NHS
Thurrock
Clinical Commissioning Group

Thurrock Clinical Commissioning Group

Annual Report:

April 2022 – June 2022

Contents

Accountable Officer's Foreword

This annual report covers the period between 1 April 2022 and 30 June 2022. It will be our last report as a Clinical Commissioning Group, with our move to being an Integrated Care System.

During this time period, 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 local residents.

We do recognise that many people have had challenges accessing healthcare in recent months. The "digital first" approach that NHS England and NHS Improvement 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 has continued to listen to our communities and work with them to develop models of care that meet everyone's needs. This work will carry on as we begin the next chapter as an Integrated Care System.

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.

Finally, I was to pass on my heartfelt thanks to our local workforce without whom none of this would be possible. I look forward to pushing forward together as an alliance with our local authority, trusts, community providers and wider community and voluntary sector.

Anthony McKeever
Accountable Officer

26 June 2023

PERFORMANCE REPORT

Performance Overview

The purpose of the performance report is to provide information on the CCG's objectives for the 2022/23 financial year, the principal risks to their achievement and how the CCG performed against these objectives. This section provides a precis of the rest of the annual report and accounts.

Accountable Officer's Introduction

Across the mid and south Essex system all services continue to be under extreme pressure with demand higher than capacity. We need to work with our partners to ensure that services are able to safely support our residents with long term conditions and respond to their health needs in a timely manner. Across acute, community and mental health partners the increase in the acuity of people presenting to their services is impacting on length of stay and the ability to meet demand and release capacity. Work continues with wider System partners including local authority and voluntary sector who work collaboratively to enable discharge and care out of hospital enabling people to return to their usual place of residence with the right package of care.

Public services depend on trust. Every time the question of trusted professionals is raised, 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 is evident across the public services we all rely upon. During difficult times collaboration and confidence helps us work effectively and support one another.

Our transition to an "integrated care system" (ICS) on 1st July 2022 – will promote confidence and enhance collaborative working. Over the first quarter of 2022/23 we have been preparing the new ICS to build on the legacy of the five 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. This document reflects the seriousness with which we take our responsibilities as part of an ICS.

Anthony McKeever
Accountable Officer

26 June 2023

What Thurrock CCG does

Our Purpose

NHS Thurrock CCG is a clinically led organisation, established on 1 April 2013, that decides how to spend the NHS budget on the majority of health services for people living in the Thurrock area.

This includes the care and treatment you receive in hospital, maternity services, community, and mental health services. The CCG also assumes full responsibility for commissioning of GP services (since 1 April 2021).

Our role is to specify outcomes that we want to achieve for our population, and then contract with Providers to provide care to achieve those outcomes. We're committed to ensuring the provision of local, high-quality services that meet the specific needs of our population.

We've a statutory obligation to achieve our financial targets and ensure that we live within our means, whilst assuring all centrally set performance targets are met.

Established under the Health and Social Care Act 2012 as a statutory body, every GP from the 27 GP practices is a member of NHS Thurrock CCG. As a CCG, we work hard to understand the needs of people living in Thurrock to commission the right services for the those that live there.

To do this, the vast majority of decisions about how we use public money is made by local clinicians who are closest to the people they look after. We work in partnership with health and social care partners (e.g., local hospitals, local authorities, the community, and voluntary sector). Our governing body is made up of eight representatives of general practice (GPs) from across Thurrock along with a Joint Accountable Officer, Joint Chief Finance Officer, Executive Director of Nursing, NHS Alliance Director, secondary care (hospital) specialist and three Lay Members that are part of a joint management team across mid and south Essex.

The key providers from which the CCG buys health services for the residents of Thurrock 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.
- 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 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.

GP Practices within our CCG have formed Primary Care Networks (PCNs) to develop local primary care services to meet the needs of our residents.

A formal document, called a constitution, sets out the arrangements the CCG has made to ensure it meets its responsibilities for commissioning high quality services for the people of Thurrock.

It describes the governing principles, rules and procedures which will ensure integrity, honesty, and accountability. Also, it commits the CCG to taking decisions in an open and transparent way and places the interests of patients and public at its heart. We last refreshed our constitution in March 2021 to reflect joint working arrangements with the mid and south Essex CCGs.

Our constitution can be requested by emailing icb.enquiries@nhs.net.

Thurrock CCG – facts and figures	
Office Location	Civic Offices, 2nd floor, New Road, Grays RM17 6SL
Communities covered	Borough of Thurrock
Population (registered GP)	184,541 (as at 1 April 2022)
Number of member GP practices on 31 March 2022	27
Total health funding and running costs expenditure (Q1 2022/23)	£66.9m
Average number of employees	55 staff, 50.65 whole time equivalent (WTE)

Our Strategy

The MSE Health & Care Partnership developed its five-year strategy in December 2019. The strategy outlines 4 key ambitions, with the overarching aim to **reduce health inequalities.** The strategy outlines that we would 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 starting work to implement our agreement to a system-wide Anchor Charter in 2021.

- **Supporting health and wellbeing** – including continuing our focus on prevention, self-care, lifestyle support. We have undertaken much work in this area continuing to work in partnership to target prevention opportunities and we have been working with public health colleagues to focus particularly on healthy weight as well as through schemes such as BP at Home.

- **Bringing Care Closer to Home** – where this is safe and possible. We have been progressing with a number of developments through PCNs and Alliances 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 has started to develop and will continue to be key in our future approach to service improvement and transformation.

We will take the five-year strategy into the new ICS and use the early period of the Integrated Care Partnership (ICP) formation to begin work to develop the Integrated Care Strategy – taking our three upper tier local authority Joint Strategic Needs Assessments (JSNAs)[1] and health and wellbeing strategies to develop a single strategy for Mid & South Essex.

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

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.

NHS Mid and South Essex

Key activities in quarter 1 of 2022/23

During 2022/23 the system completed the establishment of the ICS by:

[1] 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, well-being and social care services. They are often, but not always, led by the local authority(ies) of an area but do 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.

- Successfully navigating assurance processes to establish the Mid and South Essex Integrated Care Board (ICB) on 1st July 2022.

- Developing Partnership and governance structures to enable the new Integrated Care Partnership to meet its statutory obligations and continue our collaborative working with partnership organisations as we become established.

- Developing our strategies, policies, and processes to support our working as an Integrated Care System.

- Supporting our four Alliances to further develop their partnership working with local authority colleagues, Healthwatch and community and voluntary sector organisations to further develop delivery plans for their local population.

- Undergoing a staffing re-structure to reflect the change from CCGs to the ICB, supporting our staff through this complex process.

- Completing the closure of the five mid and south Essex CCGs and ensuring responsibilities are appropriately transferred to the new ICB.

- Preparing to take on new responsibilities from NHS England as part of our establishment as an ICB.

- Beginning to embed our Population Health Management (PHM) programme working in collaboration with our PCNs.

- Publishing our engagement strategy that defines how we will gain and use insight from our communities in the work that we do.

- Developing and agreeing a system wide quality strategy, bringing together all aspects of the health system.

- Further developing our system finance approach through the System Finance Leaders Group.

- Embedding joint accountability and assurance through our System Oversight and Assurance Committee, 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 our approach to clinical and professional leadership, including how the clinical and multi-professional congress supports the ICS and our Stewardship programme to ensure the expertise of clinicians and care professionals is at the heart of our work.

- Developing the work of MSE Partners as a means to supporting innovation and improvement.

Integrated Care Board

The ICB will take on all of the functions of the CCGs and, over time, some commissioning functions from NHSE. 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 the Chief Executive Officer (CEO) designate of the new ICB and Professor Michael Thorne CBE, has been appointed as Chair designate of the ICB. Non-executive members for the new ICB Board have been appointed and remaining appointments to the executive team have now been finalised.

NHS England confirmed the creation of the ICB and ICS on 1st July 2022.

Integrated Care Partnership

The ICP has been established as 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 started to develop its work programme. The first task of the ICP is underway whereby we are beginning to develop a new Integrated Care Strategy for the ICS, and for the population of Mid & South Essex.

Local Achievements

Matured the PLACE based Alliance conversation to a stage where we now formalising the governance structures to be business ready from 1/11/22

Increase in the number of ARRS roles recruited to

Thurrock CCG has worked tirelessly through the ups and downs of the pandemic to ensure it meets its statutory duties and goes further in supporting residents with their health, mental health, and wellbeing needs. Below are some of the highlights of the CCG's work that has also included maturing the place-based Alliance conversation to a stage where we are now formalising governance structures to be business ready from 1st August 2022.

Primary Care Delegation

From April 2021, Thurrock CCG has taken on Primary Care delegation for its 27 practices and 4 Primary Care Networks. This will help us to plan, support and shape future primary care services in Thurrock in a way that will benefit patients. NHS England (NHSE) continues to commission services such as Dentists, Pharmacists and Ophthalmology.

Cloud based telephony

The CCG has supported an accelerated upgrade for telephony systems, piloting an innovative project incorporating a cloud-based telephony system on a PCN footprint - run by staff specialising in care navigation. This improves access to support for patients

with minor health concerns and frees up individual practice phone lines. It is envisaged additional functionality such as direct booking for same day face to face appointments via community pharmacies could be added to this service during the pilot phase.

Serious Mental Illness Health Checks

SMI Health Checks – Thurrock has historically had a low uptake for SMI Health Checks, during 2021/22 dedicated Mental Health practitioner were introduced into PCNs, this resulted in 58.9% of SMI Health Checks being completed against a national target of 60%. At the end of Q1 2022/23 49.9% of SMI Health Checks have been completed.

Learning Disability (LD) Health Checks

Learning Disability Health Checks – During 2021/22, Thurrock practices exceeded the national LD Health Check of 80%, carrying out 83.6% of LD Health Checks for eligible patients. Thurrock has also been identified as achieving the highest LD Health Check within MSE during this year. Work during 2022/23 to build on this success is underway with PCNs, setting a local target of 90% and working with system partners to share learning and gain knowledge of good practice throughout the system.

COVID vaccinations

This continued to be a focus throughout 2021/2022 with first, second and booster doses offered via a variety of options, including through two local vaccination sites (GP led), through community outreach/mobile clinics, picking up the hard to reach, including minority ethnic and showman communities. Further work continues to improve uptake following Thurrock Council's UK Health Security Agency's Surge Rapid Response Team (SRRT) and the CCG is supporting their vaccine outreach to continue to increase vaccine uptake in specific areas and certain communities. A dedicated local vaccine website was set up to support better access to information across greater Essex at www.essexcovidvaccine.nhs.uk.

Linking with system partners to improve vaccination rates in relation to the Autumn Booster campaign. Targeting and using initiatives to target hard to reach communities and high-risk groups within Thurrock.

Thurrock Lung Health Checks

Thurrock and Luton CCGs were selected as part of a national programme to detect lung cancers at earlier stages, resulting in better outcomes for all involved. Targeted lung health checks are an important part of our overall strategy to reduce deaths from lung disease in Thurrock. The programme started in 2020 and was paused during COVID but restarted fully in April 2021 and will run until April 2024.

Long term conditions support via GP practices

BP@Home, Diabetes Three Treatment Improvement Targets (3TT) Project, ACR Testing at Home Programme, Skin Analytics, tele-dermatology pilot and community COPD Asthma Diagnostic Services were all launched in this financial year. These programmes are designed to support people with common long-term conditions and pick up conditions early so treatment can start as soon as possible. They also avoid unnecessary admissions/attendances at hospital.

Many of these programmes of work involve the use of apps and technology and are replicated across practices in mid and south Essex, resulting in significant improvements in patient outcomes.

Funding has been made available for Thurrock to improve the management of patients with diabetes. The project (3TT) began in September 2021, with 90% of practices signed up. During this period, there has been an increase of 49% of the number of patients screened, equalling 842 additional patients screened. A significant improvement in patients has been recorded. 3TT will continue into 2022/23 with 100% practices signed up to the programme.

National Diabetes Prevention Programme (NDPP) – within Thurrock GP referrals at the end of Q1 are at 242 of the profile target of 210 to date. During 2021/22 GPs made 1,301 referrals against a target on 855. Thurrock has also achieved 95% uptake of patient sign up and engagement with the programme. Thurrock is the best performing CCG across Mid and South Essex for NDPP.

Aerosol Generating Procedures (AGP)

During the COVID-19 pandemic AGPs were suspended in line with guidelines. Due to the gap in service provision and an unmet need, Thurrock commissioned Microsuction services through all 4 PCNs and a spirometry respiratory service through a Primary Care provider for the population of Thurrock during 2021/22.

Winter Access Service

Implemented in December 2021, this service provided extra capacity and appointments in general practice, supporting with pressures during the Omicron wave. 14,000 additional face-to-face appointments were created and delivered through the Winter Extended Health Hubs.

Self-Management Apps

The CCG has continued to fund tools for patients on the My mHealth platforms, including myDiabetes, myCOPD, myAsthma enabling greater monitoring for patients and health professionals. In Thurrock over 1000 licences have been activated for these apps.

Clinical / Pharmaceutical

At July 2022, Thurrock is demonstrating the 3rd lowest prescription cost per patient for NHS England Low Priority Treatments, a national measure that looks at prescription items which should not be prescribed in primary care due to lack of evidence, cost-effectiveness, or safety issues.

How we have performed

The CCG monitors health outcomes against a range of NHS Constitutional Standards' that are set nationally[1]. Performance across the system has generally been below the set standards due to capacity pressures throughout the health and care system.

The CCG has been 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 affecting the delivery of performance and recovery is ensuring workforce is in place to meet the delivery of the increased capacity required to recover and meet demand.

Key issues and risk

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

Measuring our performance against a range of indicators, including nationally agreed quality standards, is important for our patients and the public as they relate to key areas such as access, treatment times and quality of care. Performance against these targets, and the plans we have to improve them, is overseen by the Finance and Performance Committee.

2022/23 has, as outlined within this report, provided challenges to delivery and recovery of performance standards. The below summary shows the performance as reported in June 2022, this is the most up to date information at time of writing this report.

Mid and South Essex continues to work collaboratively with our provider partners to support recovery of performance standards and outcomes for our population. This work is ongoing and continues in the work of the ICB.

Performance summary

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

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

The UEC Strategic Board oversees performance and planning for all UEC services (East of England Ambulance Service (EEAST), NHS111, A&E, Urgent Community Response Team (UCRT), Mental Health Emergency Department (ED) and has members from both health and social care.

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.

Organisations across the system are working collaboratively to improve ambulance offload times (for conveyed patients) and the flow through ED. For example, community providers have an Urgent Community Response Team (UCRT) team working with EEAST to, where appropriate, provide an alternative to conveying patients to acute hospital. 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. The EEAST Hospital Ambulance Liaison Officer (HALO) are working within Mid and South Essex Foundation Trust (MSEFT) 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.

The key issues for the UEC programme include the following where performance is below standards:

Ambulance Response Times

Standards:

- *Respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes*
- *Respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes*
- *Respond to 90% of Category 3 calls in 120 minutes*
- *Respond to 90% of Category 4 calls in 180 minutes*

The ambulance response times remain below the NHS constitutional standards.

The following table shows the range of 90th centile and mean response times across Thurrock CCG for each of the four categories of calls and respective standards.

Metric		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Category 1 Calls (Total category 1 calls) (Standard: Mean <= 7min; 90th Centile <= 15min)	*Mean*	*00:11:27*	*00:11:16*	*00:11:15*									
	90th Centile	*00:17:38*	*00:19:37*	*00:18:24*									
Category 2 Calls (Standard: Mean <= 18min; 90th Centile <= 40min)	*Mean*	*01:25:29*	*01:12:23*	*01:09:52*									
	90th Centile	*03:13:20*	*02:37:31*	*02:32:43*									
Category 3 Calls (Standard: 90th Centile <= 120min (02:00:00))	*90th Centile*	*12:17:18*	*12:50:45*	*12:12:31*									
Category 4 Calls (Standard: 90th Centile <= 180min (03:00:00))	*90th Centile*	*20:17:18*	*01:07:23*	*16:26:41*									

Emergency Department – waiting times.

Standard:

- *95% of patients have a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge*

Within MSEFT A&E (Type 1), the 95% four-hour performance is below the constitutional standard as per following table.

Metric		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22 to 27/09	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Emergency Department - 4 hour standard - type 1 (Standard: >=95%)	*Total*	*28,175*	*31,117*	*29,872*	*29,832*	*27,586*	*24,790*						
	Breaches	*9,881*	*10,342*	*10,009*	*10,605*	*10,077*	*9,429*						
	Performance	64.9%	66.8%	66.5%	64.5%	63.5%	62.0%						

- **Elective Care**

Key issues for the Elective programme include waiting time performance being below standards for Diagnostics, Cancer and RTT (Referral To Treatment).

Diagnostics Waiting Times

Standard:

- *The constitutional standard is no more than 1% of patients waiting 6 weeks or more for a diagnostic test and no patients waiting 13+ weeks.*

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.

The waiting times for diagnostic tests remain below the NHS constitutional standards.

During Quarter one 2022/23, 52% of patients waited less than six weeks (below standard of >= 99%) with circa 23% of patients waiting over 13 weeks (below standard of zero) at Thurrock CCG.

The System Diagnostic Board oversees performance and planning for diagnostics across MSE supported by sub-groups including assurance.

A significant acute challenge lies in non-obstetric ultrasound. An identified issue includes workforce capacity regarding Sonographers.

Cancer Waiting Times

Standards: For people with suspected cancer:

- *To see a specialist within 14 days of being urgently referred by their GP or a screening programme.*
- *To not wait more than 28 days from referral to getting a cancer diagnosis or having cancer ruled out.*
- *To receive first definitive treatment within 31 days from decision to treat*
- *To start drug, radiotherapy, and surgery subsequent treatments within 31 days*
- *To receive their first definitive treatment for cancer within 62 days of receipt of urgent referral.*

The waiting times for patients on a cancer pathway remain below the NHS constitutional standards.

The following table shows the Quarter one 2022/23 position for Thurrock CCG for each of the waiting time standards.

Two week wait	Two week wait breast symptomatic	28 Day Faster Diagnosis Standard	31 day first treatment	31 day subsequent treatment Drug Treatments	31 day subsequent treatment Radiotherapy Treatments	31 day subsequent treatment Surgery	62 day standard	62 day standard (Screening)	62 day standard (Upgrade)
Standard (>=93%)	Standard (>=93%)	Standard (>=75%)	Standard (>=96%)	Standard (>=98%)	Standard (>=94%)	Standard (>=94%)	Standard (>=85%)	Standard (>=90%)	
44.4%	21.1%	50.2%	88.2%	98.5%	84.5%	67.7%	38.0%	41.7%	50.0%

The MSE HCP Cancer, Palliative & End of Life Care Board oversees cancer assurance and transformation supported by sub-groups including the Cancer Programme Delivery Group (for assurance and focus on national, regional, and local commitments and deliverables); Quality Cancer meeting; and the Palliative Care Delivery group.

The wider system 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.

Referral to Treatment (RTT) Waiting Times

Standards:

- *The constitutional standard is starting consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. Since the significant increase in waiting times following the global COVID pandemic, the NHS is working to achieve the following 2022/23 planning round asks:*
  - *eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 (except where patients choose to wait longer)*
  - *Reduce the number of patients waiting 78+ weeks on an RTT pathway to zero by March 2023*
  - *Reduce the number of patients waiting 52+ weeks on an RTT pathway to zero by March 2025*

As of Quarter one 2022/23, there were 6 patients waiting 104+ weeks, 92 patients waiting 78+ weeks and 1,338 patients waiting 52+ weeks on an RTT pathway for Thurrock CCG.

The Elective Board oversees RTT assurance.

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 to 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.

- **Mental Health**

A key issue for the mental health work programme is workforce capacity and constraints with recruitment to mitigate against workforce vacancies. In terms of governance, performance is overseen at the Mental Health Partnership Board.

Improving access to psychology therapies (IAPT)

Standards include:

- *75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within 6 weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral*

The six and 18-week waiting time standards for people referred to the IAPT programme to start treatment is being sustainably achieved across Thurrock CCG.

A priority is to increase IAPT in terms of number of people accessing the programme.

Early Intervention in Psychosis (EIP) access

Standard:

- *more than 50% of people experiencing first episode psychosis commence a National Institute for Health and Care Excellence (NICE)- recommended package of care within two weeks of referral.*

The EIP access standard is being sustainably met for Thurrock CCG.

Improve Quality

Q1 2022/23 has continued to bring challenges and demands on our services, during which time colleagues from all sectors have worked hard to ensure we continue to maintain quality care to thousands of patients across our system.

Mid and South Essex CCGs (MSE) have continued to maintain core quality functions, such as serious incident monitoring and investigation, safeguarding, quality assurance and infection prevention and control. At times having to prioritise our work to flex with the needs of the system working towards the transformation of services and processes in readiness for transition to the ICB.

Care Quality Commission (CQC)

The ratings of our primary providers remain as:

- Provide Community Interest Company - Outstanding
- Essex Partnership University Trust (EPUT) Community - Good
- Mid and South Essex Foundation Trust (MSEFT) – Requires Improvement
- EPUT Mental Health Services – Requires Improvement
- North East London Foundation Trust Community Services – Required Improvement
- East of England Ambulance service – Requires Improvement

Following a review of Maternity services, the 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, with ongoing support provided through 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.

System Quality

The establishment of the Mid and South Essex System Quality Group has significantly strengthened the quality surveyance, oversight and wider system learning from all key

providers and partners. This group has been instrumental in developing system strategy leading into the Integrated Care Board and Partnership.

Patient Safety Specialist meetings continued as one of the elements from the National Patient Safety Strategy. These meetings aim 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.

Mental Health Quality Teams have continued to work closely with Essex Partnership University NHS Foundation Trust (EPUT), the newly formed Mental Health Provider Collaborative and other local providers to ensure robust oversight of the quality and safety of care provided.

Special Educational Needs and Disability (SEND)

The Ofsted & CQC revisit took place between 13 and 15 December 2021. The area was found to have made sufficient progress in addressing all three of the significant weaknesses identified at the initial inspection. They noted that:

- Area leaders had invested significantly in staffing and resources to improve oversight
- Leaders have established a holistic approach across health, social care and education that is centred on achieving improved services, provision and outcomes for children and young people with SEND
- Improvement in the quality of EHC plans alongside better processes were evident.

Infection Prevention and Control

The Infection Prevention and Control team have remained busy with continued oversight of the Covid-19 response as well as healthcare associated infections such as Methicillin resistant Staphylococcus aureus bacteraemia (MRSAB) and Clostridioides difficile infection (CDI) cases. The team continue to support all providers across the Mid and South Essex locality

Patient Experience

The Quality Teams have continued to ensure the voice of the patient is heard for example through the programme of patient stories which capture authentic lived experiences. This, in turn, is shared with Commissioners and has directly influenced commissioning decisions. Furthermore, co-production with patients and services users was a key focus of stakeholder development of the MSE Quality Strategy.

Care Sector

The Quality team continued to support the provision of Enhanced Care in Care Homes. This has furthered the support provided to homes during the Covid-19 pandemic with

continued training and new technology to support remote and daily hub calls to enable rapid responses to our homes.

Reducing Health Inequality

Duty to reduce 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. This in turn can 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 an enhanced 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.

The work to reduce health inequalities is driven by a maturing network of equity leadership. All system providers have a named Inequalities Senior Responsible Officer (SRO), and each Alliance has named inequalities leads who will support the Primary Care Networks (PCN's).

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. 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. Following a co-design initiative for people with Learning Disabilities accessing hospital services in 2021-22, MSEFT began to implement a detailed action plan 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 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 which are Cardiovascular disease, Maternity, Cancer, Respiratory and Mental Health). 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.

The work across the health partners within Mid and South Essex continues to be focused on:

- Restoring NHS services inclusively which incorporated analysing the waiting lists by ethnicity and deprivation to support local action plan to reduce the barriers to accessing service for certain groups
- Mitigating against digital exclusion by maintaining access to face-to-face consultations to ensure digital access does not disadvantage some patients
- Ensuring datasets are complete and timely by improving data collection on ethnicity across all healthcare settings
- Accelerating preventive programmes that proactively engage those at greatest risk of poor health outcomes which includes ensuring high level of vaccination uptake across all areas of the population, health checks are undertaken for people with Learning Disabilities or Serious Mental Illness, and a focus on the five clinical areas within the Core20 plus 5 framework.

Within Primary Care, the Tackling Neighborhood 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 will be 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.

We have also begun the development of an overarching ICS Health Inequalities Strategy.

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. 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.

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 engagement activities that have taken place in this reporting period (April – June 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 Thurrock 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 Thurrock Commissioning Reference Group held every two months with invitees including delegates Healthwatch Essex, GP patient participation groups, charities, and local authorities.
- Attending CCG meetings and Governing Body meetings held in public.
- Seeking involvement with 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. In 2022 we asked for their views on; GP access and shared decision making. 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.

Partnerships across the health and care system

We actively worked and collaborated with our local Healthwatch and voluntary, community and faith sector colleagues.

Following the successful work undertaken by the Essex Vax Van which enabled a new model of outreach and ensured a culturally sensitive approach for communities not engaging in the national Covid-19 vaccination programme, was then used for spirometry testing into the community.

We listened to feedback on a local weight management clinical pathway which has informed a new model and covers the whole of mid and south Essex.

Improving accessibility to healthcare information

The CCGs have continued to improve accessibility to healthcare information working closely with the Council for Voluntary Services (CVS). Work includes providing information in a number of formats; easy read, information in different languages or through for learning disabilities and videos produced by the CCG with subtitles and where possible a British Sign Language interpreter on the screen.

Children's Health Matters**:** we worked with parents and carers of children aged 0-5 living in mid and south Essex to co-design a useful guide to better manage childhood Illnesses. It provided an opportunity for them to influence local communications and behaviour interventions and support our campaign. This has led to the delivery of regular electronic newsletters to the right audiences, with the right messages, that parents and carers have supported.

Social media and digital marketing

The CCG has also presented appealing, insights-driven digital communications in line with priorities, offer opportunities for engagement and are viewed as a trusted source of information.

Our digital communications channels including social media, website and e-publications have been used to:

- ✓ Explain and showcase CCG work to residents of mid and south Essex, health, and social care colleagues and beyond.
- ✓ To encourage residents to engage with the CCG via its digital channels, motivate those individuals to take action that will help them stay well and use health and care resources appropriately, and support them to lead their best lives.
- ✓ To build the CCGs online presence.
- ✓ To analyse digital engagement data to build insight-driven campaigns that are supported, shaped, and shared by organisations across the Partnership, and to measure and evaluate the effectiveness of those campaigns

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 which continues to 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 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 (HWB) Boards, as well as district, borough, and city fora. CCG leaders are core members of the HWB 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 (UTLAs) we have continued work on a joint mental health strategy, as well as a children's partnership plan.

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

Financial Review

Financial overview

Our full statutory financial accounts are included from page 78 onwards. This section provides a summary of our 2022/23 financial position from 1 April 2022 to the cessation of the CCG on 30 June 2022. Our Head of Internal Audit offers an opinion on Financial Systems Key Controls and other matters which can be found on page 53. whilst our overall financial management arrangements and financial statements were subject to audit review and opinion by our external auditors, KPMG, as part of their annual review of our accounts (see page 106 for their full audit opinion).

CCG funding

During the period 1 April 2022 to 30 June 2022 (Q1) the CCG has continued to operate under the financial regime and allocation methodology that was put in place at the beginning of 2020/21 to support the ongoing response to the Covid pandemic this has been subject to a few modifications.

Firstly, arrangements for healthcare have been considered to be in a period of post pandemic recovery resulting in a cessation of funding for the Hospital Discharge Programme (HDP) to support discharges from Hospital once patients have been medically optimised to allow for recovery of the Elective backlog and secondly the

transition from CCGs to Integrated Care Boards that has been agreed nationally and became effective from 1 July 2022.

This has led to funding changes for the final CCG reporting period where the final CCG allocation has been matched to equal CCG costs incurred with any under or over expenditure compared to the anticipated allocation being adjusted in the remaining allocation for the successor body the Integrated Care Board.

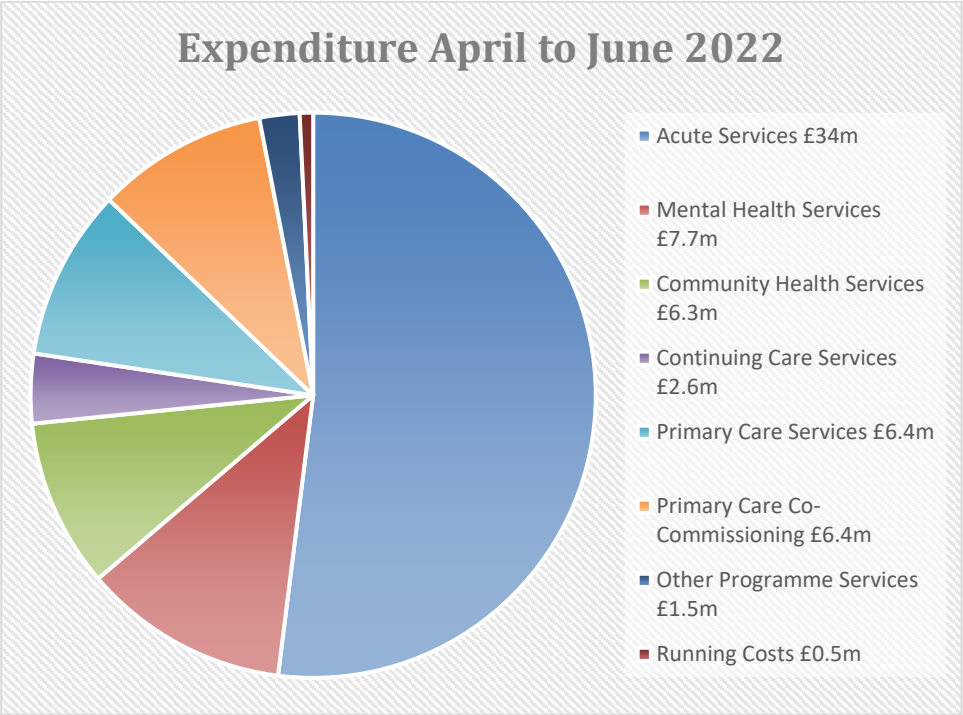
Mid Essex CCG has continued as the nominated lead CCG for receiving and managing the distribution of most non-organisational specific system allocations. As a CCG we received allocations directly attributable to Thurrock CCG healthcare services.

In Q1 2022/23, our in year total healthcare funding was £65.4m CCG expenditure for Q1 was £65.4m, resulting in a net breakeven position.

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 2022/23 the MHIS was set for the whole financial year and was achieved.

How your money was spent

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



Capital spending

We did not require a CCG capital allocation for Q1 2022/23, 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 the latter. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. In Q1 2022/23 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 of the Prompt Payment Code. The government designed this initiative with the Chartered Institute of Credit Management 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 ceased to exist on 30 June 2022 and on 1 July 2022 the 5 CCGs became Mid and South Essex Integrated Care Board.

Published allocations for 2022/23 have been split between CCGs and the Mid and South Essex Integrated Care Board although performance will be monitored on a full year basis. Following the demise of the CCGs on 30 June 2022 the Mid and South Essex Integrated Care Board manage and oversee the balance of £1.891bn healthcare funding and investment on behalf of the healthcare system and will report following closure of its first period of accounts running from 1 July 2022 to 31 March 2023.

Risks

The CCG's risk profile as a 30 June 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	1	4	0	5

Workstream	RAG Rating			Total No of Risks
	Green	Amber	Red	
Digital and Business Intelligence	1	3	0	4
Estates	0	2	0	2
Finance	0	2	3	5
Health Inequalities	0	1	0	1
Integrated Care System	2	3	0	5
Maternity	0	2	1	3
Medicines Optimisation	0	1	0	1
Mental Health and Learning Disability	0	4	3	7
People	1	1	1	3
Planned Care	1	2	2	5
Population Health Management	1	2	0	3
Primary Care	2	5	0	7
Stewardship	0	0	0	0
Urgent Emergency Care	1	6	0	7
Vaccination	0	1	0	1
Total as at 30 June 2022	**13**	**46**	**8**	**67**
Total as at 31 March 2022	13	47	8	68

During Q1 of 2022/23 the MSE CCGs' risk profile has seen the total number of risks reduce by 1 (from 68 at 31 March 2022 to 67), although the number of red rated risks remains static.

As of 30 June 2022, there were 8 red-rated risks, which related to the following 4 areas of the CCG's business:

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

The MSE 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 in Donna Ockenden's reports following an 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 and Learning Disability 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 is planned to be concluded and to publish its report in Spring 2023.

The quality assurance of Autism Spectrum Disorder (ASD) services was added to the risk register in May 2022 due to a significant number of individuals waiting over 12 months for assessment and diagnosis.

An impact of this is primarily due to an overall increase of referrals which has meant patients dealing with longer waiting times, and large referral backlogs across the ICB. Having to wait a long time for an ASD diagnosis can have a negative impact on the person's daily life, their physical and mental health, social functioning, and employment.

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. The system will begin a one workforce approach through a Health Education England funded academy for Health Care Support Workers. The aim is to develop a sustainable pipeline by onboarding and developing our unqualified workforce through associate and apprenticeship roles.

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".

An ICS Green Plan has been in 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.

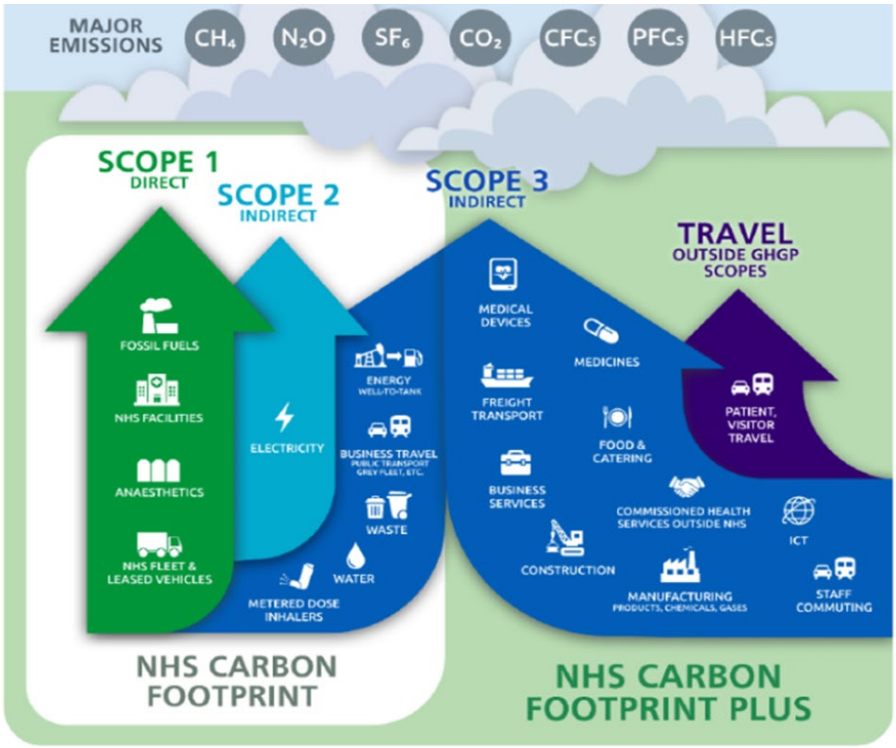


Figure 1: Greenhouse Gas Protocol (GHGP) scopes in the context of the NHS

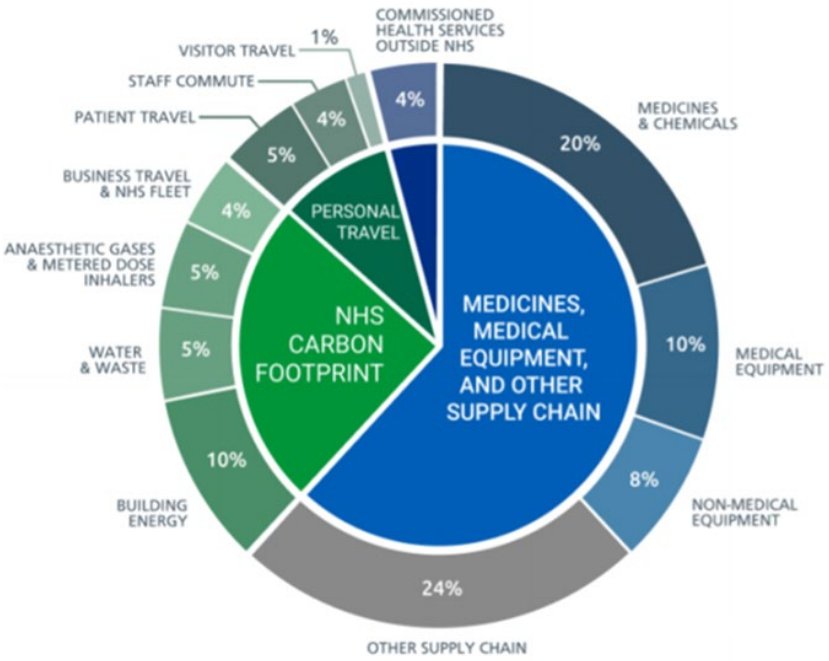


Figure 2: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

ACCOUNTABILITY REPORT

Corporate Governance Report

Members Report

Member Profiles

CCGs are clinically led membership organisations made up of general practices. As of 30 June 2022, the following 27 NHS practices are members of Thurrock CCG:

Member Name	Practice Address
Hassengate Medical Centre	Southend Road, Stanford-le-Hope, Essex, SS17 0PH
Neera Medical Centre	2 Wharf Road, Stanford-le-Hope, Essex, SS17 0BY
Orsett Surgery	63 Rowley Road, Orsett, Essex, RM16 3ET
The Surgery, Horndon-on-the-Hill	High Road, Horndon-on-the-Hill, Essex, SS17 8LB
The Sorrells Surgery	7 The Sorrells, Stanford-le-Hope, Essex, SS17 7DZ
Southend Road Surgery	271A Southend Road, Stanford-le-Hope, Essex, SS17 8HD
Balfour Medical Centre	2 Balfour Road, Grays, Essex, RM17 5NS
Chafford Hundred Medical Centre	Drake Road, Chafford Hundred, Essex, RM16 6RS
The Dell Medical Centre	111 Orsett Road, Grays, Essex, RM17 5HA
East Thurrock Road Medical Centre	34 East Thurrock Rd, Grays, Essex, RM17 6SP
The Grays Surgery	78 High Street, Grays, RM17 6HU
Milton Road Surgery	12 Milton Road, Grays, Essex, RM17 5EZ
Oddfellows Hall Health Centre	Odd Fellows Hall, Dell Road, Grays, Essex, RM17 5JY
Primecare Medical Centre	167 Bridge Road, Grays, Essex, RM17 6DB
Stifford Clays Medical Practice	Crammavill Street, Stifford Clays, Grays, Essex, RM16 2AP
Thurrock Health Centre	55-57 High Street, Grays, Essex, RM17 6NB PCN
Aveley Medical Centre	22 High Street, Aveley, Essex, RM15 4AD
Derry Court Medical Centre	Derry Court, Derry Ave, South Ockendon, Essex, RM15 5GN
Pear Tree Surgery	Pear Tree Close, South Ockendon, Essex, RM15 6PR

Member Name	Practice Address
Purfleet Care Centre	Tank Hill Road, Purfleet, Essex, RM19 1SX
The Sancta Maria Centre	Daiglen Drive, South Ockendon, Essex, RM15 5SZ
Dr Yasin Surgery	Darenth Lane, South Ockendon, Essex, RM15 5LP
Commonwealth Health Centre	Quebec Road, Tilbury, Essex, RM18 7RB
Medic House	Ottawa Road, Tilbury, Essex, RM18 7RJ
The Rigg Milner Medical Centre	2 Bata Avenue, East Tilbury, Essex, RM18 8SD
Sai Medical Centre	105 Calcutta Road, Tilbury, Essex, RM18 7QA
Tilbury Health Centre	London Road, Tilbury, Essex RM18 8EB

Composition of Governing Body

The CCG's Governing Body is the accountable body for the performance of the CCG. It has 8 GP members elected by their fellow GPs to lead the organisation alongside the Executive membership. One of these elected GPs, Dr Anil Kallil, chairs the Governing Body meeting.

The Governing Body also has three lay members (one vacant post as at 30 June 2022). Their roles include 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. In addition, 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 Governing Body.

The Governing Body also comprises of the Accountable Officer, Chief Finance Officer, Executive Director of Nursing, NHS Alliance Director. Representatives from the Local Authority and other CCG Executive Directors are regular attendees.

As of 30 June 2022, the board consisted of 15 members. Of these, 4 are female, 11 are male.

The main function of the Governing Body is to ensure that the group has appropriate arrangements in place to exercise its functions effectively, efficiently, and economically and in accordance with the group's principles of good governance. The other key functions are outlined in the CCGs constitution.

In February 2022, the Governing Bodies of Basildon and Brentwood, Castle Point and Rochford, Mid Essex, Southend, and Thurrock CCG, collectively referred to as Mid and South Essex (MSE) CCGs, agreed to 'meet in common' until establishment of the MSE Integrated Care Board on 1 July 2022. This meant that each Board met in the same place (virtually via MS Teams), at the same time, although they still made decisions as separate bodies. These arrangements enabled decisions affecting the whole MSE population to be made collectively.

The following people have been CCG Board Members during 2022/23:

- **Dr Anil Kallil, CCG Chair**

  Dr Kallil has been working as a GP in Orsett for 14 years. Before this he worked in Hospital Medicine. Dr Kallil is one of the clinical leads for the Thurrock Health Hubs and on 26 February 2020 was selected by the governing body to become the CCG Chair. Dr Kallil has been a former Board Member and interim Medical Director for a former out-of-hours primary care provider. Dr Kallil was also a board member for Thurrock Primary Care Trust before it was officially granted the legal status as a Clinical Commissioning Group.

- **Anthony (Mac) McKeever, 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 was appointed Interim Joint Accountable Officer for the Mid and South Essex CCGs from 1 March 2020.

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

- **Mark Barker, 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.

- **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.

- **Mark Tebbs, NHS Alliance Director**

  Mark joined Thurrock CCG in 2013 and has been a member of the board for the last five years, driving work on integrated care within the CCG as well as undertaking the role of senior responsible officer for mental health across the Mid and South Essex Health and Care Partnership. In March 2020, Mark became the Deputy Accountable Officer for the CCG and from November 2020 Mark's primary responsibilities are as the NHS Alliance Director for Thurrock. This enables him to continue developing effective working relationships, with our partners and a culture of delivery across the Thurrock Alliance, supporting Primary Care Network development and ensuring the effective operation of the local urgent care system.

- **Lesley Buckland, Deputy CCG Chair, Lay Member (Governance) and Chair of Audit Committee**

  Lesley's professional background is in Human Resource Management. Lesley has held senior management roles in Industry and within the NHS. The latter part of her career as Head of an Academic Department and the Director of the Institute of Vocational Learning, based in London Southbank University. Lesley has also held non-executive roles in the NHS for over nineteen years. Lesley chairs the Audit Committee and is a member of several other committees in her role as Lay Member Governance. Lesley also chairs the Mid and South Essex Joint Committee Finance and Performance Committee which met in common across Mid and south Essex during the pandemic. Lesley was Chair and continues as a Trustee of a Charity /Social Enterprise, focussing on the Care of the Elderly with an emphasis on supporting clients with Dementia.

- **Pauline Stratford, Lay Member**

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

- **Dr Rachael Liebmann, Secondary Care Consultant**

  Dr Rachael Liebmann is a secondary care clinician and board member for NHS Thurrock Clinical Commissioning Group (CCG). Rachael is a past vice president of the Royal College of Pathologists and has over 20 years' experience as an NHS consultant. Dr Liebmann has also been shortlisted for the National Patient Safety Awards and Health Service Journal 'Clinical Leader of the Year' and was awarded the College Medal for Distinguished Service. In 2020 Dr Liebmann was awarded an OBE for her service to pathology.

- **Dr Anjan Bose, GP Governing Body Member and Clinical Tutor Lead**

  Dr Bose is the Clinical Lead and Educational Tutor in NHS Thurrock CCG. He has been a GP since 1992 and specialises in pulmonology and diabetes (GPwSI). Dr Bose is an active participant in the Diabetes Network, is a member of the Foot Care Network and has been actively running educational courses

since 1999 and champions Medicines Optimisation. Dr Bose facilitated the Primary Care Time to Learn sessions and continues to do so having be re-elected as a GP Board Member in February 2020.

- **Dr Anand Deshpande, GP Governing Body Member**

  Dr Deshpande has sat on the CCG's governing body since 2013, serving as the Chair between April 2013 and February 2020. Before becoming Chair of NHS Thurrock CCG, he has been a board member of previous Thurrock NHS organisations related to primary care, holding various portfolios. He has also been Executive Board Member of the South Essex Primary Care Trust and chaired the South Essex Local Medical committee for three years. Dr Deshpande has represented GPs from the whole of Essex in the British Medical Association (BMA) GP Committee in London for six years. He has been instrumental in leading on primary care transformation and supported the bid to fund Thurrock's four health hubs. Dr Deshpande has been practising as a GP since 1991 in Thurrock and practices with a partner as a GP at Neera Medical Centre, Stanford-Le-Hope. His ambition is to work with NHS England to develop services in the community nearer to the patients in Thurrock.

- **Dr Luis Leighton, GP Governing Body Member and Respiratory Lead**

  Dr Leighton, re-elected as a GP Board Member in February 2020, trained at The Middlesex Hospital Medical School in London qualifying in 1979 and completed his GP training in Chesterfield. He has over 33 years' experience as a GP in Thurrock and is also an occupational health specialist in the locality. He also works for the local Hub. Dr Leighton is the Respiratory Lead for the CCG.

- **Dr Sanjeev Maskara, GP Governing Body Member and Chair of the Clinical Engagement Group**

  Dr Maskara joined NHS Thurrock CCG as a Governing Body member in November 2017 and is chair of the Clinical Engagement Group, continuing this role into 2020/21 having been elected as a GP Board Member in February 2020. Dr Maskara is a GP partner, trainer, NHS GP appraiser and GP Specialist Adviser (GP SpA) for the Care Quality Commission (CQC). Dr Maskara's areas of expertise are elderly care, chronic disease management, and he is passionate about teaching and training especially medical education.

- **Dr Rajan Mohile, GP Governing Body Member and Mental Health Lead**

  Dr Mohile has been a member of the CCG governing body since April 2013, having been re-elected in February 2020. He is Mental Health Lead for the CCG and works as a GP in Grays. Dr Mohile trained at St Bartholomew's Hospital before receiving his GP training in Maidenhead. He has over 35 years' experience as a GP and was a founding Chairman of an out of hours service. He is also the former Chairman of South West Essex Diabetes Network and a member of the Grays Thurrock Rotary Club.

- **Dr Thamotherampillat Nimal-Raj, GP Governing Body Member and Cancer Lead**

  Dr Nimal-Raj has been a long-standing Member of NHS Thurrock CCG, he has been a GP Governing Body Member, having been re-elected in February 2020. Dr Nimal-Raj works as a GP at surgeries in Purfleet and East Tilbury. Dr Nimal-Raj was a senior GP in Purfleet Care Centre from when it was established in 2003 until 2016. Dr Nimal-Raj is the lead for unplanned care and cancer care.

- **Dr Henry Okoi, GP Governing Body Member, Medicines Optimisation Lead**

  Dr Okoi has been working in Thurrock as a GP since October 2006. He became a CCG board member in January 2017 when he was also appointed as Medicines Management lead and continues this role having been re-elected in February 2020. As a governing body member, Dr Okoi has provided independent robust scrutiny to the work of the CCG, specifically in chairing the CCG Quality and Patient Safety Committee, supporting the CCG to improve the health of residents of Thurrock. As Medicines Management lead, Dr Okoi has worked closely with his team to enhance the safety of prescribing in Thurrock. Dr Okoi is also a GP Trainer, preparing the next generation of GPs for the NHS.

- **Ahmed Yasin, Practice Manager Governing Body Member**

  Ahmed is a retired pharmacist having spent the majority of his working life in the pharmaceutical industry and leaving GSK in 2015 as the Head of Formulation Development for macromolecules. He spent one year as a CMC director at Novaliq in Germany before joining his GP wife at her surgery in South Ockendon as a non-clinical partner. He is also the non-clinical lead for the Aveley, South Ockendon and Purfleet (ASOP) PCN and he joined the board having been elected as the Practice Manager Board Member in February 2020.

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 39 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. This is available upon request by contacting mseicb.enquiries@nhs.net.

Modern Slavery Act

The CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. The Modern Slavery Act statement of the MSE CCGs has been adopted by the MSE ICB and is published on the website at Modern Slavery Act Statement (hyperlinks)

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 Q1 2022/23, there were 46 complaints opened and 42 complaints closed, with 4 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.

No complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) in 2022/23.

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 Anthony McKeever to be the Accountable Officer of Thurrock 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; and
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced, and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced, and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Thurrock 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.

Anthony McKeever
Accountable Officer

26 June 2023

Governance Statement

Introduction and Context

Thurrock 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. In particular, the CCG is 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 of 1 April 2022, the CCG is 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. As outlined within the CCG's 2021/22 Annual Report, due to business continuity arrangements implemented by the CCGs from mid-December 2021 to the end of February 2022, all business delegated to the JC was conducted by the CCG Boards meeting in common 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 CCG 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 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. 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 27 member practices within Thurrock CCG, serving a registered population of approximately 184,541patients as of 1 April 2022. The practices were formed into 4 Primary Care Networks (PCNs) across Thurrock from 1 July 2019. Details of the PCNs are shown in the table below:

Primary Care Network	Number of Practices	Registered Patient Population as at 1 April 2022
Stanford-le-Hope and Corringham	6	32,753
Grays	10	73,561
Aveley, South Ockendon & Purfleet	6	40,392
Tilbury & Chadwell	5	37,988

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.

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) was established. The Boards met in common on one occasion during Quarter 1 (Q1) of 2022/23 on 26 May 2022. The Boards also approved the MSE System Financial Plan for submission to NHS England in June 2022 via an Emergency Powers decision.

The Board meeting was broadcast via 'MS Teams' which enabled members of the public to listen to discussions held and submit questions.

The decisions of the CCG Board were quorate whereby any member who was not present at the meeting confirmed their support for the recommendations made.

Membership of the Board is set out on page 31 of the Members Report.

The Board undertakes an annual review of its effectiveness. The 2021/22 review determined that it fulfilled 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 is set out below.

During Q1 of 2022/23 the five MSE CCGs held their main committee meetings in common, these being Audit; Finance & Performance; Patient Safety & Quality (or equivalent); Primary Care Commissioning; and Remuneration.

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 MSE CCGs' main providers, met in private during Q1 of 2022/23.

In principle, each main committee submits its approved minutes to the Board[2]. 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, resilience and response (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, Lesley Buckland. As of 30 June 2022, the Committee's other members were Pauline Stratford, Lay Member (Primary Care) and Dr Rachael Liebmann, Secondary Care Consultant.

During Quarter 1 of 2022/23, the Committee met in common with the other MSE CCG Audit Committees on 2 occasions, plus 1 extraordinary meeting to review draft policies developed for the MSE ICB. Decisions were quorate in line with its Terms of Reference (minimum of two core members) on all occasions. Where any member was not present at the meeting their support for the recommendations made were submitted virtually.

During Q1 of 2022/23 the Audit Committee continued to focus upon ensuring the review of the systems, policies, procedures, and processes fundamental to the governance of the organisation. The committee also undertook a review of policies being developed

[2] where minutes had not been approved in time to submit to the final meeting of the CCG Boards, they were submitted to the relevant committee of the Integrated Care Board.

for the MSE ICB relating to areas within the committee's remit and had oversight of the governance of transition to the ICB.

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 for 2021/22 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 also received 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 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 for 2021/22 which identified 'reasonable' assurance. The requirement to submit quarterly returns to NHS England regarding the CCG's adherence to the mandatory guidance continued to be suspended during Q1 of 2022/23.

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 of 30 June 2022, the membership of the Remuneration Committee comprised of two lay Board members and the Board Secondary Care Specialist. The committee is chaired by a Lay Board Member.

The Remuneration Committee met in common with the other MSE CCG Remuneration Committees on 2 occasions. Decisions were quorate in line with its Terms of Reference (minimum of two core members) on all occasions. Where any member was not present at the meeting their support for the recommendations made were submitted virtually.

Patient Safety and Quality Committee

The 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.

The Committee was chaired by a GP Board Member and its core decision making membership comprised the Executive Director of Nursing & Quality, two GP Board Members and Lay Member.

Committee meetings were also attended by other senior managers with specific responsibility for areas within the remit of the committee.

The committee met in common with the other MSE CCG Patient Safety and Quality Committee's on one occasion during Q1 of 2022/23 in May 2022, with a further 'virtual' meeting held in June 2022 to approve the CCG's responses to the Quality Accounts of its main providers.

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 2021/22 from the main Providers of services commissioned by the CCG; 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.

Decisions were quorate in line with its Terms of Reference on all occasions. Where any member was not present at the meeting their support for the recommendations made were submitted virtually.

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).

During Q1 of 2022/23 it met on two occasions in common with the other MSE CCG Finance & Performance Committees 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 Q1 of 2022/23 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, contract planning, awards and procurement decisions, performance reports from System Oversight and Assurance Group (SOAG), Adult Mental Health Transformation Plan contracts, system financial sustainability, 2022/23 Business Plan and CCG budgets, approval of terms of reference/frequency of meetings, receipt of System Finance Leaders Group (SFLG) minutes.

Thurrock Alliance

The aim of the Thurrock Alliance (Thurrock Integrated Care Partnership (TICP)) is to bring all key partners from across Thurrock together to provide the localism needed within the mid and south Essex system to create opportunities for people to live well in Thurrock.

Its membership comprises Director level representation from the CCG, PCN Clinical Directors, the CCG Chair, representation from Thurrock Council, EPUT, NELFT, MSEFT, Thurrock CVS and Healthwatch.

The Alliance meets monthly with good representation from all partners. An Alliance plan was developed with all Thurrock partners for 2021/22 which determined the priorities, vision, outcomes, and measures for improving health and wellbeing of the population, grouped into the following key areas:

- Health inequalities
- Primary Care
- Governance & Leadership
- Transformation, and
- Place-based prevention schemes.

Primary Care Commissioning Committee

This Committee is chaired by the Lay Member for Patient and Public Engagement.

During Q1 of 2022/23 two meetings were held in common with the other MSE CCGs Primary Care Commissioning Committees.

The Committee focused on contractual updates/breaches/requests for contractual changes from general practices; local contract decisions; GP primary care quality and safety reports; budget reports; information technology and digital updates; estates issues; primary care workforce; and review of primary care risks.

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. As national guidance had not been received in relation to the 2022/23 BCF utilisation of the BCF funds was in line with the latest Section 75 Agreement and reporting for the period focused upon expenditure on the approved services and monitoring against previously agreed performance targets.

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 for 2021/22 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.

A review of Board effectiveness was not undertaken during Q1 of 2022/23 as the CCG was dis-established on 30 June 2022.

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 worked 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.

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 BAF is reviewed at each Part I Board meeting.

Capacity to Handle Risk

During Q1 of 2022/2 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 Patient Safety and Quality Committee.
- Monitoring of completion of Equality and Health Inequality Impact Assessments, Quality Impact Assessments and Privacy Impact Assessments
- Regular review of anti-fraud, bribery, and security arrangements by the Audit Committee.
- Emergency Planning, Resilience and Response and Business Continuity Management Policies and Procedures.

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 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 is summarised under the 'Review of the Effectiveness of Governance, Risk Management and Internal Control' section, which includes the monitoring, review and management of the Assurance Framework by the Audit Committee and Board.

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 met in common with the other M&SE CCGs during Q1 of 2022/23, exercises the Board's functions in respect of the oversight of financial control.

Risk Assessment

Risk assessments have been carried for each workstream identified on page 46 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's 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 2021/22, which was undertaken as part of the wider audit of the CCG's risk management and governance arrangements, identified 'reasonable' assurance.

Data Quality

In 2020/21 and 2021/22, when the annual contracting round coincided with peak periods of the pandemic, the requirement for signed contracts with NHS Trusts and NHS Foundation Trusts was relaxed. However, in 2022/23, as we revert to more normal working arrangements, it is important, from a governance perspective, that properly documented contracts are put in place in all cases.

The NHS Standard Contract (SC28) includes a specific requirement for the provider to use all reasonable endeavours to optimise its performance under NHS Digital's Data Quality Maturity Index (DQMI), where applicable, demonstrating its progress through implementation of a DQIP or other appropriate mean. The DQMI currently covers the national datasets for admitted patient care, A&E, community services, diagnostic imaging, IAPT, mental health, maternity, and outpatients.

Data Quality Improvement Plans (DQIPs) allow the commissioner and the provider to agree a local plan to improve the capture, quality, and flow of data to meet the requirements of the Information Schedule (6A) and to support both the commissioning and contract management processes, generally targeting areas of particular concern, or in relation to new data capture as a result of service transformation. Completion of a DQIP is not mandatory for each contract, however in 2022/23 there are a number of recommended DQIPs depending on the nature of the service provided. These include providers of maternity services (to improve the accuracy and completeness of maternity services data), providers of mental health and LD services (focussing on mental health clinically led review of standards), providers of inpatient services (to record diagnoses of LD and autism), and providers of community services (to improve the accuracy and completeness of Community Dataset submissions).

Commissioners are able to use DQIPs (where agreed) to address data quality issues highlighted through direct reporting or through the nationally available NHS Digital's Data Quality Maturity Index (DQMI).

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 Q1 of 2022/23.

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 Q1 of 2022/23 in line with operational and Government requirements and have developed new policies and procedures for the MSE ICB.

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.

Human Resources transactional, recruitment and workforce services are now provided in house directly by the CCG. 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

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 a joint pan Essex review (known as the Taskforce) of the systems and processes within CCGs 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 are being taken forward and overseen by the Mental Health Partnership Board to ensure that delivery and progress is maintained going forward.

Review of economy, efficiency & 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 Q1 2022/23 in response to the ongoing challenges of the Covid-19 pandemic. The CCG has reported a breakeven position at the end of Q1 2022/23.

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 Q1 2022/23 running (management) costs were within nationally permitted expenditure limits.

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 Q1 2022/23 are included in their report immediately preceding the Annual Accounts (page 106 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 Chief Nurse 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 Government Counter Fraud Functional Standards GovS 013.

There is executive support and direction from the Chief Finance Officer for a proportionate proactive work plan to address identified risks. The 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 the financial year, the CCG submits a self-assessment to the NHS Counter Fraud Authority against the Government Counter Fraud Functional Standards. The Chief Finance Officer and Chair of the Audit Committee authorise the assessment prior to submission.

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 2022/23 Internal Audit issued the following audit reports:

Assignment	Assurance Opinion
Review to confirm that governance processes continued to operate during Q1 of 2022/23	Reasonable
Part 1 - Review of 'due diligence' processes established in preparedness for transition to the ICB	Reasonable
Part 2 - Review of 'due diligence' processes established in preparedness for transition to the ICB	Reasonable

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 Q1 2022/23 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

26 June 2023

REMUNERATION AND STAFF REPORT

Remuneration Report

For 2022/23 the membership of the Remuneration Committee was as follows:

- Pauline Stratford, Third Lay Member – Chair
- Lesley Buckland, Lay Member (Governance)
- Rachael Liebmann – Secondary Care Board Member

This committee met in common with the other 4 MSE CCGs on 2 occasions during Q1 2022/23 both meetings were quorate.

HR and remuneration advice was provided by Human Resources and the committee was informed by local and national guidance on remuneration matters.

Policy on remuneration of senior managers

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

Remuneration of Very Senior Managers

The Accountable Officer/CEO salary is set within national salary boundaries for the AO/CEO of a CCG/ICB. The determination within this broad salary boundary is set with NHS England and the CCG Remuneration Committee.

Senior Manager's 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 the accounting period.

Senior manager remuneration (including salary and pension entitlements)

CCG Remuneration Reports 2022/23 (April 22 to June 22)

This Clinical Commissioning Group Remuneration Report for 2022-23 is shown in two sections, representing the Salary and Allowances and Pension entitlements of the senior leadership of the CCG.

CCG Salaries and Allowances Table:

This includes the Clinical Commissioning Group specific Remuneration Report table of directors and senior managers.

CCG Pension Table:

This includes the Clinical Commissioning Group specific Pension entitlements of directors and senior manager.

For the April 22 to June 22 period the CCGs operated a Board Meeting in Common and did not operate the Joint Committee.

NHS Thurrock CCG - Remuneration Report 2022-23 (April 22 to June 22)

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

2022-23 (April 22 to June 22)							Dates served	
Name	Title	Salary (bands of £5,000) £000	Expense payments (Taxable) (to the nearest £100) £	Other Remuneration (bands of £5,000) £000	All pension-related benefits [1] (bands of £2,500) £000	Total (bands of £5,000) £000	Commenced	Ceased
Executive Directors								
Anthony McKeever [2]	Joint Accountable Officer	0	0	0	0	0	03-Mar-20	30-Jun-22
Mark Barker [2]	Joint Chief Finance Officer	0	0	0	0	0	01-Jan-21	30-Jun-22
Rachel Hearn [2]	Executive Director of Nursing & Quality	0	0	0	0	0	02-Nov-20	30-Jun-22
Mark Tebbs [3]	NHS Alliance Director, Thurrock	30 - 35	0	0	10 - 12.5	40 - 45	02-Nov-20	30-Jun-22
Governing Body Members								
Dr Anil Kallil [4]	GP Board Member and CCG Chair	15 - 20	0	0	0	15 - 20	01-Jan-17	30-Jun-22
Lesley Buckland	Lay Member Governance & Deputy CCG Chair	5 - 10	0	0	0	5 - 10	01-May-13	30-Jun-22
Pauline Stratford [5]	Lay Member	0	0	0	0	0	01-Aug-21	30-Jun-22
Dr Anand Deshpande [6]	GP Board Member	0	0	0	0	0	01-Apr-13	30-Jun-22
Dr Anjan Bose	GP Board Member	0 - 5	0	0	0	0 - 5	01-Apr-13	30-Jun-22
Dr Henry Okoi [4]	GP Board Member	0 - 5	0	0	0	0 - 5	01-Jan-17	30-Jun-22
Dr Luis Leighton	GP Board Member	0 - 5	0	0	0	0 - 5	01-Jan-17	30-Jun-22
Dr Rajan Mohile [6]	GP Board Member	0	0	0	0	0	01-Apr-13	30-Jun-22
Dr Sanjeev Maskara [4]	GP Board Member	0 - 5	0	0	0	0 - 5	01-Nov-17	30-Jun-22
Dr Thamotherampillat Nimal-Raj	GP Board Member	0 - 5	0	0	0	0 - 5	01-Jul-17	30-Jun-22
Dr Rachael Liebmann [7]	Secondary Care Consultant	0	0	0	0	0	01-Aug-21	30-Jun-22

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

[2] 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 was not shared across the five CCGs, and is only shown in the table above if employed by the CCG. The total remuneration (inclusive of pension benefits and taxable expense payments) for Rachel Hearn, was in the range £30k-£35k, for Mark Barker in the range £35k-£40k, and for Anthony McKeever in the range £65k-£70k.

[3] Mark Tebbs is a member of the Joint Executive Team, as a NHS Alliance Director supporting the mid Essex locality and leading on Mental Health across the five CCGs in mid and south Essex. Mark Tebbs total remuneration is shown in the Salaries and Allowances table above.

[4] The Salary disclosure includes Employers Pension contributions to the GP SOLO Pension scheme.

[5] Pauline Stratford, Lay Member is also a member of NHS Castle Point & Rochford CCG, NHS Southend CCG and NHS Mid Essex CCG Boards. No remuneration was charged to NHS Thurrock CCG in the period. The total remuneration for Pauline Stratford, paid by Castle Point & Rochford CCG, was in the range £0k-£5k.

[6] No remuneration was paid to Dr Anand Deshpande or Dr Rajan Mohile during the period.

[7] Dr Rachael Liebmann, Secondary Care Consultant, is also member of NHS Castle Point & Rochford CCG Board. No remuneration was charged to NHS Thurrock CCG in the period. The total remuneration for Dr Rachael Liebmann, paid by Castle Point & Rochford CCG, was in the range £0k-£5k.

[8] The pension figures for staff who are also included in CCG remuneration reports are shown in full in that CCG's remuneration report and have not been apportioned to more than one organisation.

Dr Jo Broadbent, Director for Public Health, Thurrock Council, attends the board in a non-voting capacity as the Thurrock Council representative. No remuneration is paid to Thurrock Council and is therefore not included in the above table.

- Ahmed Yasin, Practice Manager Board Member, attends the Board in a non-voting capacity as the Practice representative. No remuneration was paid to Ahmed Yasin in relation to this role in the period.

Thurrock CCG Pension Entitlements 2022-23 (April 22 to June 22)

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

Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 30th June 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 30th June 2022 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2022 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 30th June 2022 £000	Employers contribution to stakeholder pension £00
Executive Directors									
Mark Tebbs	NHS Alliance Director	0-2.5	0	30-35	55-60	521	6	547	0

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

Cash Equivalent Transfer Values

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008

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. 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 is required. 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.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer.

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

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

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

CCG Remuneration Reports 2021-22

This CCG Remuneration Report 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:

CCG Tables:

CCGs will prepare CCG specific schedules

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 & Quality, 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.

The Joint Committee table shows those staff employed to discharge these commissioning functions across the five CCGs.

From the 1 October 2020, some of these staff transferred to the new Joint Executive Team (see below).

Joint Executive Team Table:

From 1st October 2020, the Joint Executive Team was 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.

NHS Thurrock CCG - Remuneration Report 2021-22

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

2021-22							Dates served	
Name	Title	Salary (bands of £5,000) £000	Expense payments (Taxable) (to the nearest £100) £	Other Remuneration (bands of £5,000) £000	All pension-related benefits [1] (bands of £2,500) £000	Total (bands of £5,000) £000	Commenced	Ceased
Executive Directors								
Anthony McKeever [2]	Joint Accountable Officer	20 - 25	0	0	2.5 - 5 [7]	25 - 30	03-Mar-20	-
Mark Barker [2]	Joint Chief Finance Officer	15 - 20	0	0	0 [8]	15 - 20	01-Jan-21	-
Rachel Hearn [2]	Executive Director of Nursing & Quality	15 - 20	0	0	0 [8]	15 - 20	02-Nov-20	-
Mark Tebbs [3]	NHS Alliance Director, Thurrock	125 - 130	0	0	60 - 62.5	190 - 195	02-Nov-20	-
Governing Body Members								
Dr Anil Kallil [4]	GP Board Member and CCG Chair	80 - 85	0	0	0	80 - 85	01-Jan-17	-
Lesley Buckland	Lay Member Governance & Deputy CCG Chair	20 - 25	0	0	0	20 - 25	01-May-13	-
Alan Hudson	Lay Member	5 - 10	0	0	0	5 - 10	26-Feb-20	15-Dec-21
Pauline Stratford [5]	Lay Member	0 - 5	0	0	0	0 - 5	01-Aug-21	-
Dr Anand Deshpande	GP Board Member	5 - 10	0	0	0	5 - 10	01-Apr-13	-
Dr Anjan Bose	GP Board Member	0 - 5	0	0	0	0 - 5	01-Apr-13	-
Dr Henry Okoi [4]	GP Board Member	10 - 15	0	0	0	10 - 15	01-Jan-17	-
Dr Luis Leighton	GP Board Member	5 - 10	0	0	0	5 - 10	01-Jan-17	-
Dr Rajan Mohile	GP Board Member	5 - 10	0	0	0	5 - 10	01-Apr-13	-
Dr Sanjeev Maskara [4]	GP Board Member	30 - 35	0	0	0	30 - 35	01-Nov-17	-
Dr Thamotherampillat Nimal-Raj	GP Board Member	15 - 20	0	0	0	15 - 20	01-Jul-17	-
Dr Rachael Liebmann [6]	Secondary Care Consultant	0 - 5	0	0	0	0 - 5	01-Aug-21	-
Non-Voting Members								
Ahmed Yasin	Practice Manager Board Member	0 - 5	0	0	0	0 - 5	26-Feb-20	-

[1] The pension-related benefit figures do not represent cash payments made to an individual's pension provider. The quoted figures provided by NHS Pensions Agency are an estimate of the increase in the accrued pension over their estimated pensionable life.

[2] 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.

[3] Mark Tebbs is a member of the Joint Executive Team, as a NHS Alliance Director supporting the mid Essex locality and leading on Mental Health across the five CCGs in mid and south Essex. Mark Tebbs total remuneration is shown in the Salaries and Allowances table above.

[4] The Salary disclosure includes Employers Pension contributions to the GP SOLO Pension scheme.

[5] Pauline Stratford, Lay Member is also a member of NHS Castle Point & Rochford CCG, NHS Southend CCG and NHS Mid Essex CCG Boards. The agreed remuneration as shown in the table above relates to NHS Thurrock CCG. The total remuneration for Pauline Stratford, was in the range £15k-£20k.

[6] Dr Rachael Liebmann, Secondary Care Consultant, is also member of NHS Castle Point & Rochford CCG Board. The agreed remuneration as shown in the table above relates to NHS Thurrock CCG. The total remuneration for Dr Rachael Liebmann, 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 that CCG's remuneration report and have not been apportioned to more than one organisation.

Dr Jo Broadbent, Director for Public Health, Thurrock Council, attends the board in a non-voting capacity as the Thurrock Council representative. No remuneration is paid to Thurrock Council and they are therefore not included in the above table.

Joint Committee and Joint Executive Team 2021-22

(subject to audit):

Joint Committee

Note	Joint Committee Members
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 Joint 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.

Name	Title	Whole time equivalent	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Commenced (if during year)	Ceased (if during year)	salary (bands of £5,000)	Expense payments (bands of £100)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
									Salary	Expenses	Pension	Totals
									NHS Thurrock CCG share			
Rotational role (note 4)	Chair (note 3, 4)	0.0	0	0	0	0	-	-	0	0	0	0
Anthony McKeever	Joint Accountable Officer	0.0	0, (note 2)	0, (note 2)	0, (note 2)	0, (note 2)	-	-	0	0	0	0
Dr José Garcia Lobera	Chair - Southend CCG	0.0	0, (note 2)	0, (note 2)	0, (note 2)	0, (note 2)	-	-	0	0	0	0
Dr Sunil Gupta	Chair - Castle Point & Rochford CCG	0.0	0, (note 2)	0, (note 2)	0, (note 2)	0, (note 2)	-	-	0	0	0	0
Dr Anil Kallil	Chair - Thurrock CCG	0.0	0, (note 2)	0, (note 2)	0, (note 2)	0, (note 2)	-	-	0	0	0	0
Dr Anna Davey	Chair - Mid Essex CCG	0.0	0, (note 2)	0, (note 2)	0, (note 2)	0, (note 2)	-	-	0	0	0	0
Dr Boye Tayo	Chair - Basildon & Brentwood CCG	0.0	0, (note 2)	0, (note 2)	0, (note 2)	0, (note 2)	-	-	0	0	0	0

Note	Joint Committee Executive
5	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.
6	Andy Ray is on secondment to the Finance Director Purchase of Healthcare & Contracting role. The costs included under salary payments reflect the payment made to his employing NHS organisation.
7	The pension figures have not been apportioned to more than one organisation.

Name	Title	Whole time equivalent	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Commenced (if during year)	Ceased (if during year)	salary (bands of £5,000)	Expense payments (bands of £100)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Karen Wesson	Director of Commissioning, Performance & EPRR	1.0	125 - 130	0	125 - 127.5	250 - 255	-	-	15 - 20	0	0, (note 7)	15 - 20
Andy Ray	Finance Director, Purchase of Healthcare & Contracting	1.0	140 - 145	0	42.5 - 45	185 - 190	-	-	20 - 25	0	0, (note 7)	20 - 25
Donald McGeachy	Joint Committee Medical Director	0.6	20 - 25	0	0	20 - 25	-	02-Jul-21	0 - 5	0	0	0 - 5

Joint Executive Team

Note **Joint Executive Team, Members**

8 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

Note **Joint Executive Team, Executives**

9 0.8 wte of this role is funded by the CCGs as the Joint Accountable Officer of all five CCGs. The Employers contribution to stakeholder pension has been show in line with the proportion funded by each CCG.

10 The pension figures for staff who are also included in CCG remuneration reports are shown in full in that CCG's remuneration report and have not been apportioned to more than one organisation.

11 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; Patricia D'Orsi, Castle Point & Rochford and Southend CCGs; William Guy, Basildon & Brentwood CCG; Mark Tebbs, Thurrock CCG.

Name	Title	Whole time equivalent	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Commenced (if during year)	Ceased (if during year)	Total (bands of £5,000)	Expense payments (bands of £100)	Total (bands of £5,000)	Total (bands of £5,000)
Anthony McKeever	Joint Accountable Officer (note 9)	0.8	155 - 160	0	30 - 32.5	185 - 190	-	-	20 - 25	0	2.5 - 5 (note 9)	25 - 30
Mark Barker	Joint Chief Finance Officer	1.0	135 - 140	0	30 - 32.5	165 - 170	-	-	15 - 20	0	0, (note 10)	15 - 20
Rachel Hearn	Executive Director of Nursing & Quality	1.0	125 - 130	0	62.5 - 65	185 - 190	-	-	15 - 20	0	0, (note 10)	15 - 20
Daniel Doherty	NHS Alliance Director, Mid Essex	1.0	0, (note 11)	0, (note 11)	0, (note 11)	0, (note 11)	-	-	0	0	0	0
Tricia D'Orsi	NHS Alliance Director, SE Essex	1.0	0, (note 11)	0, (note 11)	0, (note 11)	0, (note 11)	-	-	0	0	0	0
William Guy	NHS Alliance Director, Basildon & Brentwood	1.0	0, (note 11)	0, (note 11)	0, (note 11)	0, (note 11)	-	-	0	0	0	0
Mark Tebbs	NHS Alliance Director, Thurrock	1.0	0, (note 11)	0, (note 11)	0, (note 11)	0, (note 11)	-	-	0	0	0	0

Thurrock CCG - Pension Entitlements 2021-22

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

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2022 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2021 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2022 £000	Employers contribution to stakeholder pension £000
Executive Directors									
Mark Tebbs	NHS Alliance Director, Thurrock	2.5 - 5	2.5 - 5	30 - 35	50 - 55	454	46	521	0
Joint Executive Team, Executive Directors									
Anthony McKeever	Joint Accountable Officer	0	0	0	0	0	0	0	30
Mark Barker	Joint Chief Finance Officer	2.5 - 5	0	0 - 5	0	9	19	48	0
Rachel Hearn	Executive Director of Nursing & Quality	2.5 - 5	2.5 - 5	35 - 40	65 - 70	484	48	553	0
Joint Committee, Executive									
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

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

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 the 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 is required.

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

Real Increase in CETV

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

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

GP Board Menbers are classified as Off payroll worker and no pension disclosure is therefore required.

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

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.

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 NHS Thurrock CCG in the period April 22 to June 22 was £125k - £130k (2021-22: £125k - £130k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay Ratio information table:

2022/23 (April 22 to June 22)	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	£29,169	£42,479	£65,708
*Salary component of total remuneration (£)	£29,169	£42,479	£65,708
Pay ratio information	4.4 : 1	3.0 : 1	1.9 : 1
2021/22	25th percentile	Median	75th percentile
Total remuneration (£)	£23,319	£40,972	£57,606
*Salary component of total remuneration (£)	£23,319	£40,972	£57,606
Pay ratio information	5.5 : 1	3.1 : 1	2.2 : 1

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

In 2022-23 (April 22 to June 22), 1 (2021-22, 2) employees received remuneration in excess of the highest-paid director.

As at 30 June 2023, remuneration ranged from £2k to £130k (+9% against 2021-22: £1k to £143k) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). The increase was primarily driven by the CCG not being charged a percentage of joint directors in the quarter. 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 senior managers

In 2022/23, the CCG had 11 senior managers.

Staff numbers and costs

Pay Band	2	3	4	5	6	7	8a	8b	8c	8d	9	Other	Grand Total
									Senior Managers				
Female	1	1	3	2	7	12	5	3	5	2	1	1	43
Male			1		3	1	2	1	1	1	1	1	12
Grand Total	1	1	4	2	10	13	7	4	6	3	2	2	55

Staff composition

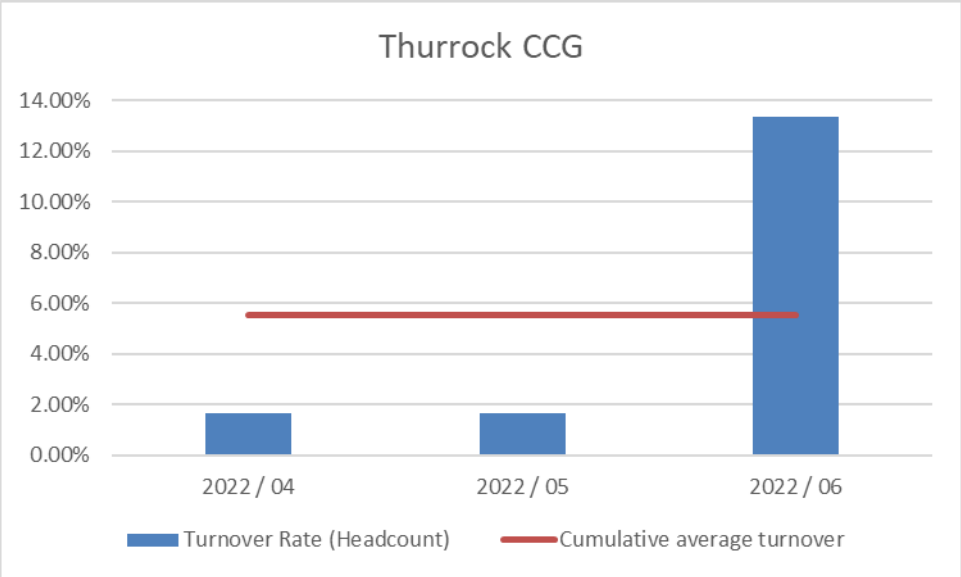
EMPLOYED STAFF		
Employee category	Headcount	WTE
Permanent	41	39.85
Fixed-term	12	10.60
TOTAL	53	50.45
AGENCY & INTERIM		
TOTAL	2	0.20
GRAND TOTAL	**55**	**50.65**

Sickness absence data

Average FTE for 2022	Average Annual Sick Days per FTE	Sum of FTE Days Sick	Sum of FTE Days Available	Months
52	6.5	185	6,384	4

Sickness absence data can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover percentages



Staff Engagement

For the first year, 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 had 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.

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.

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

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

The CCGs also participated 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 the accounting period.

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 and has continued this year.

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.

Expenditure on consultancy

Administrative	£10k
Programme	-£46k

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 30 June 2022 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 30 June 2022	3
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	3
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	3
No. subject to off-payroll legislation and determined as out of scope of IR35	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

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 2022 and 30 June 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.	13

Losses and Special Payments

In the accounting period, the total number of NHS clinical commissioning group losses and special payments cases were nil (2021/22: nil).

Exit packages, including special (non-contractual) payments

In the accounting period, the total number of NHS clinical commissioning group exit packages were nil (2021/22: nil)

PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

The 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 page 76. An audit certificate and report is also included in this Annual Report.

ANNUAL ACCOUNTS

I confirm that the annual accounts adhere to the reporting framework.

Anthony McKeever
Accountable Officer

26 June 2023

Entity name:	NHS Thurrock CCG
	Statutory Accounts
This period	**1-Apr-22 to 30-Jun-22**
Last year	2021-22
This period ended	**30-Jun-22**
Last year ended	31-Mar-22
This period commencing:	**1-Apr-22**
Last year commencing:	1-Apr-21

CONTENTS

Statement of Comprehensive Net Expenditure for the period ended 30 Jun 22

	Note	1-Apr-22 to 30-Jun-22 £'000	2021-22 £'000
Income from sale of goods and services	2	(374)	(1,826)
Total operating income		**(374)**	**(1,826)**
Staff costs	4	891	4,091
Purchase of goods and services	5	66,380	275,314
Depreciation and impairment charges	5	12	-
Provision expense	5	(1,491)	2,062
Other operating expenditure	5	25	218
Total operating expenditure		**65,817**	**281,685**
Net operating expenditure		**65,443**	**279,859**
Finance costs	7	1	-
Comprehensive expenditure for the year		**65,444**	**279,859**

The notes on pages 7 to 25 form part of this statement

Statement of Financial Position as at 30 Jun 22

	Note	30-Jun-22 £'000	31-Mar-22 £'000
Non-current assets:			
Right-of-use assets	8	224	-
Total non-current assets		224	-
Current assets:			
Trade and other receivables	9	712	3,336
Cash and cash equivalents	10	1,789	41
Total current assets		2,501	3,377
Total assets		**2,725**	**3,377**
Current liabilities			
Trade and other payables	11	(10,484)	(17,137)
Lease liabilities	8	(48)	-
Provisions	12	(424)	(424)
Total current liabilities		(10,956)	(17,561)
Non-current assets plus/less net current assets/liabilities		**(8,231)**	(14,184)
Non-current liabilities			
Lease liabilities	8	(176)	-
Provisions	12	(186)	(1,678)
Total non-current liabilities		(362)	(1,678)
Assets less Liabilities		**(8,593)**	(15,862)
Financed by taxpayers' equity			
General fund		(8,593)	(15,862)
Total taxpayers' equity:		**(8,593)**	(15,862)

The notes on pages 7 to 25 form part of this statement

The financial statements on pages 3 to 6 were approved by the governing body on 26 Jun 23 and signed on its behalf by:

Chief Accountable Officer
Anthony McKeever

Statement of Changes In Taxpayers Equity for the period ended 30 Jun 22

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for 1-Apr-22 to 30-Jun-22		
Balance at 01-Apr-22	(15,862)	**(15,862)**
Adjusted NHS clinical commissioning group balance at 31-Mar-22	**(15,862)**	**(15,862)**
Changes in NHS clinical commissioning group taxpayers' equity for 1-Apr-22 to 30-Jun-22		
Net operating expenditure for the financial period	(65,444)	**(65,444)**
Net recognised NHS clinical commissioning group expenditure for the financial period	(65,444)	**(65,444)**
Net funding	72,713	**72,713**
Balance at 30-Jun-22	**(8,593)**	**(8,593)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01-Apr-21	(20,713)	**(20,713)**
Adjusted NHS Clinical Commissioning Group balance at 31-Mar-21	**(20,713)**	**(20,713)**
Changes in NHS clinical commissioning group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	(279,858)	**(279,858)**
Net recognised NHS clinical commissioning group expenditure for the financial year	**(279,858)**	**(279,858)**
Net funding	284,709	**284,709**
Balance at 31-Mar-22	**(15,862)**	**(15,862)**

The notes on pages 7 to 25 form part of this statement

Statement of Cash Flows for the period ended 30 Jun 22

	Note	**1-Apr-22 to 30-Jun-22 £'000**	2021-22 £'000
Cash flows from operating activities			
Net operating expenditure for the financial period		(65,444)	(279,859)
Depreciation	5	12	-
Interest paid		0	-
decrease/(increase) in trade & other receivables	9	2,624	(2,638)
(decrease) in trade & other payables	11	(6,653)	(4,388)
(decrease)/increase in provisions	12	(1,492)	2,063
Net cash inflow (outflow) from operating activities		**(70,953)**	**(284,822)**
Cash flows from financing activities			
Grant in aid funding received		72,713	284,709
Repayment of lease liabilities		(12)	-
Net cash inflow from financing activities		**72,701**	**284,709**
Net increase/(decrease) in cash & cash equivalents	10	**1,748**	**(113)**
Cash & cash equivalents at the beginning of the financial period		**41**	154
Cash & cash equivalents at the end of the financial period		**1,789**	**41**

The notes on pages 7 to 25 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of NHS 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 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to 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.

1.1 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 an NHS 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 financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

Following the approval of the Health and Care Bill on 28 April 2022 NHS Thurrock Clinical Commissioning Group (the CCG) was dissolved on 30 June 2022. Whilst the CCG as an entity ceased to exist on that date, the activities undertaken by the CCG continued 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 and have been be prepared on a going concern basis.

1.2 Accounting Convention

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

1.3 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 Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the 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.

1.4 Joint Arrangements

The NHS clinical commissioning group has not been part of any pooled budget arrangements in 2021-22. The NHS commissioning group and Thurrock 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 operated in 2021-22 do not constitute a pooled budget as the risks of each scheme have remained with the respective commissioners. See Note 15 for further information.

1.5 Operating Segments

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

Notes to the financial statements

1.6 Revenue

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

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

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

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

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

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS pensions schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the period. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

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

1.8 Other Expenses

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

1.9 Leases

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

Notes to the financial statements

1.9.1 **The NHS Clinical Commissioning Group as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

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

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

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

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

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

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

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

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

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

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.10 **Cash & Cash Equivalents**

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

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

1.11 **Provisions**

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

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

Notes to the financial statements

1.12 Clinical Negligence Costs

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

1.13 Non-Clinical Risk Pooling

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

1.14 Contingent Liabilities and Contingent Assets

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

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

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

1.15 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.

1.15.1 Financial Assets at Amortised cost

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

1.15.2 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.

1.15.3 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.

1.16 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the NHS 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.

Notes to the financial statements

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.

1.17 **Value Added Tax**

Most of the activities of the NHS 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.

1.18 **Foreign Currencies**

The NHS 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 30 June 2022. Resulting exchange gains and losses for either of these are recognised in the NHS clinical commissioning group’s surplus in the period in which they arise.

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

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

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

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

The NHS clinical commissioning group has operated a Better Care Fund with Thurrock Council during 2022-23, under a section 75 agreement. This arrangement has been reviewed and all parties have agreed that it does not constitute a pooled budget, as the risks of each scheme have remained with the respective commissioner. See Note 15 for further information.

1.19.2 **Sources of Estimation Uncertainty**

We have not identified an 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.

1.20 **Adoption of New Standards**

On 1 April 2022, the NHS clinical commissioning group adopted IFRS 16 ‘Leases’. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the NHS clinical commissioning group recognise a right-of-use asset representing the NHS clinical commissioning group’s right to use the underlying asset, and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Notes to the financial statements

1.20.1 **Impact Assessment**

The NHS clinical commissioning group has applied the modified retrospective approach, and recognise the cumulative effect of adopting the standard at the date of initial application, as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and, therefore, the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The NHS clinical commissioning group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.
As of 1 April 2022, the group recognised £235k or right-of-use assets and lease liabilities of £235m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0k impact to tax payers' equity.
The NHS clinical commissioning group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position, and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 2021/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31-Mar-22	240
Impact of discounting at 1-Apr-22 using the weighted average incremental borrowing rate of 0.95%	2
Operating lease commitments discounted used weighted average IBR	237
Add: Finance lease liabilities at 31-Mar-22	0
Add: Residual value guarantees	0
Add: Rentals associated with extension options reasonably certain to be exercised	0
Less: Short term leases (including those with <12 months at application date)	0
Less: Low value leases	-1
Less: Variable payments not included in the valuation of the lease liabilities	-1
Lease liability at 1-Apr-22	**235**

1.21 **New and revised IFRS Standards in issue but not yet effective**

● 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.

2 Operating Revenue

	1-Apr-22 to 30-Jun-22 £'000	2021-22 £'000
Income from sale of goods and services		
Non-patient care services to other bodies	106	725
Other contract income	268	1,101
Total Income from sale of goods and services	**374**	**1,826**
Total operating income	**374**	**1,826**

3 Disaggregation of Income - Income from sale of good and services

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other contract income £'000
Source of Revenue			
NHS	-	4	-
Non NHS	-	102	268
Total	**-**	**106**	**268**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other contract income £'000
Timing of Revenue			
Point in time	-	0	-
Over time	-	106	268
Total	**-**	**106**	**268**

4. Employee Benefits and Staff Numbers

4.1.1 Employee benefits / Staff costs

	1-Apr-22 to 30-Jun-22		
	Permanent employees £'000	**Other £'000**	**Total £'000**
Employee benefits			
Salaries and wages	625	63	**688**
Social security costs	83	-	**83**
Employer contributions to NHS pension scheme	120	-	**120**
Apprenticeship levy	0	-	**0**
Gross employee benefits expenditure	**828**	**63**	**891**
Net employee benefits	**828**	**63**	**891**

No Exit Packages were paid from **1-Apr-22 to 30-Jun-22** or 2021-22

4.1.1 Employee benefits / Staff costs

	2021-22		
	Permanent employees £'000	Other £'000	Total £'000
Employee benefits			
Salaries and wages	2,899	334	**3,233**
Social security costs	325	-	**325**
Employer contributions to NHS pension scheme	532	-	**532**
Apprenticeship levy	1	-	**1**
Gross employee benefits expenditure	**3,757**	**334**	**4,091**
Net employee benefits	**3,757**	**334**	**4,091**

4.2 Average number of people employed (WTE)

	1-Apr-22 to 30-Jun-22		
	Permanently employed Number	**Other Number**	**Total Number**
Total number of people employed (WTE)	51.29	2.88	**54.17**

	2021-22		
	Permanently employed Number	Other Number	Total Number
Total number of people employed (WTE)	62.95	3.38	**66.33**

4.3 Pension Costs

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

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

4.3.1 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 Mar 22, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.3.2 Full actuarial (funding) valuation

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

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

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

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

5 Operating expenses

	1-Apr-22 to 30-Jun-22 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	234	890
Services from foundation trusts	38,326	143,760
Services from other NHS trusts	5,147	18,716
Purchase of healthcare from non-NHS bodies	10,795	50,479
Prescribing costs	6,153	25,424
GPMS/APMS and PCTMS	6,736	27,711
Supplies and services – clinical	1	2
Supplies and services – general	(1,099)	7,436
Consultancy services	(36)	253
Establishment	32	208
Premises	35	194
Audit fees	47	56
Other professional fees	(10)	107
Legal fees	10	72
Education, training and conferences	9	6
Total purchase of goods and services	**66,380**	**275,314**
Depreciation and impairment charges		
Depreciation	12	-
Total depreciation and impairment charges	**12**	**-**
Provision expense		
Provisions	(1,491)	2,062
Total provision expense	**(1,491)**	**2,062**
Other operating expenditure		
Chair and non-executive members	22	207
Other expenditure	3	11
Total other operating expenditure	**25**	**218**
Total operating expenditure	**64,926**	**277,594**

There were no Losses or special payments in 1-Apr-22 to 30-Jun-22 or 2021-22

6 Better Payment Practice Code

Measure of compliance	1-Apr-22 to 30-Jun-22 Number	1-Apr-22 to 30-Jun-22 £'000	2021-22 Number	2021-22 £'000
Non-NHS payables				
Total non-NHS trade invoices paid in the period	2,463	21,762	10,959	93,560
Total non-NHS trade Invoices paid within target	2,430	21,596	10,676	90,730
Percentage of non-NHS trade invoices paid within target	**98.66%**	**99.24%**	**97.42%**	**96.98%**
NHS payables				
Total NHS trade invoices paid in the period	166	45,444	564	166,781
Total NHS trade invoices paid within target	159	45,369	551	165,906
Percentage of NHS trade Invoices paid within target	**95.78%**	**99.84%**	**97.70%**	**99.48%**

7 Finance Costs

	1-Apr-22 to 30-Jun-22 £'000	2021-22 £'000
Interest		
Interest on lease liabilities	1	-
Total interest	**1**	**-**
Total finance costs	**1**	**-**

8 Leases

8.1 Right-of-use assets

1-Apr-22 to 30-Jun-22	Buildings excluding dwellings £'000	Total £'000
Cost/valuation at 01-Apr-22	-	-
IFRS 16 transition adjustment	235	**235**
Cost/valuation at 30-Jun-22	**235**	**235**
Depreciation 01-Apr-22	-	**-**
Depreciation charged during the period	11	**11**
Depreciation at 30-Jun-22	11	**11**
Net book value at 30-Jun-22	**224**	**224**

8.2 Lease liabilities

1-Apr-22 to 30-Jun-22	1-Apr-22 to 30-Jun-22 £'000
Lease liabilities at 01-Apr-22	-
IFRS 16 transition adjustment	236
Interest expense relating to lease liabilities	1
Repayment of lease liabilities (including interest)	(12)
Lease liabilities at 30-Jun-22	**225**

8.3 Lease liabilities - maturity analysis of undiscounted future lease payments

	30-Jun-22 £'000
Within one year	(48)
Between one and five years	(180)
Balance at 30-Jun-22	**(228)**
Effect of discounting	3
Included in:	
Current lease liabilities	(48)
Non-current lease liabilities	(177)
Balance at 30-Jun-22	**(225)**

8 Leases continued.

8.4 Amounts recognised in statement of comprehensive net expenditure

	1-Apr-22 to 30-Jun-22 £'000	2021-22 £'000
Depreciation expense on right-of-use assets	12	-
Interest expense on lease liabilities	1	-

8.5 Amounts recognised in statement of cash flows

	1-Apr-22 to 30-Jun-22 £'000	2021-22 £'000
Total cash outflow on leases under IFRS 16	(12)	-
Total cash outflow for lease payments not included within the measurement of lease liabilities	-	-

8.6 Leases narrative

The leasing activities falling under IFRS 16 relate to the administration premises at the Thurrock Borough Council Civic Offices for the NHS clinical commissioning group.

There are also the below charges relating to this lease, which are excluded from the calculation of the liability and asset.

- Service Charge
- Landlord's costs
- Utilities

The NHS clinical commissioning group hold the lease directly with Thurrock Borough Council.

9 Trade and other receivables

	30-Jun-22	31-Mar-22
	£'000	£'000
NHS receivables: revenue	380	674
NHS accrued income	-	1,683
Non-NHS and other WGA receivables: revenue	142	308
Non-NHS and other WGA prepayments	77	503
Non-NHS and other WGA accrued income	45	139
VAT	68	29
Total trade & other receivables - current	**712**	**3,336**

9.1 Receivables past their due date but not impaired

	30-Jun-22	**30-Jun-22**	31-Mar-22	31-Mar-22
	DHSC group bodies	**Non DHSC group bodies**	DHSC group bodies	Non DHSC group bodies
	£'000	**£'000**	£'000	£'000
By up to three months	-	141	14	7
By three to six months	-	-	-	-
By more than six months	-	-	-	-
Total	**-**	**141**	**14**	**7**

10 Cash and cash equivalents

	1-Apr-22 to 30-Jun-22 £'000	2021-22 £'000
Opening Balance	41	154
Net change in period	1,748	(113)
Closing Balance	**1,789**	**41**
Made up of:		
Cash with the government banking service	1,789	41
Closing Balance	**1,789**	**41**

11 Trade and other payables	**Current 30-Jun-22 £'000**	Current 31-Mar-22 £'000
NHS payables: revenue	339	1,187
NHS accruals	633	996
NHS deferred income	-	151
Non-NHS and other WGA payables: revenue	2,814	2,466
Non-NHS and other WGA accruals	5,633	7,004
Non-NHS and other WGA deferred income	45	61
Social security costs	49	48
Tax	35	42
Other payables and accruals	936	5,181
Total trade & other payables	**10,484**	**17,137**

Other payables include £215k outstanding pension contributions at 30-Jun-22

12 Provisions

	Current 30-Jun-22 £'000	**Non-current 30-Jun-22 £'000**	Current 31-Mar-22 £'000	Non-current 31-Mar-22 £'000
Restructuring	424	-	424	-
Continuing care	-	186	-	1,678
Total provisions	**424**	**186**	**424**	**1,678**
Total current and non-current		**610**		**2,102**

	Restructuring £'000	**Continuing Care £'000**	**Total £'000**
Balance at 1-Apr-22	**424**	**1,678**	**2,102**
Arising during the period	-	176	**176**
Reversed unused	-	(1,668)	**(1,668)**
Balance at 30-Jun-22	**424**	**186**	**610**
Expected timing of cash flows:			
Within one year	424	-	**424**
Between one and five years	-	186	**186**
After five years	-	-	**-**
Balance at 30-Jun-22	**424**	**186**	**610**

Restructuring provision

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 Mar 22, 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.

Continuing Health Care (CHC) provision

This provision is to cover the cost of reimbursing residents for CHC amenity top ups back to 2012 as per the national CHC guidance. The provision calculation is based on the current year's packages grossed up for a full year. The figure has then been extrapolated back to 2012. Following legal advice and an internal review this provision has been reduced to the current expeced required level.

13 Financial Instruments

13.1 Financial risk management

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

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

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

13.1.1 Currency risk

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

13.1.2 Interest rate risk

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

13.1.3 Credit risk

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

13.1.4 Liquidity risk

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

13.1.5 Financial Instruments

As the cash requirements of NHS England are met through the estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy 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.

13 Financial instruments continued

13.2 Financial assets

	Financial assets measured at amortised cost 30-Jun-22 £'000	Total 30-Jun-22 £'000
Trade and other receivables with NHSE bodies	127	127
Trade and other receivables with other DHSC group bodies	253	253
Trade and other receivables/accruals with external bodies	187	187
Cash and cash equivalents	1,789	1,789
Total at 30-Jun-22	**2,356**	**2,356**

13.3 Financial liabilities

	Financial liabilities measured at amortised cost 30-Jun-22 £'000	Total 30-Jun-22 £'000
Trade and other payables/accruals with NHSE bodies	113	**113**
Trade and other payables/accruals with other DHSC group bodies	859	**859**
Trade and other payables/accruals with external bodies (incl. IFRS 16 lease liabilities).	9,607	**9,607**
Total at 30-Jun-22	**10,579**	**10,579**

14 Operating Segments

The NHS clinical commissioning group has only one segment, commissioning of healthcare services (2021-22 one segment).

15 Joint Arrangements - Interests in Joint Operations

The NHS clinical commissioning group shares of the income and expenditure handled by the Better Care Fund in the financial year were:

	1-Apr-22 to 30-Jun-22 £'000	2021-22 £'000
Income	4,281	17,021
Expenditure	(4,281)	(17,021)

The lead commissioner for the Better Care Fund (BCF) from 1-Apr-22 to 30-Jun-22 was Thurrock Council. The Health and Wellbeing Board (HWB) was charged with responsibility for the BCF. The HWB delegated monthly monitoring to the Better Care Fund (BCF) Delivery Group which reports to the Thurrock Integrated Care Partnership (TICP). The TICP comprises senior executives across the CCG and Thurrock Council and was jointly chaired by the Alliance Director of the CCG and the Director of Adult Social Care from Thurrock Council.

16 Related Party Transactions

Details of related party transactions with individuals are as follows:

	Payments to related party £'000	Receipts from related party £'000	Amounts owed to related party £'000	Amounts due from related party £'000
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.				
There are no other individuals who are considered to meet the definition of related parties under IAS24 as intepreted by the GAM 2022-23.				
Part two - Transactions in relation to interests declared by Governing Board Members				
Thurrock Health Hubs - Dr Deshpande, Host and Contract Holder & GP Board Member	643	-	0	-
Lakeside Medical Diagnostics - Organisation providing diagnostics, Dr Nimal Raj, Director & GP Board Member	82	-	53	-
NHS Mid Essex CCG - Anthony McKeever (Joint Accountable Officer), Rachel Hearn (Joint Executive Director of Nursing), Mark Barker (Joint Chief Finance Officer) sit on the executive team of this CCG	0	1	0	-
Part Three - Transactions in relation to practices where the GP has served during the period of the Governing Body				
Aveley Medical Centre - Dr Leighton (GP Board Member) - GP at the Surgery and Member Practice	357	-	28	-
Orsett Surgery - Dr Kalil (GP Board Chair) - GP Partner at the Surgery and Member Practice	353	-	15	-
Neera Medical Centre - Dr Desphande (GP Board Member) - Principal GP at Surgery - Dr Bose (GP Board Member) - Locum GP at the Surgery and Member Practice	553	-	15	-
Stifford Clays Medical Practice - Dr Mohile (GP Board Member) - Principal GP at the Surgery and Member Practice	224	-	42	-
Dr Yasin Surgery - A. Yasin (Practice Manager Board Member) - Practice Manager at the Surgery and Member Practice	385	-	163	-
Derry Court Medical Centre - Dr Okoi (GP Board Member) - Principal GP at the Surgery and Member Practice	197	-	19	-
Southend Road Surgery - Dr Desphande (GP Board Member - Principal GP at the Surgery - Dr Bose (GP Board Member) Locum GP at the Surgery and Member Practice	94	-	13	-
Tilbury Health Centre - Dr Maskara (GP Board Member) Self employed GP at Surgery & Member Practice	424	-	41	-
Commonwealth Health Centre - Dr Maskara (GP Board Member) Self employed GP at Surgery & Member Practice	559	-	207	-
Milton Road Surgery - Dr Maskara (GP Board Member) Self employed GP at Surgery & Member Practice	88	-	8	-
Appledore & Medic House - Dr Maskara (GP Board Member) Self employed GP at Surgery & Member Practice	146	-	17	-
Odd Fellows Hall & St Clements Health Centre - Dr Maskara (GP Board Member) Self employed GP at Surgery & Member Practice	242	-	298	-

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

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

• Barking, Havering and Redbridge NHS Trust;
• Barts and the London NHS Trust;
• East of England Ambulance Service NHS Trust;
• Essex Partnership University NHS Foundation Trust;
• Mid and South Essex NHS Foundation Trust;
• Midlands Partnership NHS Foundation Trust;
• NHS England;
• NHS Resolution;
• NHS Business Services Authority;
• North East London NHS Foundation Trust;
• NHS Property Services

The NHS clinical commissioning group has had a number of joint working arrangements and transactions with Essex clinical commissioning groups such as Basildon & Brentwood CCG, Castle Point and Rochford CCG, Mid Essex CCG, Southend CCG, North East Essex CCG and West Essex CCG.

In addition, the NHS clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Thurrock Borough Council.

Part Five - Department of Health and Social Care

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group. We have reviewed the list of individuals and entities and the CCG does not have any material disclosable transaction with any of the entities.

17 Events After the End of the Reporting Period

The Health and Care Bill, as approved by Parliament on 28 Apr 22, approved the formation of Integrated Care Boards and for them to take over the functions of Clinical Commissioning Groups. As a result, NHS Thurrock CCG dissolved on 30 Jun 22 and the Mid and South Essex Integrated Health and Care Board was formed from the following day. In line with the provisions of the Group Accounting Manual the assets and liabilities of the CCG transfered to the newly formed Integrated Care Board at book value. Further details are provided in the annual report and in the accounting policies.

18 Financial Performance Targets

NHS clinical commissioning group have a number of financial duties under the NHS Act 2006 (as amended).

NHS clinical commissioning group performance against those duties was as follows:

	1-Apr-22 to 30-Jun-22 Target £'000	**1-Apr-22 to 30-Jun-22 Performance £'000**	**1-Apr-22 to 30-Jun-22 Duty achieved?**
Expenditure not to exceed income	65,818	65,818	Yes
Revenue resource use does not exceed the amount specified in Directions	65,444	65,444	Yes
Revenue administration resource use does not exceed the amount specified in Directions	495	495	Yes

	2021-22 Target £'000	2021-22 Performance £'000	2021-22 Duty achieved?
Expenditure not to exceed income	281,685	281,685	Yes
Revenue resource use does not exceed the amount specified in Directions	279,858	279,858	Yes
Revenue administration resource use does not exceed the amount specified in Directions	3,441	3,441	Yes

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS MID & SOUTH ESSEX INTEGRATED CARE BOARD IN RESPECT OF NHS THURROCK CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Thurrock Clinical Commissioning Group ("the CCG") for the three month period ended 30 June 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 30 June 2022 and of its income and expenditure for the three month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 June 2022 as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 July 2022, NHS Thurrock CCG was dissolved, and its services transferred to NHS Mid & South Essex Integrated Care Board. Under the continuation of service principle the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in respect of this matter.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis as the CCG has been dissolved and its services transferred to another public sector entity, the ICB, and the Accountable Officer has not been informed by the relevant national body of the intention to cease the services previously provided by the CCG. 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 associated with the continuity of services provided by the CCG and transferred to the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and

- we have not identified and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the 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 services provided by the CCG will continue to be provided by the successor body.

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 of the successor ICB and internal audit 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.
- Reading Governing Body and Audit Committee minutes of the CCG.
- Using analytical procedures to identify any unusual or unexpected relationships.

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

As required by auditing standards, 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.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual double entries where one side included either Cash & Borrowings or Revenue.

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

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

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

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

Firstly, the CCG is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the CCG is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law recognising the regulated nature of the CCG's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

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

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

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as 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, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

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

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") 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 2022/23. 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 all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 37, the Accountable Officer of the ICB 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 either cease the services provided by the CCG or dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

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

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 37, 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 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 Board of NHS Mid and South Essex Integrated Care Board in respect of NHS Thurrock 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 Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, 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 Thurrock CCG for the three month period ended 30 June 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
Dragonfly House
2 Gilders Way
Norwich
NR3 1UB

28 June 2023