 | 229,306 | 12,870 | 157,257 |
| Total Non-NHS Trade Invoices paid within target | 11,747 | 222,252 | 12,573 | 144,039 |
| **Percentage of Non-NHS Trade invoices paid within target** | **95.92%** | **96.92%** | **12,573** | **144,039** |
| **NHS Payables**  Total NHS Trade Invoices Paid in the Year | 668 | 662,643 | 1,572 | 440,482 |
| Total NHS Trade Invoices Paid within target | 642 | 657,668 | 1,538 | 439,438 |
| **Percentage of NHS Trade Invoices paid within target** | **96.11%** | **99.25%** | **97.84%** | **99.76%** |

NHS Mid Essex CCG - Annual Accounts 2021-22

1. **Operating Leases**
   1. **As lessee**

NHS Property Services charges the clinical commissioning group for the use of the properties occupied. Despite no leases being formally in place, the substance of these arrangements suggests otherwise.

As such, the arrangements are likely to be leases. IFRIC4 (paragraph1) describes arrangements that appear to mirror this situation, i.e. an arrangement comprising a transaction or a series of related transactions, that does take the legal form of a lease but conveys the right to use an asset (e.g. an item of property, plant or equipment) in return for a payment or series of repayments.

Even though there are no contracts in place (leases or MOTOs), the transactions involved do convey the right of the clinical commissioning group to use property assets.

This would suiggest that (under paragraph 9 IFRIC 4), these arrangements are (or contain) leases. As such they have been accounted for in accordance with IAS 16.

**7.1.1 2021-22** 2020-21

**Buildings Other Total** Buildings Other Total

**£'000 £'000 £'000** £'000 £'000 £'000

**Payments recognised as an expense**

Minimum lease payments 1,089 1 **1,089** 1,049 1 **1,050**

Contingent rents - - **-** - - **-**

Sub-lease payments - - **-**  - - **-**

**Total**  **1,089 1 1,089**  **1,049 1 1,050**

**7.1.2 2021-22** 2020-21

**Buildings Other Total** Buildings Other Total

**£'000 £'000 £'000** £'000 £'000 £'000

**Payable:**

No later than one year - 1 **1** - 1 **1**

Between one and five years - 1 **1** - 2 **2**

After five years - - **-**  - - **-**

**Total**  **- 2 2**  **- 3 3**

**The clinical commissioning group did not receive any revenue as leasor.**

NHS Mid Essex CCG - Annual Accounts 2021-22

**8 Property, plant and equipment**

|  |  |  |
| --- | --- | --- |
|  | **Furniture &** |  |
| **2021-22** | **fittings**  **£'000** | **Total**  **£'000** |
| **Cost or valuation at 01 April 2021** | 78 | 78 |
| Disposals other than by sale | (78) | (78) |
| **Cost/Valuation at 31 March 2022** | **-** | **-** |
| **Depreciation 01 April 2021** | 78 | 78 |
| Disposals other than by sale | (78) | (78) |
| **Depreciation at 31 March 2022** | **-** | **-** |

The clinical commissioning group does not hold any revaluation reserve balances for property, plant and equipment.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22  **9 Trade and other receivables** | **Current** | **Non-current** | Current | Non-current |
|  | **2021-22**  **£'000** | **2021-22**  **£'000** | 2020-21  £'000 | 2020-21  £'000 |
| NHS receivables: Revenue | 191 | - | 2,131 | - |
| NHS accrued income | 739 | - | 6,041 | - |
| Non-NHS and Other WGA receivables: Revenue | 380 | - | 25 | - |
| Non-NHS and Other WGA prepayments | 255 | - | 357 | - |
| Non-NHS and Other WGA accrued income | 40 | - | 74 | - |
| VAT | 48 | - | 97 | - |
| **Total Trade & other receivables** | **1,652** | **-** | **8,725** | **-** |
|  |  |  |  |  |
| **Total current and non current** | **1,652** |  | **8,725** |  |
| Included above:  Prepaid pensions contributions | - |  | - |  |

NHS accrued income for 2021 included receivables of £4.5m which related to the clinical commissioning group's role as system banker and is offset by an equivalent amount owed to another NHS partner in the System. This accrual was transacted during the year and no further accruals were required no further significant accruals were required to be made in the financial year ending 2021-22.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **9.1 Receivables past their due date but not impaired** |  | | | | |
|  | **2021-22** | **2021-22** | 2020-21 |  | 2020-21 |
|  | **DHSC Group** | **Non DHSC Group** | DHSC Group |  | Non DHSC Group |
|  | **Bodies** | **Bodies** | Bodies |  | Bodies |
|  | **£'000** | **£'000** | £'000 |  | £'000 |
| By up to three months | 18 | 159 |  | 10 | - |
| By three to six months | 21 | - |  | - | 25 |
| By more than six months | - | - |  | - | - |
| **Total** | **39** | **159** |  | **10** | **25** |

|  |  |  |  |
| --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22  **10 Cash and cash equivalents** |  | | |
| **Balance at 01 April 2021** | **2021-22**  **£'000**  (548) |  | 2020-21  £'000  (650) |
| Net change in year | (3,751) |  | 102 |
| **Balance at 31 March 2022** | **(4,299)** |  | **(548)** |
| Bank overdraft: Government Banking Service Bank overdraft: Commercial banks  **Total bank overdrafts** | (4,300)  -  **(4,300)** |  | (548)  -  **(548)** |
| **Balance at 31 March 2022** | **(4,300)** |  | **(548)** |
| No patients money was held by the clinical commissioning group. | - |  | - |

The clinical commissioning group's cash position is reported in the financial statements as an overdraft at 31 March 2021 due to outstanding payments due to clear after the year end. As at 31 March 2022, the clinical commissioning group had a net positive cash balance deposited in its Government Banking Service bank account of £103k.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **11 Trade and other payables** | **Current 2021-22**  **£'000** | **Non-current 2021-22**  **£'000** | Current 2020-21  £'000 | Non-current 2020-21  £'000 |
| NHS payables: Revenue | 4,318 | - | 772 | - |
| NHS accruals | 1,650 | - | 6,123 | - |
| NHS deferred income | - | - | 3 | - |
| Non-NHS and Other WGA payables: Revenue | 2,148 | - | 323 | - |
| Non-NHS and Other WGA accruals | 37,630 | - | 35,245 | - |
| Non-NHS and Other WGA deferred income | 75 | - | 359 | - |
| Social security costs | 149 | - | 124 | - |
| Tax | 132 | - | 114 | - |
| Other payables and accruals | 829 | - | 388 | - |
| **Total Trade & Other Payables** | **46,931** | **-** | **43,451** | **-** |
| Total current and non-current | **46,931** |  | **43,451** |  |
| There are currently no liabilities for early retirement. |  |  |  |  |

Other payables include the following outstanding payments: £167k NHS pension contributions, £446k GP pension contributions,

£29k to NEST pension providers and £2k in respect of GP SOLO pension contributions at 31 March 2022.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22 | **Current** |  | **Non-current** |  | Current |  | Non-current |
| **12 Borrowings** | **2021-22** |  | **2021-22** |  | 2020-21 |  | 2020-21 |
|  | **£'000** |  | **£'000** |  | £'000 |  | £'000 |
| **Bank overdrafts:** |  |  |  |  |  |  |  |
| · Government banking service | 4,300 |  | - |  | 548 |  | - |
| · Commercial banks | - |  | - |  | - |  | - |
| **Total overdrafts** | **4,300** |  | **-** |  | **548** |  | **-** |
| **Total Borrowings** | **4,300** |  | **-** |  | **548** |  | **-** |
| **Total current and non-current** | **4,300** |  |  |  | **548** |  |  |
| **12.1 Repayment of principal falling due** | **Department of** |  |  |  |  |  |  |
|  | **Health** |  | **Other** |  | **Total** |  |  |
|  | **2021-22** |  | **2021-22** |  | **2021-22** |  |  |
|  | **£'000** |  | **£'000** |  | **£'000** |  |  |
| Within one year | - |  | 4,300 |  | 4,300 |  |  |
| **Total** | **-** |  | **4,300** |  | **4,300** |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22  **13 Provisions** | **Current** | **Non-current** | Current | Non-current |
| Restructuring | **2021-22**  **£'000**  919 | **2021-22**  **£'000**  - | 2020-21  £'000  - | 2020-21  £'000  - |
| Continuing care | 494 | 2,351 | 536 | 2,351 |
| Other | 156 | 198 | 169 | 198 |
| **Total** | **1,569** | **2,549** | **705** | **2,549** |
| **Total current and non-current** | **4,118** |  | **3,254** |  |
|  |  | **Continuing** |  |  |
|  | **Restructuring**  **£'000** | **Care**  **£'000** | **Other**  **£'000** | **Total**  **£'000** |
| **Balance at 01 April 2021** | **-** | **2,887** | **367** | **3,254** |
| Arising during the year | 919 | - | 55 | **973** |
| Utilised during the year | - | (43) | (68) | **(111)** |
| **Balance at 31 March 2022** | **919** | **2,844** | **353** | **4,116** |
| **Expected timing of cash flows:**  Within one year | 919 | 494 | 156 | **1,569** |
| Between one and five years | - | 2,350 | 197 | **2,547** |
| **Balance at 31 March 2022** | **919** | **2,844** | **353** | **4,116** |

A restructuring provision has been calculated across all CCGs and shared proportionately to the size of each CCG. The provision has been made as the CCGs are in the process of restructuring resources for transition. Engagement on the restructure began during March 2022, with the information available the CCG has estimated potential one-off costs which could come to bear throughout 2022-23 as a result of decisions made during 2021-22. These costs are associated with displacement of staff, retraining or redeployment on the basis of the new organisational form.’

The CCG continues to provide for the costs of settling outstanding continuing healthcare retrospective claims received since 31s March 2013 and which are outside of the NHS England risk pool arrangement and the liability of the clinic commissioning group..

Other provisions include delapidations costs relating to the clinical commissioning group's headquarters and premises.

NHS Mid Essex CCG - Annual Accounts 2021-22

1. **Financial instruments**
   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.

* + 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.

* + 1. **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.

* + 1. **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.

* + 1. **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.

* + 1. **Financial Instruments**

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

|  |  |  |
| --- | --- | --- |
| NHS Mid Essex CCG - Annual Accounts 2021-22 |  |  |
| **14 Financial instruments cont'd** |  |
| **14.2 Financial assets** |  |
|  | **Financial Assets** |
|  | **measured at** |
|  | **amortised cost** | **Total** |
|  | **2021-22**  **£'000** | **2021-22**  **£'000** |
| Trade and other receivables with NHSE bodies | 884 | 884 |
| Trade and other receivables with other DHSC group bodies | 86 | 86 |
| Trade and other receivables with external bodies | 380 | 380 |
| **Total at 31 March 2022** | **1,350** | **1,350** |
| **14.3 Financial liabilities** |  |  |
|  | **Financial Liabilities** |  |
|  | **measured at** |  |
|  | **amortised cost** | **Total** |
|  | **2021-22**  **£'000** | **2021-22**  **£'000** |
| Loans with external bodies | 4,300 | **4,300** |
| Trade and other payables with NHSE bodies | 4,506 | **4,506** |
| Trade and other payables with other DHSC group bodies | 1,881 | **1,881** |
| Trade and other payables with external bodies | 39,679 | **39,679** |
| **Total at 31 March 2022** | **50,366** | **50,365** |
| **15. Operating Segments** |  |  |

The clinical commissioning group only has one segment, commissioning of healthcare services.

NHS Mid Essex CCG - Annual Accounts 2021-22

1. **Joint arrangements - interests in joint operations**

CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

**Better Care Fund**

The clinical commissioning group has operated a Better Care Fund of £26.9m during 2021-22 (2020-21 £25.6m) together with Essex County Council under a section 75 agreement. This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. This conclusion has been reached as both parties have retained the financial risks associated with each of the schemes as existed before the fund was set up.

The arrangements for each scheme within the Better Care Fund have been reviewed to determine the appropriate accounting treatment by the clinical commissioning group and agreed with 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 Essex County Council to be recorded in the clinical commissioning group's ledger - £11.8m (2020-21 - £11.3m). Where the clinical commissioning group has control over the commissioning of the service the transactions with individual provider(s) are recorded in the ledger - £15m (2020-21 - £14.3m).

In addition to the £26.9m accounted for as above, Essex County Council has received disabilities facilities grants which have been passed to housing authorities in accordance with allocations determined by the Ministry of Housing, Communities and Local Government. The amount of disabilities facilities grants aligned to the clinical commissioning group's localities was £2.8m (2020-21 £2.4m). This scheme is technically within the Better Care Fund but as the clinical commissioning group has no control or input into how this is spent it is not recorded within the clinical commissioning group's accounts.

NHS England has operated a Hospital Discharge Programme during 2020-21 whereby priority has been given to the discharge and care of patients from Hospital settings to ensure capacity was available for Covid-19 patients. NHS England funded both the health and local auhtority costs of care for discharged patients, of the first 6 weeks of care during the first half of the year and the first 4 weeks of care, during the second half of the financial year. The arrangements for the additional funding were captured via variation to BCF section 75

**Transforming Care Partnership**

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

1. **Related party transactions**

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

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

Transactions with the chair, chief executive or members of the board of directors are shown in the remuneration report on page XX There are no other individuals who are considered to meet the definition of related parties under IAS24 as interpreted by the GAM 21/22.

**Part two - Transactions in relation to interests declared by Governing Body Members**

**Payments to Related Party**

**Receipts from Related Party**

**Amounts owed to Related Party**

**Amounts due from Related Party**

**£'000 £'000 £'000 £'000**

All Saints Primary School Maldon-Daniel Doherty (Alliance Director, Mid Essex) - holds a position as Chair of Governors of 0 0 0 0

Active Essex-Daniel Doherty (Alliance Director, Mid Essex) - also a Board Member 0 0 0 0

NHS Basildon and Brentwood CCG - Rachel Hearn (Executive Director of Nursing), Anthony McKeever (Joint Accountable

Officer), Mark Barker (Joint Chief Finance Officer) 107 (1,836) 1,112 (17)

Nursing for NHS Thurrock CCG - Rachel Hearn (Executive Director of Nursing), Anthony McKeever (Joint Accountable

Officer), Mark Barker (Joint Chief Finance Officer) 102 1,800 973 (191)

NHS Castle Point and Rochford CCG - - Rachel Hearn (Executive Director of Nursing), Anthony McKeever (Joint Accountable

Officer), Mark Barker (Joint Chief Finance Officer) 290 (1,318) 992 (34)

NHS Southend CCG - Rachel Hearn (Executive Director of Nursing ), Anthony McKeever (Joint Accountable Officer), Mark

Barker (Joint Chief Finance Officer) 150 (1,775) 749 (602)

Dr Julie McGeachy (GP Board Member) - spouse is employed as Chief Medical Officer at Provide 31,545 - 4 -

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

**Payments to Related Party**

**Receipts from Related Party**

**Amounts owed to Related Party**

**Amounts due from Related Party**

**£'000 £'000 £'000 £'000**

Dr Julie McGeachy (GP Board Member) - a GP partner at Dengie Medical Partnership 1,184 - 28 -

Dr Fatai Salau (GP Board Member) - Douglas Grove Surgery partner 818 - 35 -

Dr Anna Davey (Chair of Mid Essex CCG and Partner at Coggeshall Surgery) 944 - 37 -

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

The Department of Health and Social Care is regarded as a related party. During the year the NHS clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department

Mid and South Essex NHS Foundation Trust

East Suffolk and North Essex NHS Foundation Trust Princess Alexandra Hospital NHS Trust

Cambridge University Hospitals NHS Foundation Trust Specialist acute London hospitals

Essex Partnership University NHS Foundation Trust Hertfordshire Partnership University NHS Foundation Trust North East London NHS Foundation Trust

East of England Ambulance Service NHS Trust North East Essex CCG

West Essex CCG

Basildon & Brentwood CCG Castlepoint & Rochford CCG Southend CCG

Thurrock CCG

NHS Business Services Authority

NHS Arden & GEM Commissioning Support Unit

NHS Mid Essex CCG - Annual Accounts 2021-22

1. **Events after the end of the reporting period**

On 28th April 2022, the Health and Care Bill was approved by Parliament. The Health and Care Bill approves the formation of Integrated Care Boards and for them to take over the functions of Clinical Commissioning Groups. As a result NHS Mid Essex CCG will be dissolved on 30 June 2022 and the Mid and South Essex Integrated Health and Care Board 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 5.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **19 Losses and Special Payments** |  | | | |
| **No losses of special payments have been made in either 2021-22 or 20-21** |
| **20 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: |
| Expenditure not to exceed income | **2021-22**  **Target**  929,272 | **2021-22**  **Performance**  929,017 | 2020-21  Target  634,886 | 2020-21  Performance  634,475 |
| Revenue resource use does not exceed the amount specified in Directions | 928,552 | 928,297 | 634,404 | 633,993 |
| Revenue administration resource use does not exceed the amount specified in Directions | 7,808 | 7,789 | 7,862 | 7,830 |