NHS
East and North Hertfordshire
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS

Q1 2022/23

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CONTENTS

Dr Jane Halpin
Accountable Officer

NHS East and North Hertfordshire
Clinical Commissioning Group (CCG)

NHS Herts Valleys
Clinical Commissioning Group (CCG)

NHS West Essex
Clinical Commissioning Group (CCG)

Hertfordshire and West Essex
Integrated Care System (ICS)

Dr Prag Moodley
Chair

NHS East and North Hertfordshire
Clinical Commissioning Group (CCG)

PERFORMANCE REPORT: OVERVIEW OF PERFORMANCE

This section contains a summary of our performance as an organisation between 1st April 2022 to 30th June 2022 plus a flavour of the work we do. You can read more about our work at: www.enhertsccg.nhs.uk

ABOUT US

We are the local NHS organisation which plans and pays for the health services used by almost 575,000 people who live in our area. Led by local GPs, the CCG works closely with clinicians, patients and partner organisations to decide how our annual budget of more than £954m should be spent.

We aim to:

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

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

WHAT IS COMMISSIONING?

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

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

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

Our role is to:

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

Our strategic objectives, which guide our work, are available on **www.enhertsccg.nhs.uk** Performance of the organisation is regularly reported to and discussed at the CCG's Governing Body which met virtually in public twice during Q1 2022/23.

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

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

COMMISSIONING

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

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

PROVIDING CARE

As a commissioning organisation, we do not directly care for patients. Acute hospital services - where a patient receives short-term treatment for a severe injury or illness, an urgent medical condition, or during recovery from surgery - are provided for our residents by NHS hospital and community trusts, NHS foundation trusts and other independent providers of health services.

The CCG has contracts with more than twenty providers, and we also pay for care at other Care Quality Commission (CQC)-registered providers where needed. The main hospitals our patients use are **East and North Hertfordshire NHS Trust**, **Princess Alexandra Hospital NHS**

Trust and **Royal Free London NHS Foundation Trust**.

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

For urgent care, our patients use the Integrated Urgent Care service delivered by **HUC** through NHS 111. There are also minor injuries services at Cheshunt and Bishop's Stortford and the Urgent Treatment Centre at the New QEII Hospital.

The CCG also commissions around twenty other community providers to deliver services including termination of pregnancy, vasectomy, IVF, end of life care, non-emergency patient transport and optometry.

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

Provider	Service category
East and North Hertfordshire NHS Trust	Acute
Hertfordshire Partnership University NHS Foundation Trust	Mental Health
Princess Alexandra Hospital NHS Trust	Acute
Hertfordshire Community NHS Trust	Community and Minor Injuries
Royal Free London NHS Foundation Trust (including Chase Farm Hospital)	Acute
East of England Ambulance Service NHS Trust	Ambulance and non-emergency patient transport
Cambridgeshire University Foundation Hospital Trust (including Addenbrookes Hospital)	Acute
HUC	Integrated Urgent Care
North Middlesex University Hospital NHS Trust	Acute
University College London Hospitals NHS Foundation Trust	Acute

12% of the CCG's budget (a total of around £113m) is spent on primary care services. More information about our expenditure in 2022/23 can be found from page 52.

HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE SYSTEM (ICS)

What are integrated care systems?

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

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

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

Providers working together

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

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

CHIEF EXECUTIVE'S SUMMARY AND ANALYSIS OF KEY PERFORMANCE

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

Governance overview

On 28 April 2022, the Health and Care Bill, the draft legislation designed to reform health and care services and the way they work together, was granted 'Royal Assent' by the

Queen with the measures in the Bill becoming law in the UK, under the Health and Care Act 2022 on 1 July 2022.

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

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

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

Hertfordshire and West Essex Integrated Care Partnership development

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

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

Supporting our staff through transition

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

Tackling waiting lists for treatment

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

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

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

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

We know there is also increased demand from people for whom the pandemic has delayed getting a diagnosis for their symptoms. We are rapidly building our capacity to provide more diagnostic tests, opening up evening x-ray and ultrasound clinics at our area's new Community Diagnostic Centre (CDC) at the New QEII Hospital, with plans for that service to steadily increase the type of tests offered and its opening hours to a 12 hour a day, seven day a week service by the autumn. Key to delivering this extra capacity is people; we are fully aware of the additional pressure this extra workload is putting on staff who have given over and above the demands of their roles throughout the pandemic. Each NHS trust has support in place for staff wellbeing and this offer is being expanded all the time. Work is also underway to recruit internationally for allied health professionals, such as

radiographers, and with Health Education England to introduce ‘academies’ for imaging and endoscopy staff to support the development of the existing and future workforce.

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

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

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

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

Urgent and emergency care

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

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

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

Understanding GP practice pressures

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

- patients being understandably reluctant to contact the NHS at the peak of COVID which for some has led to symptoms developing further or becoming more complex and urgent
- the role that GP practices play in ensuring that people can access the tests and specialist input they need for their condition, so as the NHS tackles the backlog of people waiting for diagnostic tests, this increases the volume of administration work required by practice teams
- an increase in the number of people needing help for a range of mental health issues
- people not feeling as confident to manage their minor health issue themselves, as they might have done pre-pandemic and contacting a health professional for advice

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

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

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

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

Our response to the COVID pandemic

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

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

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

Working with People and Communities

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

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

Developments at 'place' level

Our area's three health and care partnerships, which represent the interests of the areas served by the three former Hertfordshire and west Essex CCGs, plus the Hertfordshire-wide collaborative for mental health, learning disabilities and autism, have developed and

established their priorities. The ICB's three place directors are leading engagement with the partnerships to help them deliver on their aims. More information about each health and care partnership can be found on the ICS website: **https://hertsandwestessexics.org.uk/**

Dr Jane Halpin
Accountable Officer

Date signed: 16th November 2023

THE CCG'S WORK IN 2022/23

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

PRIMARY CARE

What are Primary Care Networks?

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

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

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

Although primary care networks will be delivering services, they are also expected to think about the wider health of their population, taking a proactive approach to managing population health and assessing the needs of their local population alongside

commissioners like the CCG to identify people who would benefit from targeted, proactive support.

Access to Primary Care

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

The overall demand on primary care services has risen substantially, long-term conditions requiring monitoring and stabilisation, help whilst waiting on hospital waiting lists for surgical procedures. This increased demand is reflected in primary care appointment data collected by NHS Digital[1], the total number of appointments attended across ENHCCG in quarter 1, 2022/23 rose to 717,839 an increase of 212,266 compared to quarter 1, 2020/21 representing an overall 30% increase.

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

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

Appointment data published by NHS Digital during this period indicates that 47% of all appointments were provided on the day that they were requested and that 86% of appointments were offered within 14 days[2]. Considering the high demand for appointments including those of a routine nature, these waiting times highlight how hard local primary care services have been working in order to provide care for our local population which is so important and valued.

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

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

Vaccination Programme

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

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

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

Seasonal Influenza Vaccination Programme

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

Additional Role Reimbursement (ARR) Scheme

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

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

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

PCN Development Fund

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

Support development and maturity of PCNs including enhancing integration

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

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

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

Initial accommodation Centres

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

For East and North Herts area**,** there are two IAC Hotels, one in West Essex being supported by a Local Enhanced Service arrangement by a practice in East & North Herts as the Hotel is closer to the ENH practice.-The other IAC hotel is in Welwyn Garden City (WGC) and supported by 4 local practices in WGC.

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

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

Premises

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

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

The Premises Team continued to strengthen relationships with all local authorities to ensure that health has a place setting in local plans and infrastructure development plans and the teams have also responded and engaged with local authorities on ambitious housing growth planned across the ICS geography. Developers' contributions have started to be secured in legal agreements towards future healthcare infrastructure.

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

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

Projects funded under the Estates Technology Transformation Fund (ETTF).

- Standon and Puckeridge completed their project to extensively extend their premises in May 2022
- Stanmore Medical Centre in Stevenage completed their project in May 2022 which increased the area demised to the practice where they are now the sole occupier of the site.
- South Street Surgery are looking forward to moving into part of the wing when the major reconfiguration and improvement project completes in October 2022. Parsonage Surgery that are already providing services from the Kitwood Unit are also looking forward to the completion of the project as their space will be bigger and better

Having gained full business case approval, Wallace House in Hertford are nearing completing the legal pack with a forecasted completion of late 2023/early 2024 for their new, long-awaited premises at Bircherly Green.

South Street Surgery in Bishops Stortford also gained full business case support to relocate part of their business to Stortford Fields and the work on that legal pack is in progress.

The team continues to support the practices in Letchworth, Astonia House in Baldock and Church Street Practice in Bishop Stortford on business case development for improved, extended or new practice premises.

Primary Care Network Directed Enhanced Service (PCNDES)

NHSE PCN Plans for 2022/23

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

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

Key highlights for PCNs include:

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

SUMMARY OF PERFORMANCE QUARTER 1, 2022/23

Prior to the formation of the Hertfordshire & West Essex Integrated Care Board (ICB) on 1 July 2022, the focus for East and North Hertfordshire CCG during its final 3 months of operation was the continued recovery of key constitutional standards and waiting lists that were impacted by the COVID-19 pandemic.

The final Quarter 1 2022/23 position is set out below:

A&E four hour operational standard

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

Performance at East and North Hertfordshire Trust remains challenged and failed to achieve the national standard:

A&E	Target	Q1	2021/22
Treated / Admitted / Transferred in under 4 Hours	**95%**	**65.85%**	**73.97%**

A&E attendances have remained consistently above historical average placing pressure on the Urgent and Emergency Care pathway, this has coincided with period of deterioration in performance against the 4hr standard.

Response times to ambulance calls

Ambulance services are measured on the time it takes from receiving a 999 call to a vehicle arriving at the patient's location. There are four categories of call with associated required average response times:

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

- **C4** Less urgent calls (90% of calls to be responded to within 180 minutes)

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

EEAST Ambulance Response	Target	Q1	2021/22
C1 People with life threatening injuries and illness	**<7 minutes**	**9:33**	**8:49**
C2 Emergency calls	**<18 minutes**	**55:09**	**41:54**
C3 Urgent calls	**<120 minutes**	**476:50**	**306:32**
C4 Less urgent calls	**<180 minutes**	**513:52**	**382:02**

Waiting times for cancer treatment

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

Two-week waits

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

28 day Faster Diagnosis Standards (FDS)

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

31 days

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

- A maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen

62 days

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

Table: Cancer waiting times for all East and North Hertfordshire patients attending any hospital

East and North Hertfordshire CCG met 2 out of 10 cancer performance standards in Quarter 1 2022/23. The CCG continue to work closely with ENHT and PAH, where the majority of patients attend, to improve cancer pathways.

Cancer Waiting Times at CCG level		Target	Q1	2021/22
Two Week Waits	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	**93%**	**89.36%**	**89.63%**
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	**93%**	**87.54%**	**89.42%**
28 Day Faster Diagnosis Standard (FDS)	A maximum 28-day wait from urgent GP referral to be diagnosed with, or have cancer ruled out	**75%**	**67.32%**	**95.75%**
31 Day Waits	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	**96%**	**93.80%**	**90.02%**
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	**94%**	**88.07%**	**99.16%**
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime	**98%**	**100%**	**99.16%**
	Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy	**94%**	**96.99%**	**97.85%**
62 Day Waits	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	**85%**	**75.83%**	**79.50%**
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	**90%**	**76.19%**	**77.29%**

	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	**85%**	**73.02%**	**83.08%**

ENSURING SAFETY & QUALITY

The work of our nursing and quality team.

Quality continues to be a leading priority for ENHCCG. One of our strategic objectives for Q1 is to commission safe, good quality services that meet the needs of the population, reducing health inequalities and supporting local people to avoid ill health and stay well.

The following section explains how we have continued to discharge our duty under Section 14R of the National Health Service Act 2006 (as amended) to improve the quality of services.

- During Q1 2022-23 assurance has been gained through quality assurance visits, quality review meetings, review of patient safety incidences.
- The CCGs Quality Alert System is a direct way for GPs and practice staff to alert healthcare providers and the CCG of any concerns
- Quality Committee reports to the Governing Body, providing assurance on the quality of services we commission. The committee is alerted to any key quality, safety and/or performance issues, relating to core services as well as the impact of COVID-19
- Monitoring complaint themes and trends from our main providers.

Serious Incidents

'Serious incidents' in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

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

The CCG's Serious Incident Panel meets weekly to review investigation reports to make sure they are robust and have considered all aspects of how an incident happened and what is being done to learn from it.

During Q1 2022/23 ENHCCG were notified of 54 SIs in total. In some cases, a SI will be downgraded following full investigation, as it has been identified that SI criteria was not actually met. These cases would still be included in the data provided.

'**Never Events**' are serious incidents that meet the following criteria:

They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers

They have the potential to cause serious patient harm or death, although serious harm is not required to have happened in order to classify as a Never Event

There is evidence that the category of Never Event has occurred in the past (nationally) and a risk of recurrence remains.

In Q1 2022/23 there were no Never Events declared across all ENHCCG providers.

Patient Experience

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

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

In Q1 ENH received 43 complaints and MP enquiries. Of these 7 were investigated by ENHCCG: 3 formal complaints and 4 MP enquiries. The themes for complaints in Q1 related to prescription of a red listed drug, IFR process and care received. The remaining were passed onto other providers or other CCGs for investigations and response.

The CCG received 19 PALS (including vaccination) enquiries. Themes related to funding enquiries and vaccinations for housebound patients.

Infection Prevention and Control (IPC)

Healthcare Associated Infection (HCAI) Data:

- ***Clostridioides difficile* infection (CDI)** – ENCCG have a rate below that of the East of England (EoE) region, and at the end of Q1, ENHT are above the rate for acute trusts within the region.
- **MRSA blood stream infection –** 1 case was reported by ENHT during Q1 and 1 case reported in ENCCG. This is currently being reviewed to identify any learning.
- **MSSA blood stream infection (BSI) –** During Q1, ENHT have a rate below region. This was also reflected in the ENCCG data.

- ***E. coli* blood stream infection –** ENCCG were below their threshold and below the regional rates for Q1, but ENHT had exceeded their thresholds but was below the regional rate.
- ***Klebsiella* spp blood stream infection –** At the end of Q1, ENCCG had exceeded their threshold but was below the regional rate.
- ***Pseudomonas aeruginosa* blood stream infection –** During Q1, ENCCG and ENHT were below their thresholds, but ENHT was slightly above the regional rate

The CCG IPC team produce a monthly HCAI report and comparative data analysis that facilitates discussion with individual service providers. There is currently a process for RCA of HCAIs and identification of learning. A review and overhaul of this process is included within the draft integrated HWE IPC 5 Year Strategy. The proposed strategy also prioritises key areas that will positively impact on rates of HCAIs such as programmes to strengthen IV access practice, Aseptic Non-Touch Technique (ANTT) and urinary catheter management.

A more detailed integrated plan will be produced following the strategy workshop which was carried out in August 2022. Assurance regarding the implementation of identified learning from case reviews is also reported and monitored via the trust IPC Committee. This includes reporting of Trust audit programmes and results. Learning and challenges are disseminated more widely and discussed at the monthly system IPC network group meetings.

Outbreaks and Incidents:

- ***COVID 19*** - Within the CCG, the number of reported outbreaks and clusters had been steadily increasing throughout Q1 – In total, there were 6 reported outbreaks in ENHT, 1 in HCT (QVM) and 4 reported in HPFT (within East and North Hertfordshire). There was also 1 outbreak reported within an independent hospital, 1 in a hospice and 1 within primary care, within ENCCG. In addition, there were 5 clusters relating to Covid – 1 in HPFT and 4 in primary care. The ICB IPC team have attended the IMTs (Incident Management Team) regularly and provided support to staff in the affected units. Outbreaks have also been discussed at the monthly network meetings where the risks associated with the hierarchy of controls were reassessed. Extraordinary meetings were also implemented to ensure appropriate development and implementation of risk assessments in terms of Living with Covid guidance and monitoring the impact on patients and services.
- **Monkeypox** The incidence of monkeypox cases had been increasing steadily during Q1. Most cases were reported in London and in gay, bisexual men and other men who have sex with men. Extraordinary meetings with all provider settings were arranged to ensure that national guidance was implemented. Adult and children's care pathways have been developed which covered the responsibilities of the clinical risk assessment, safe swabbing procedures, treatment and follow up of possible/probable and positive cases. One of the major challenges was the development of a pathway for the under 18's where it is not appropriate for them to attend the sexual health clinics. A variation of contract that covered HWE ICS was

investigated and at the time of writing this report (18th August), this contract is being finalised. Although reported in quarter 2, an incident was reported in a Nursery School. An IMT meeting was implemented, and the exposed children were followed up and offered vaccination.

- **Tuberculosis -**There were 2 separate incidents involving Tuberculosis which were both in East and North Hertfordshire. The first case involved 2 positive cases working in a Packaging Company and 20 – 30 colleagues required screening. The second case involved a worker who was employed in a food processing warehouse and approximately 8 colleagues were screened.

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

Healthwatch Hertfordshire

The Nursing and Quality Team work closely with Healthwatch Hertfordshire and with colleagues within the CCG to improve services based on feedback received from patients contacting Healthwatch Hertfordshire. The CCG has undertaken an exercise to review Healthwatch publications to extract key learning and identify where local action can be taken to improve the experience of our patients when accessing and using healthcare services.

Maternity Services

In Q1 Maternity services continue to experience challenges in recruiting to a full workforce that impacts on delivery of services to women and their families. There are a number of mitigating actions in place to support:

Recruitment and retention plans, include International recruitment with support from workforce leads, redeployment of seconded and specialist Midwives to improve clinical capacity. Use of bank and locum staff to backfill.

- Support for psychological support from various agencies and platforms
- Funds allocated through a bidding process to support capacity between establishment and birth rate +, all trusts successful in securing funding.
- Birthrate + review completed to support continuity of care
- Regional lead to build capacity across the East of England plus implementation of Regional divert and closure policies
- Forward planning for medical staff attendance at training
- Senior teams meet regularly to monitor workstreams re key actions from the Immediate and Essential Actions and local GAAP/SWOT analysis.

- Ongoing audits of compliance and action plans where indicated

Primary Care

- During Q1, quality support visits were carried out to 3 GP practices and 1 Extended Access provider. Where areas of concern were noted, action plans were agreed with the practice and have been monitored by the Nursing & Quality team. Good practice identified has been shared with fellow practices.
- ENHCCG were informed of planned CQC (Care Quality Commission) inspections during Q1 to practices in East and North Hertfordshire. The practices concerned were offered targeted support and mock inspections.
- The Nursing & Quality team continue to provide information and updates to practices through the regular GP bulletins and Practice Manager Forums, including sharing information on themes emerging from CQC inspections and good practice from those rated as outstanding.
- There were no changes to CQC inspection ratings for GP practices in Q1, although one practice will have their inspection archived due to merger. In East and North Herts in Q1, 51 practices were rated as 'good' and 1 practice is rated as 'requires improvement'. This practice is awaiting re-inspection.

Care Homes

- Quality monitoring and full Provider Assessments and Market Management Solution (PAMMS) have resumed to full scale following the easing of Covid 19 restrictions. During Q1 the monitoring team carried out 9 Quality Assurance Visits and 7 PAMMS joint monitoring visits.
- Visits support identification of patient care and safety issues and Care Homes continue to be supported through Hertfordshire Care Providers Association (HCPA).
- There is a significant and varying Personal Protective Equipment (PPE) compliance within Care Homes across Hertfordshire after the latest guidance was published by the Government. Hertfordshire County Council (HCC) has written to all Care homes encouraging them to continue following the COVID 19 guidance specific to Care Homes. Outbreaks continue to be monitored through the Outbreak Cell.
- One residential Home was closed in this quarter following an Inadequate rating and a Notice of proposal from the Care Quality Commission (CQC). A multi-disciplinary Lessons Learnt event was held to reflect on this unusual Care Home Closure. Lessons learnt are being used to develop The Safety Improvement Process and the Hertfordshire (HCC) Care Home closure policy.
- A brand-new state of the art Nursing Home has been opened within Broxbourne and another Nursing Home within the same area is changing owners. Both homes are being supported to ensure patient safety during the transition period.

- There are two Nursing Homes within the Safety Improvement process, East and North Herts Nursing and Quality team continue to work with other system partners to support these homes.
- Accident and Emergency attendance dashboard has now been developed and the Care Oversight team is working with the data insight from acute hospitals to understand hospital admission from care homes. Findings will be shared in the next quarter and will be used to improve prevention to hospital admissions from Care Homes.

Caring for vulnerable residents

Safeguarding Adults

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

Our CCG Director of Nursing and Quality and Associate Director of Adult Safeguarding are both members of the Hertfordshire Safeguarding Adult Board (HSAB), the Domestic Abuse Executive Board and the Multi-agency Prevent Board.

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

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

- Mental Capacity (Amendment) Act (2019): Coordinating the CCG response to the consultation on the draft Code of Practice and Regulations and contributing to the Hertfordshire multi-agency response. Working to ensure a strong foundation in the knowledge and use of the MCA within the CCGs and our providers.
- CCG staff are supported to complete their safeguarding learning through a blended approach of e-learning and participatory sessions. We continue to provide safeguarding supervision for all CCG staff who have patient contact to support them in their roles and promote best practice.
- Worked with partnership agencies to support care homes and care providers to monitor quality and management of risk with the CCG, chairing the Hertfordshire Safeguarding adult Board (HSAB) Strategic Quality Improvement Group to drive forward quality assurance processes, shared learning and response to areas of concern. Delivered training about quality and how to report concerns in care homes to community practitioners.
- As part of the HSAB we chair the Safeguarding Adult Review (SAR) subgroup to promote effective learning and improvement.

- Represented the CCG in the recommissioning of the Independent Domestic Violence Advocate Service. We also chair the Quality and Innovation sub-group of the Domestic Abuse Partnership Board. One of the objectives of this sub-group is to identify learning, ensuring that it is shared and implemented by partners.
- The team supported CCG staff in managing complex cases through individual case discussions and group supervision. Support and guidance were also given for colleagues in providers and primary care managing complex cases through individual case discussions and interventions

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

Safeguarding children
Safeguarding and promoting the welfare of children is a key responsibility of the CCG as responsibilities for safeguarding are a statutory requirement supported in legislation. The Children Acts 1989/2004, and Children and Social Work Act 2017 and the Health and Care Act 2022 places a duty on local authorities to promote and safeguard the welfare of children in need in their area.

- The safeguarding team continue to work towards an integrated structure to reflect changes introduced by the Health and Care Act 2022 to support transition to the ICB.
- The NHSE/I safeguarding program funding in 2021/2022 has supported key areas of learning in relation to safeguarding priorities, in particular upskilling the workforces understanding of Mental Capacity Assessment in preparation for the impending Liberty Protection Safeguards, and supporting acute organisations manage complex trauma cases in clinical settings.
- The National Safeguarding Practice Review Panel (2022) and local Hertfordshire Serious Safeguarding Reviews have identified practice gaps in relation to:
    - Information sharing and risk assessments for fathers and co-habiting partners,
    - Safety planning where risk is known

The Designated team are participating in multi-agency task groups under the Governance of two Boards (The Hertfordshire Safeguarding Children Partnership and Family Safeguarding Board) with a view to improving the reach to fathers and partners and to make recommendations to the Boards around universal and targeted Programmes for fathers and partners along with more robust processes for information seeking and sharing.

The National Panel published the findings of the reviews into the deaths of Arthur Labinjo-Hughes and Star Hobson. Key recommendations include a review of multi-agency arrangements and the integration of skilled professionals into Multi-Agency Child Protection Units.

The Designated team have joined Statutory Partners to review the arrangements of the existing Multi-Agency Safeguarding Hub which includes the recommendation for an increase in health partner capacity in the MASH. These temporary posts are out for recruitment. The Designated team plan to host senior and front-line practitioner events in Quarter 2, 2022-2023

Ukraine refuges and unaccompanied children: Work is in progress to support the safe placement of unaccompanied children from the Ukraine into Private Fostering by the Local Authority. Oversight of arrangements is via the Essex Tactical Coordination Group and the Hertfordshire Ukraine Support Group. A Health needs group provides oversight of mental health support, processes for sponsors and appropriate escalations.

Child Death Overview Panel (CDOP): HCC and ICB risk registers have been updated due to recommended timescales not being met. A business case to support a revised model of CDOP delivery is currently in development to increase capacity and reduce inequality in service provision between expected and unexpected death.

Children Looked After (CLA): The Corporate Parenting Board has been revised to include a new Executive Board, that will include representatives from Looked After Children and business and commerce sector.

There are an increased number of CLA, with complex risk factors, which places an increased demand on the Provider service to meet additional requirements.

This ability of out of area providers to fulfil their statutory requirements in a timely manner also impacts on the capacity of the Hertfordshire team who are:

- Seeking to understand the current capacity within service for statutory in county placements
- Working towards business case to support increased activity – expected Autumn 2022.
- Improving collection of information in for the older child cohort which will also inform the transition process.

Child Looked After statutory Health Assessments (includes out of county) There are increasing numbers of delays with assessments of children placed out of county where reliance on another service is required to complete the assessment process. These are being escalated by the Health Team and are being addressed individually as they occur along with escalation to the Regional Team. All CLA have a regular review of their health action plans and these are continuing.

Initial Health assessment (IHA)/ Review Health Assessment (RHA) Compliance

Compliance is over the locally agreed KPI of 85%

- Initial Health Assessment Hertfordshire compliance - 86%
- Review Health Assessment Hertfordshire compliance – 91%

Mental Health

During Q1, there were 4 Quality assurance visits carried out throughout Hertfordshire Partnership Foundation Trust (HPFT). The areas of concerns were addressed with HPFT and action plan shared and monitored through follow up visits.

There was no CQC visit in HPFT in Q1. HPFT is waiting for CQC follow up visit at Forest House Adolescent Unit.

Themes identified through SI are being addressed through Quality assurance visits.

Risk Assessments

HPFT carried out a CQI project to explore the reasons for underperformance, particularly where there are large medical caseloads. HPFT introduced the simplification of recording risk via case-note entries. It was successfully piloted and rolled out to all areas. Data for June 2022 showed significant improvements.

Improving the health of people with a learning disability

- The local **LeDeR (Learning from Lives and Deaths)** Leadership group and Improving Health Outcomes Group (IHOG) continues to meet virtually to ensure requirements of the policy are met and that learning from reviews, leads to cross system service improvement.

- Delivery of **Annual Health Checks** for people with learning disabilities continues to be a priority. The Learning Disability Nursing Service continues to promote An Annual Healthcheck preparation tool to increase the quality of completed checks and embed a collaborative approach.

- The **STOMP/STAMP programme** to address over-medication of people with a learning disability or autism with psychotropic medications continues to be supported by the STOMP nurse. This work to continues to support reductions of medications for adults and is contributing to a national pilot to understand prescribing and medications for children and young people.

- Significant effort has been focused on the Covid vaccination programme. A collaborative approach between health and social care has ensured maximum uptake of both the primary vaccinations and boosters for people with a learning disability.

- Care and Treatment Reviews are carried out virtually for both community and inpatient settings and regular monitoring visits of specialist LD hospitals are carried out on-site. Host commissioner responsibilities continue, overseeing community and inpatient specialist LD hospital services in the Hertfordshire footprint.

REDUCING HEALTH INEQUALITIES

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

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

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

There are differences in people's health outcomes in different districts[3]. For example:

- Life expectancy for women in east Hertfordshire is two years longer than in north Hertfordshire. In the Welwyn Hatfield area – the gap is 8.9 years between the most and least deprived areas of this borough.
- More people in the borough of Broxbourne have been diagnosed with diabetes than other areas of the county
- Stevenage generally tends to have poorer health outcomes than other districts in the county.

Working with partners to tackle health inequalities

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

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

[3]https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2017to2019

We know that people's health, access to services and experiences can be affected by many factors. The COVID-19 pandemic has exposed how health inequalities can affect people not just over a lifetime but in a matter of weeks. The CCG is committed as a commissioner to planning services that meet the needs of everyone in our communities and we strive to continue to improve access for patients, in part by meeting our Public Sector Equality Duty and our requirements under the Equality Act 2010. We are also working hard to give equal priority to physical and mental health needs.

Tackling health inequalities for people of all ages, or 'life stages', is a key local ambition.

The role of Hertfordshire's Health and Wellbeing Board

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

The CCG works with partners taking a joined-up approach to tackle the causes of poor health as well as supporting people to make healthier lifestyle choices and improving healthcare. Hertfordshire has a strong history of partnership working and to date has had one of the largest pooled Better Care Funds[4] in the country. This brings NHS and social care money into a single shared fund to help prevent older and vulnerable people going into hospital when they don't need to and provide them with support in their community.

The overall ambition of the Health & Wellbeing Board is to reduce the gap in life expectancy, increase years of healthy life expectancy and reduce the differences between health outcomes in our population. To reach these long-term ambitions, six key overarching priority areas have been identified:

- Aim to keep people safe and reduce inequalities in health, attainment and wellbeing outcomes.
- Use public health evidence, other comparison information and Hertfordshire citizen's views to make sure that we focus on the most significant health and wellbeing needs in Hertfordshire.
- Centre our strategies on people, their families and carers, providing services universally but giving priority to the most vulnerable.
- Focus on preventative approaches – helping people and communities to support each other and prevent problems from occurring for individuals and families in the future.
- Always consider what we can we do better together – focussing our efforts on adding value as partners to maximise the benefits for the public.

[4] **Better Care Funds**

- Encourage opportunities to integrate ours services to improve outcomes and value for taxpayers

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

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

The strategy was reviewed and refreshed during 2021/22 and into 2022/23 following disruption from the COVID pandemic. Engagement with a wide range of stakeholders has taken place to gain a better understanding of the diversity and variety of health and wellbeing activity that takes place across the county and the role that local areas, networks and communities can play in helping to achieve improvements.

Hertfordshire Health and Wellbeing Board has consulted on a new health and wellbeing strategy which is expected to be launched in Summer 2022

The CCG's approach on inequality

Using insight

To help plan our work and identify need, we use information, data and insight. This is provided by our partnership with Mede Analytics and the information available to us through Public Health Hertfordshire, **Herts Health Evidence** and **Public Health England**. We use the NHS RightCare Pack for our area to help us understand how we compare to other parts of the country with similar demographics. These packs have been developed by a partnership of the NHS and a number of universities and aim to support health and care systems design and deliver services that work to reduce health inequalities in access to services and health outcomes for their diverse local populations.

One of the challenges facing Hertfordshire is how we deliver the best care for our increasingly ageing population. We expect the number of over-75s to increase by 37% in the next 10 years. We are working to increase the support available, and we aim to identify people at risk of avoidable hospital admission sooner, before they reach the point where they are no longer managing to cope. We will achieve this by creating integrated teams; with primary care, community health, mental health and learning disability, ambulance and social care services working together in the community.

We will ensure people who are most "at risk" – due to social vulnerabilities and their clinical needs – are prioritised for integrated care plans that are person, carer and whole-system owned. This will include groups of people who have the biggest inequalities in health such as looked after children, those with serious mental illness and people with

learning disabilities, as well as those with a high frailty score. We are also seeking to develop personalised plans around people who have had multiple A&E attendances, multiple emergency admissions and those who have used 999 or 111 multiple times.

Clinical evidence

We have been using our 'prioritisation framework' to provide a structured, evidence-based way of considering which services could be commissioned by the CCG within its limited budget. This framework, used alongside our detailed equality impact assessment process allows our governing body to evaluate all proposals ensuring they produce the best outcomes for patients, offer good value for money and don't negatively impact on particular groups of people.

The CCGs employ a number of 'clinical fellows' whose role is to provide clinical insight to support the CCGs in developing plans. They review the available evidence to develop robust, evidence-based care pathways, new models of care and service transformation plans, which support the implementation of a population health management approach within the CCG and ICS.

Improving our equality impact analysis

The CCG is continuously improving its approach to equality impact analysis (EIA). All CCG staff are reminded of the requirement to undertake thorough equality impact assessments at the planning stage of any project and training is available for those who need extra support.

A number of other CCG projects aim to ensure patients have access to the same standard of care, wherever they live and whatever their background:

The CCG were involved in a bid to NHS Charities Together (NHSCT) on behalf of HCT Trust as lead charity and the ICS, in partnership with Hertfordshire County Council, following consultation with NHS Charities and local voluntary organisations working with the Volunteering and Personal Assistance Cell (VPAC). This has funded five Herts projects:

- Two full-time-equivalent BAME COVID-19 Recovery workers who started work in April (2-year project). The workers are linked to the COVID-19 Information workers and volunteers (Public Health England[1] funded) and are reaching into communities to provide a mixture of BAME social prescribing (SP) and advocacy and to provide input into the SP system (88 workers) to support cultural competence. They have worked with the BAME community on VCFSE capacity, but also particularly in partnership to assist in addressing vaccine hesitancy. The project runs to March 2023
- As at June 2022, the Digital Inclusion project (Staying Connected) has received 177 donated IT devices, engaging 11 private companies, supplied 57 users with free

[1] In October 2021 Public Health England became known as the UK Health Security Agency.

equipment, and 58 with connectivity; 239 users have been supported to use kit by a volunteer Digital Champion and 57 Champions have been trained in 277 sessions. 90 Afghan refugees have benefited, including children helped with using IT for homework.

- A winter small grants process distributed £75k of NHSCT funding to projects on the basis of £1500 per PCN in consultation with CDs or link workers as well as an additional £30k to projects suggested by Districts or the VCFSE. Projects addressed digital exclusion, social isolation during Omicron, and local health inequalities. Additional funding was levered from Mental Health commissioners
- The Hospital and Community Navigator service continues to develop, including among its 80 staff, 25 PCN link workers, a new Veterans worker and a Sensory Impairment worker. 26% of clients come from the most deprived 2% of the ICS population, which shows the important work being done to reach those facing the greatest health inequalities

Identification

The CCG 'knowing our population' from an equality perspective and access and use wider public health information used to commission services **https://www.enhertsccg.nhs.uk/intelligence-and-evidence-led-commissioning** .

The CCG also work with voluntary organisations who provide support to most communities.

Accessibility of information to support engagement

To ensure the CCG support engagement from our population, the CCG have shared easy-read, Purple Superstars and non-English language social media for major campaigns such as the 'flu and COVID-19 vaccination programmes.

The CCG shared English-language content for these campaigns aimed at specific groups as well as producing easy-read versions of important information and publications which are checked by a panel of service users with learning disabilities before publication.

Engagement and consultation exercises always include the option of telephoning or posting a response, to minimise the risk of digital exclusion and our website translates all content into more than 50 languages, at the touch of a **button**[5].

Hertfordshire's Community Navigators and Social Prescribing Link Workers made 'keeping in touch calls' to the most vulnerable and have helped us to distribute copies of a **CCG booklet giving health and wellbeing advice to older people** who may be digitally excluded.

[5] **https://www.enhertsccg.nhs.uk/ensuring-our-involvement-accessible**

PATIENT AND PUBLIC ENGAGEMENT

ENGAGING PEOPLE AND COMMUNITY

Priorities in 2022 were focussed around the COVID vaccination programme and combating vaccine misinformation, as well as ensuring GP practices and patients were supported throughout the many changes facing primary care.

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

Health inequalities

Work to tackle health inequalities and achieve equity continues to gain momentum. This is partly because of the work to increase uptake of the COVID-19 vaccinations[6] and boosters, which created new opportunities to connect and engage with many local communities and hard-to-reach groups.

NHS Core20Plus5

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

Primary Care Networks

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

Voluntary and charity organisations come together

[6] Further information can be found on page 17

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

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

Cost of living impact

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

Representatives from Citizens Advice, the district councils, NHS, and voluntary sector have sparked joint action on priorities such as income maximisation and debt management support, as well as better intelligence and information sharing between service providers.

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

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

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

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

The CCG has been engaging with patient representatives on priorities and strategy going forward, key considerations around access to services and communications and will be key in helping to shape engagement with Integrated Care Board (ICB) going forward.

Work began in late winter/spring to encourage members of our Citizens Panel to also join wider, Hertfordshire and west Essex engagement workshops to discuss how we would

engage with the public and patients as an ICB and to form a working group to collaborate on the strategy.

Patient Participation Groups (PPG)

Our CCG has continued to work with, and advocate for, GP surgeries' patient participation groups (PPGs) via their local network arrangements, known as Patient Locality Networks (PLNs)[7]. Lead members from the PPGs across east and north Hertfordshire regularly come together to represent the areas they live in and worked tirelessly during the pandemic to stay connected with their communities. Some have been able to attract more people to online PPG meetings and many have supported local people who are isolated, or worried about accessing NHS services. They have also assisted the CCG and ICS in involving 'experts by experience' such as those with long term conditions.

Our CCG's Primary Care Commissioning (PCCC) and Quality committees each have a patient involvement representative, and the engagement team hosts the Patient Network Quality (PNQ). There are two representatives on the Governing Body, and a Lay Member for Patient and Public Involvement.

Social Media

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

Engaging with primary care colleagues

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

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

COVID-19 briefing

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

Practice Manager Meetings

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

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

[7] **https://www.enhertsccg.nhs.uk/patient-groups-and-involvement**

Our engagement team has been busy day-to-day working with CCG and integrated care system (ICS) colleagues in Hertfordshire and west Essex alike on projects and programmes at all stages of the commissioning cycle. We have also contributed to internal audits, highlighted opportunities to take part in research and insight work.

Regular engagement with volunteer members and other stakeholders[8] has helped us to reflect on engagement practices and make improvements to our approaches.

Service design, commissioning, and change

Feedback from a range of stakeholders - patients, families and carers with experience of using services, patient voice volunteers, and stakeholder organisations such as Healthwatch Hertfordshire – as well as data and other insight, plays a huge part in our CCG's ongoing commitment to improve. The engagement team works with different CCG teams to help ensure the value of patient and public involvement and engagement is spread across the organisation.

Community Diagnostic Hub

Community diagnostic hubs (CDHs) are intended to improve the way in which the health service diagnoses illness across England, and to bring diagnostic facilities closer to more patients away from main 'acute' hospital sites; in our CCG area's case, the Lister Hospital in Stevenage.

East and North Hertfordshire Health and Care Partnership has been awarded capital and revenue funding for our area's hub, at the New QEII Hospital, Welwyn Garden City. The developments will include extended opening hours for radiology (CT, MRI, Plain Film X-Ray and Ultrasound), eventually offering a 12-hour a day, Monday-Sunday service. New cardiology and gastroenterology pathways are also being explored and further plans will be submitted to NHS E/I to expand this even further over the next five years.

During August and September 2022, a public engagement survey is being run to seek patient feedback on diagnostic services to ensure patient experiences help to shape the development of diagnostic services over the years to come.

Community engagement and education

'Cancel Out Cancer'

The CCG's 'Cancel out Cancer' (CoC) campaign remains our flagship community health education programme. Set up in 2019, it involves running 60-minute interactive sessions to help people understand screening programmes, symptoms and reducing their risks of

[8] **https://www.enhertsccg.nhs.uk/working-all-our-communities**

getting cancer. Volunteer presenters work with the engagement team on strategic and tactical elements of the programme.

The move from face-to-face to online sessions in 2020 continues to be a success; at the time of writing, more than 40 people have benefited from these sessions since April 2021, thanks to marketing and stakeholder relation work.

To date, we have achieved well against this programme:

- around 70 GP practice patients alone have taken part in sessions
- we have set up a volunteer training programme to introduce new volunteers
- a closed Facebook group has been established for past participants, to keep sharing their experiences and stories
- monthly public-facing sessions have been established which anyone can join
- we have piloted making the presentation suitable for people with learning disabilities
- relationships have been established with partners, such as Herts Healthy Hubs and the county council.

Participants who attend a Cancel Out Cancer session can complete anonymous surveys before and afterwards. These help with quality monitoring and compare our participants' knowledge and awareness going into the session with what they learn from it. Attendees have reported significant increases in confidence in:

- recognising symptoms
- going to their GP within a week of symptoms appearing
- changing their lifestyle to avoid cancer
- and taking part in future cancer screening.

To get involved, please visit: **www.enhertsccg.nhs.uk/canceloutcancer**

East and North Hertfordshire Health and Care Partnership (HCP)

The CCG's Public Engagement Manager has helped lead the development of the stakeholder voice in the new Health and Care Partnership (HCP), which was working in shadow form until July 2022. This has involved establishing a Community Assembly which met in May 2022.

The Assembly's purpose and objectives were co-produced with members, and are broadly based on these three key areas:

- to help the partnership understand the challenges, needs, and views of the residents in east and north Hertfordshire

- to play a crucial role in the development of health and care services in our area

- to act as a ‘one stop shop’ to enable our community to help us to achieve our objectives.

Involving patient and public representatives

During this period, the Patient Locality Network (PLN) helped us link into communities and in reaching out to GP practices’ patient participation groups (PPGs) and beyond for people with ‘lived experience’ of using NHS services.

We have run nearly all engagement work online but recognise that online engagement isn’t an option for every volunteer we work with or indeed every stakeholder group we want to engage with, and while there are many benefits to engaging in this way, we continue to explore inclusive and sustainable solutions that can help everyone stay connected.

Involving all our communities

We want to ensure all our population is considered and consulted with when our organisation makes decisions about services. The CCG’s projects are subject to equality impact assessments, which are published as part of the Governing Body papers on the website here: **https://www.enhertsccg.nhs.uk/governing-body-meetings-in-public**

Our engagement with partners, stakeholders and community groups acting as advocates or representatives in Hertfordshire contributes to this work. In 2022/23, the CCG has continued to be involved in, or engaged with, many groups including:

- local authority Health and Wellbeing Boards
- the Carers Co-production Board (*known as the Carers Strategy Group*)
- the Hertfordshire Tackling Loneliness Steering Group
- the Hertfordshire LGBTQ+ Partnership.

We look for opportunities to engage with specialist organisations such as local voluntary, community, faith and social enterprise (VCFSE) organisations and invite speakers to Patient Locality Network and Patient Network Quality meetings to help raise awareness of their work.

Herts Health Matters is a fortnightly e-newsletter sent directly to almost 300 subscribers, and promoted on social media. It includes local and national health news, and highlights involvement and volunteering opportunities and local events: **www.enhertsccg.nhs.uk/newsletter-social-media.**

We work with an external company to produce different formats of documents and materials, including ‘easy read’ formats, and we will keep exploring inclusive and sustainable solutions to help everyone stay connected, overcoming any digital exclusion brought about by a change in approach because of the pandemic. We aim to ensure

meetings and access to engagement meet the needs of those taking part; traditional face-to-face engagement in halls and conference centres are not particularly accessible to people with mobility needs, carers, or those who rely on public transport, so a balance needs to be made. We must ensure that if people cannot engage online, they can do so by telephone or post and plan to re-introduce face-to-face engagement as an option.

NHS England and Improvement Oversight Framework

While everyone in the CCG is responsible for maintaining and protecting its good reputation, our team are subject experts and support a range of work to ensure engagement and inclusion. In the past, we have carried out an assessment as part of NHS E/I's National Oversight Framework (NOF) which has a Patient and Community Engagement Indicator (PCEI) to enable CCGs to demonstrate compliance with statutory guidance on patient and public participation.

Our CCG was rated with the highest 'Green Star' for patient and public participation in 2019/20, improving on our 'Green' rating for 2018/19, and 'Amber' for 2017/18.

Due to the continued impact of COVID-19, NHS E/I changed the assessment approach for 2020/21 and a narrative assessment, based on performance, leadership, and finance, replaced the ratings system previously used. This approach has been adapted for 2021/22 and so the assessment approach of evidence submitted against a PCE indicator no longer exists.

However, we continue to evidence patient and community engagement-related activity on the CCG's website in the spirit of showing progress and improvement in that area. Also, the learning from previous Patient and Community Engagement Indicators will help to inform our work to develop a system-wide strategy for engaging with people and communities by July 2022.

The year ahead

Hertfordshire and West Essex's three CCGs are transitioning into the new ICB and the communications teams in the three CCGs are working together more closely than ever as the process of becoming one team continues. A new communications and engagement strategy covering Hertfordshire and west Essex is being developed to reflect and support the priorities of the new ICB.

The CCG continues throughout the transition period to:

- use co-production and engagement methods to ensure patient and public views are central to the development and transformation of services
- nurture the well-established relationships we have with stakeholders, such as partner organisations and bodies, Voluntary, community, faith and social enterprise

(VCFSE) organisations, local politicians and Healthwatch Hertfordshire and Essex throughout the transition process.
- help stakeholders and the public to navigate the changes in health and social care services (direct and indirect) brought about by the COVID pandemic
- lead engagement activity to help the public to access information on the COVID-19 and vaccination programmes to support take-up, help to protect the population's health and maintain public and stakeholder confidence in the vaccination programme – with a specific focus on tackling health inequalities and ensuring no-one is left behind.

Other activities we will focus on include:

- tackling health inequalities by improving stakeholder involvement and engagement
- supporting PCN colleagues to develop a wider reach to their population and stakeholders
- engagement work related to living with, and managing, long term health conditions
- continuing to support the engagement model for the East and North Health and Care Partnership (HCP).

The CCG would like to thank our patient member volunteers and stakeholders for supporting our engagement work. Your support helps us make important decisions, improve services and ensure quality is at the heart of what we do. To get involved with any of the activities you have read about, or simply have your say on local health services in east and north Hertfordshire, visit **www.enhertsccg.nhs.uk/get-involved**, call 01707 685 397 or email **enhertsccg.engagement@nhs.net**

THE WORK OF HERTFORDSHIRE, BEDFORDSHIRE AND LUTON (HBL) ICT SERVICES

Hosted by East and North Hertfordshire CCG, HBL ICT provider IT services to the five member organisations of the HBL Partnership, delivering its agreed 5-year business and digital strategy, which includes embracing collaborative technologies, automation through robotics and enhancing our communication channels to making the service more responsive and accessible to our service users.

In April 2022, WECCG become the latest NHS organisation to join the Partnership, which was a key milestone as this enables the emerging HWE ICB to have a single unified ICT provider across all three 'places' within the HWE geography. ICT services for Primary Care (GPIT) will remain with the current Provider AGEM CSU for the next 12 months, pending transition to HBL ICT. During this period, the GPIT service is service managed by the HBL Partnership to ensure consistency of provision.

Q1 of 2022-23 has been focussed on the complex task of enabling the Clinical Commissioning Groups to digitally transition to their respective emerging Hertfordshire and West Essex (HWE) & Bedfordshire, Luton, and Milton Keynes (BLMK) Integrated Care Boards. The focus being to deliver a seamless transition without compromising business and clinical care during this period in readiness for the 1st July.

In addition, the digital transformation agenda is now very much the primary focus for all NHS organisations, with our digital investments and reputation for delivery, we in HBL ICT are in a good position to realise our true potential as a valued IT Shared Service provider and play our part in the new NHS landscape.

Financial position

At the end of Q1 2022/23, HBL ICT successfully met the control total specified by the Partnership Board, based upon a new 'Activity Based Costing' model incorporating inflation and cost improvement targets, resulting in a small surplus at the financial Q1 period.

Cyber Security

Cyber security continues to be a significant threat globally, which needs to be constantly manged to protect our business and patient data. However, due to the investments in developing a highly secure, resilient and robust IT infrastructure, underpinned by tight control processes and patching regime, the HBL Partnership continues to deliver a highly available service.

Since the start of the conflict in Ukraine, the threat of cyber security events has increased significantly. In response, HBL ICT has increased its defences with the development of a new 'Security Operations Centre' to provide proactive management and monitoring of all services working with strategic 3rd Party Suppliers and NHS Digital.

PREPARING FOR EMERGENCIES

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

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

During this period the CCG remained fully compliant against the NHS EPRR Core Standards. This was endorsed by the Local Health Resilience Partnership (LHRP) and NHSE/I. The CCG is an active member of the LHRP and in June 2022 co-chairing arrangements for the LHRP transferred from NHSE/I and Director of Public Health to our Accountable Emergency Officer and Director of Public Health in readiness for the transition from a CCG to an ICB.

Incident Response

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

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

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

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

SUSTAINABLE DEVELOPMENT

Introduction

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

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

The Plan addresses all areas of the net zero NHS ambitions while also addressing the need to:

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

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

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

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

Sustainability and social values will be embedded into all procurement specifications.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heatwaves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Governing Body approved plans to address the potential need to adapt the delivery of the organisation's activities and infrastructure to mitigate climate change and adverse weather events.

Partnerships

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

Head Office Occupancy

The CCG occupies a small head office space, which is rented from NHS Property Services who also provide facilities management on behalf of the organisation. The energy rating of the building is 'F', which indicates the energy efficiency of the building fabric and the heating, ventilation, cooling and lighting systems.

	2018-19	2019-20	2020-21	2021-22	Q1 2022-23
CCG Net Internal Area of Charter House (m2)	1,730	1,796	1,796	1,796	1,796
Number of staff (Whole Time Equivalent)	286	282	286	289	288
Average floor space per staff member (m2)	6.04	6.37	6.25	6.21	6.23

Energy used (consumption in kWh)[9]

At the time of writing, energy consumption data for this period is not yet available from the property landlord, the latest available data has been included in the table below:

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Gas (natural) consumed	623,464	497,344	409,945	452,162	238,173	294,752
kg CO2e[10]						53987
Electricity consumed	575,969	620,989	352,221	351,077	314,680	313,035
kg CO2e[11]						66467
Total Cost (All Energy Supplies)						£77,220

Paper

The CCG is committed to supporting the movement to a paperless NHS and began monitoring performance in this area from a baseline in 2017-18.

Paper consumed

Material use (primary)	17-18	18-19	19-20	20-21	21-22	Q1 22-23
Paper spend £	2,783	3,308	2,829	630 [12]	876	185
Paper products used - Tonnes	4.19	5.00	3.94	0.78	2.286	0.125

[9] Please note that East and North Hertfordshire CCG shares a building with other organisations and pays a percentage of the overall cost for utilities. It is not possible to identify consumption by organisation so the figures shown are for the overall building.
[10] https://www.gov.uk/government/publications/greenhouse-gas-reporting-conversion-factors-2021
[11] https://www.gov.uk/government/publications/greenhouse-gas-reporting-conversion-factors-2021
[12] Decrease due to most CCG staff working predominantly from home from 2020/21

kg CO2e	3,890	4,778	3,753	717	2102[13]	115[14]

Travel

NHS East and North Hertfordshire CCG spent £5034 on business travel costs during this period. The total spent on business travel costs during the 2021/22 was £6106. We can improve local air quality and improve the health of our community by promoting active travel to staff and to the patients and public that use our services. CCG staff can claim cycle mileage for their business travel and the CCG has joined the government's 'cycle to work' scheme. This allows staff to purchase a bike and cycle safety equipment as a tax-free benefit.

Financial Year	Total Pedal Cycle Mileage claimed as expenses (miles)	Total Travel Mileage (cars) claimed as expenses (miles)	Average Whole Time Equivalent (WTE) staff employed	Average Travel Mileage (cars) per WTE staff employed	Total kg CO2e from Travel Mileage (cars) Estimated using figures for the average car of unknown fuel type, see here.
2016-17	18	269,889	272	992	81,204
2017-18	10	221,613	263	842	65,059
2018-19	0	203,344	285	713	59,116
2019-20	66	205,709	290	709	57,395
2020-21	36	32,906	285	115	9,305
2021-22	0	11,309	271	42	3289
Q1 2022-23	0	8876	288	31	2530

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

Waste Disposal and Recycling

[13] Greenhouse gas reporting: conversion factors 2021 - GOV.UK (www.gov.uk)
[14] Greenhouse gas reporting: conversion factors 2022 - GOV.UK (www.gov.uk)

At the time of writing, waste and recycling data for this period is not yet available from the property landlord, the latest available data has been included in the tables below:

	2017-18	2018-19	2019-20	2020-21	2021-22
Waste disposal spend (£)	11,267	18,359	10,281	10,528	2474

	General Waste (£)	General Waste (Tonnes)	Recycling (£)	Recycling (Tonnes)	Confidential (£)	Confidential (Tonnes)
2019-20	£1,320.21	6.497	£1,184.20	6.29	£4,469.00	18.53
2020-21	£897.00	1.68	£855.00	2.57	£1,735.00	7.23
2021-22	£798.93	0.87	£897.17	1.95	£421.05	5.01

Water and Sewage Cost

At the time of writing, waste and sewage cost data for this period is not yet available from the property landlord, the latest available data has been included in the table below:

	2017-18	2018-19	2019-20	2020-21	2021-22
Water costs (£)	3,787	8,888	5,110	5,447	6549

Key Initiatives 2022/23

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

Locally for East and North Hertfordshire CCG and, in line with government legislation, the organisation successfully moved largely to remote working as a result of the Covid-19 pandemic. A number of Covid-19 protection arrangements have continued to a number of sustainable positives, which support lowering the organisation's carbon footprint including:

• The use of Microsoft Teams video and telephone conferencing, reducing the need for face-to-face meetings leading to reduced business travel and commuting: cutting carbon emissions and improving air quality.

• Video and telephone conferencing for patients: reducing the need for face-to-face contact leading to reduced patient travel: cutting carbon emissions and improving air quality.

• Sustainable/active travel option: reducing carbon emissions and improving air quality; promoting better health and wellbeing.

• Reduced business travel and commuting: cutting carbon emissions and improving air quality. Reducing impact of seasonal hot and / or cold weather / heat waves: lowering need for supplemental mechanical heating, ventilation and cooling – cutting carbon from power consumption.

• Continued reduction in circulation of printed matter – papers and reports: Reduction in use of natural resources and associated carbon emissions.

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

REVIEW OF FINANCIAL PERFORMANCE

SUMMARY

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

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

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

Further details are provided in of the accounts from page 104 of this Annual Report.

Duty [and section of 2012 Act]	Relevance in 2022/23	Achievement
Expenditure does not exceed sums allotted to the CCG plus other income received [223H(1)]	Applicable	✓ **Underspend £2.548m in -year (Cumulative underspend of £21,531m)**
Capital resource use does not exceed the amount specified in Directions [223I(2)]	Not applicable; no allocation in 2022/23	
Revenue resource use does not exceed the amount specified in Directions [223I(3)]	Applicable	✓ **Underspend £2.548m in -year (Cumulative underspend of £21,531m)**
Capital resource use on specified matter(s) does not exceed the amount specified in Directions [223J(1)]	Not Applicable No allocation in 2022/23	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions [223J(2)]	Not applicable; no specified matters in 2022/23	
Revenue administration resource use does not exceed the amount specified in Directions [223J(3)]	Applicable	✓ Achieved Running costs achieved breakeven in Q1 2022/23

FUNDING ALLOCATED TO THE CCG

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

In this allocation round NHS England more than halved the previously provided Covid funding to Systems (£49m for Hertfordshire and West Essex Integrated Care System [HWEICS]), ceased the Hospital Discharge Programme and its funding (£25m for HWEICS), and reduced System top-up funding using a convergence to fair share factor (£17m or 0.7% of baseline funding for HWEICS). These funding reductions were in addition to a national efficiency requirement of 1.1%.

NHS England did allocate £2.3billion, on a fair share basis, to support elective recovery and HWEICB has initially received £45m to support additional elective activity. Where systems

deliver additional activity above the annual target, they will earn additional funding at 75% of tariff. Where activity is below the annual target, funding will be reduced at 75% of tariff capped at the total received.

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

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

This means that East and North Hertfordshire CCG is reporting an underspend of £2.548m with the cumulative underspend over the life of the CCG (£21,531m) will be carried forward. NHS England will then make decisions on how much of this carry forward will be transferred to HWEICB.

REVIEW OF STATUTORY DUTIES

East and North Hertfordshire CCG has reviewed all of the statutory duties and powers conferred on us by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. We are clear about the legislative requirements associated with each of the statutory functions for which we are responsible, including any restrictions on delegation of those functions.

Dr Jane Halpin
Accountable Officer

Date signed: 16th November 2023

ACCOUNTABILITY REPORT

PART ONE: CORPORATE GOVERNANCE REPORT

MEMBERS' REPORT

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

On 30th June 2022 Dr Prag Moodley was the Chair of the CCG and Jane Halpin was the Accountable Officer. There are 16 members of the CCG Governing Body/ East and North Hertfordshire CCG Board Information about our Governing Body members, and their responsibilities can be found on our website: **https://www.enhertsccg.nhs.uk/ccg-governing-body**

Member practices

During the year 2022/23, the membership body of the CCG was formed of 50 member practices, grouped below under their respective Primary Care Network:

https://www.enhertsccg.nhs.uk/primary-care-networks-pcns

Composition of Governing Body

The Chair of the CCG is Dr Prag Moodley, and The Accountable Officer is Dr Jane Halpin.

From 1st April 2022 to 30th June 2022, the Governing Body was composed of the following members:

Role	Name
Chair	Dr Prag Moodley
Deputy Clinical Chair	Dr Ashish Shah
Accountable Officer	Dr Jane Halpin
Managing Director	Sharn Elton
Director for Primary Care Transformation	Avni Shah

Director of Clinical and Professional Services	Dr Rachel Joyce
Chief Finance Officer	Alan Pond
Director of Nursing and Quality	Jane Kinniburgh
Director of Primary Care Transformation	Avni Shah
GP Governing Body Member, Stort Valley and Villages	Dr Sarah Dixon
GP Governing Body Member, Stevenage and Interim Governing Body Member for Lower Lea Valley	Dr Russell Hall
GP Governing Body Member, Stevenage	Dr Rini Saha
GP Governing Body Member, Upper Lea Valley	Dr Rupal Shah
Secondary Care Clinician	Dr Dermot O'Riordan
Lay-member for Primary Care Commissioning	Dianne Desmulie
Lay-member for Governance and Audit	Linda Farrant
Lay-member for Public and Patient Involvement	Alison Gardner

Committee(s), including Audit Committee

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

- Linda Farrant – Lay Member (Governance and Audit), Deputy Chair of the Governing Body and Chair of the Governance and Audit Committee.
- Dr Ashish Shah– Governing Body Deputy Clinical Chair
- Alison Gardner – Lay Member (Public and Patient Involvement)

The Remuneration Report starting on page 84 provides details of the membership of the Remuneration Committee.

The Governance Statement, from page 60 provides details of the attendance of the Governing Body and its Committee members at their respective meetings, namely:

- Governing Body in Public
- Governing Body in Private
- Governing Body Workshops
- Governance and Audit Committee
- Primary Care Commissioning Committee
- Quality Committee

- Remuneration Committee

Register of Interests

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

Personal data related incidents

The organisation has not reported any Information Governance Serious Untoward Incidents to the Information Commissioner's Office in 2020/21

Statement of Disclosure to Auditors

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

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS East and North Hertfordshire Clinical Commissioning Group fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Joint Accountable Officer to be the Accountable Officer of East and North Hertfordshire 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 East and North Hertfordshire CCGs auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

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

Dr Jane Halpin
Accountable Officer

Date signed: 16th November 2023

GOVERNANCE STATEMENT

Introduction and context

NHS East and North Hertfordshire Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

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

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and

economically and complies with such generally accepted principles of good governance as are relevant to it.

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

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

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

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

- Publishing its Constitution;
- Appointing independent lay members and a non-GP clinician to its governing body;
- Holding meetings of its governing body in public (except where the Board considers that it would not be in the public interest in relation to all or part of a meeting);
- Complying with local authority, health overview and scrutiny requirements;
- Producing annual accounts for this financial year which have been externally audited;
- Holding a virtual planned Annual General Meeting on 23rd September 2022 to publish and present the annual report and audited accounts for the year ending 2021-22;

- Having a published and clear complaints process;
- Complying with the Freedom of Information Act 2000;
- Providing information to NHS England and Improvement as required;
- Working closely with Internal Audit and Counter Fraud Services to ensure assurance and risk processes within work programmes are aligned to the statutory responsibilities of the CCG.

The Board

The Board is responsible for setting the strategic priorities of the CCG. This includes ensuring the optimal use of resources to improve health and health services. This remit includes commissioning of elective hospital care, rehabilitation, urgent and emergency care (including out of hours services), community health services, services for children and younger persons, maternity services, mental health and learning disability services.
The Board, acting on behalf of the CCG membership, is responsible for ensuring that the CCG has appropriate governance frameworks, resources, capability and capacity in place to enable the CCG to exercise its functions effectively, efficiently and economically to meet its delegated responsibilities and in accordance with accepted good governance principles.
The Board is responsible for holding the executive to account for the delivery of the CCG strategy. The Board was advised on all service and commissioning decisions taken by the Finance Committee, Quality Committee and Primary Care Commissioning Committee.

The membership of the Board can be found within the Corporate Governance Report on page 114. Attendance of the Board meetings are detailed on page 64 and 65.

Governance Structure

The Governing Body has created the statutorily-required Audit Committee and Remuneration Committee. Additionally, the Governing Body has established, a Quality Committee, and an and a Primary Care Commissioning Committee[15]

Governing Body

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

[15] The Governing Body, Renumeration Committee and Primary Care Commissioning Committee met in Common with Herts Valleys CCG and West Essex CCG during 2022/23

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

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

Governance and Audit Committee

The Governance and Audit Committee is a committee of the Governing Body. It provides assurance to the Governing Body that the organisation's overall internal control and governance system operates in an adequate and effective way. The committee's work focuses on the adequacy of the controls on finance, risk management and clinical quality. It does this by reviewing the assurance framework, strategic and operational risk and obtaining independent assurance on controls. It also oversees internal and external audit arrangements, for both financial and non-financial systems. As part of its role the committee reviews audit reports and monitors implementation of recommendations. Members also undertake in-depth analysis of specific risks.

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

Primary Care Commissioning Committee

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

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

Quality Committee

The Quality Committee is a committee of the Governing Body. It works to ensure that commissioned services are being delivered in a high quality and safe manner, ensuring that

quality sits at the heart of everything the organisation does. It is responsible for providing assurance and information on quality to allow the Governing Body to fulfil its role and responsibilities in relation to quality. It also reports on quality related risks to the Governance and Audit Committee. The committee takes on overall responsibility for leading the organisation's patient care, quality and safety agenda and reports directly to the Governing Body on these matters. To support it in this role the committee involves a Patient Network Quality representative to provide an invaluable patient perspective.

Remuneration Committee

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

Governing Body Attendance for 2022/23

Members' attendance records are detailed in the following table:

		Public	Private	Workshops
Number of meetings held during Q1 2022/23		**2**	**2**	**1**
Name:	**Title/Locality:**	**Attendance:**		
Dr Prag Moodley	Chair, Clinical Lead	2	2	1
Dr Ashish Shah	Deputy Clinical Chair	2	2	1
Dr Sarah Dixon	GP Representative - Stort Valley and Villages	1	1	1
Dr Russell Hall	GP Representative – Stevenage and Interim Governing Body Member for Lower Lea Valley	2	2	1
Dr Rini Saha	GP Representative – Stevenage	2	2	1
Dr Rupal Shah	GP Representative – Upper Lea Valley	2	2	1
Dr Dermot O'Riordan	Secondary Care Consultant	2	2	1

Linda Farrant	Lay Member – Governance and Audit	2	2	1
Alison Gardner	Lay Member – Patient and Public Involvement	0	0	1
Dianne Desmulie	Lay Member – Primary Care	2	2	1
Dr Jane Halpin	Chief Executive (Accountable Officer)	2	2	0
Sharn Elton	Managing Director	2	2	1
Dr Rachel Joyce	Director of Clinical and Professional Services	2	2	1
Alan Pond	Chief Finance Officer	2	2	1
Jane Kinniburgh	Director of Nursing and Quality	0	0	1
Avni Shah	Director of Primary Care Transformation	2	2	1
Phil Turnock	Chief Digital Officer	2	2	1

Governance and Audit Committee

Number of meetings held during Q1 2022/23	**2**
Title:	**Attendance:**
*Lay Member, Governance and Audit	2/2
Lay Member, Public and Patient Engagement	2/2
Deputy Chair, GP Lead, Welwyn and Hatfield, Prescribing Lead	2/2

* Chair of Governance and Audit Committee

Primary Care Commissioning Committee

Number of meetings held during Q1 2022/23	1
Title/Locality	**Attendance:**
*Lay Member - Primary Care Commissioning	1
Lay Member – Patient and Public Involvement	0
Lay Member – Governance and Audit	1
Managing Director	1
Chief Finance Officer	1
Director of Primary Care Transformation H&WE ICS & CCGs	1

Director of Nursing & Quality	1
Independent GP Member	1
GP Lead, North Herts	0
GP Lead, Stevenage	1
PCN Chair	1
Deputy Chair, GP Lead, Welwyn and Hatfield, Prescribing Lead	0

* Chair of Primary Care Commissioning Committee

Quality Committee

Number of meetings held during Q1 2022-23	**1**
Title/Locality:	**Attendance:**
*Lay Member – Governance and Audit	1
Director of Nursing and Quality	1
Clinical GP Lead - Stort Valley and Villages	1
Clinical GP Lead – Stevenage and Interim Governing Body Member for Lower Lea Valley	1
Patient representative from the Patient Quality Network	1
Lay Member - Patient and Public Participation	0
Associate Director Quality Improvement and Patient Safety	1
Consultant in Public Health	0

* Chair of Quality Committee

Remuneration Committee

Number of meetings held during Q1 2022-23	0
Title/Locality:	**Attendance:**
*CCG Lay Member - Governance and Audit	0
Deputy Chair, GP Lead, Welwyn and Hatfield, Prescribing Lead	0
Secondary Care Specialist Doctor	0

* Chair of Remuneration Committee

Discharge of Statutory Functions

The CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty

and power has been allocated to a lead Executive Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk Management Arrangements and Effectiveness

The CCG aligned its risk management standards with guidelines from ISO31000:2018 on managing risk, thereby focusing on the following components:

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

To implement these enhancements, the CCG reviewed its risk management policy and procedures, setting out the Risk Management Framework and Assurance Framework, which would enable robust and effective risk management at all management levels. It embedded the principles of risk management into its governance and leadership culture by establishing a Risk Review Group with meetings every two months to engage and support its senior leadership team in managing existing and emerging risks to which the CCG is exposed. Patient representatives on project working and steering groups are party to discussion about risks to project deliverables.

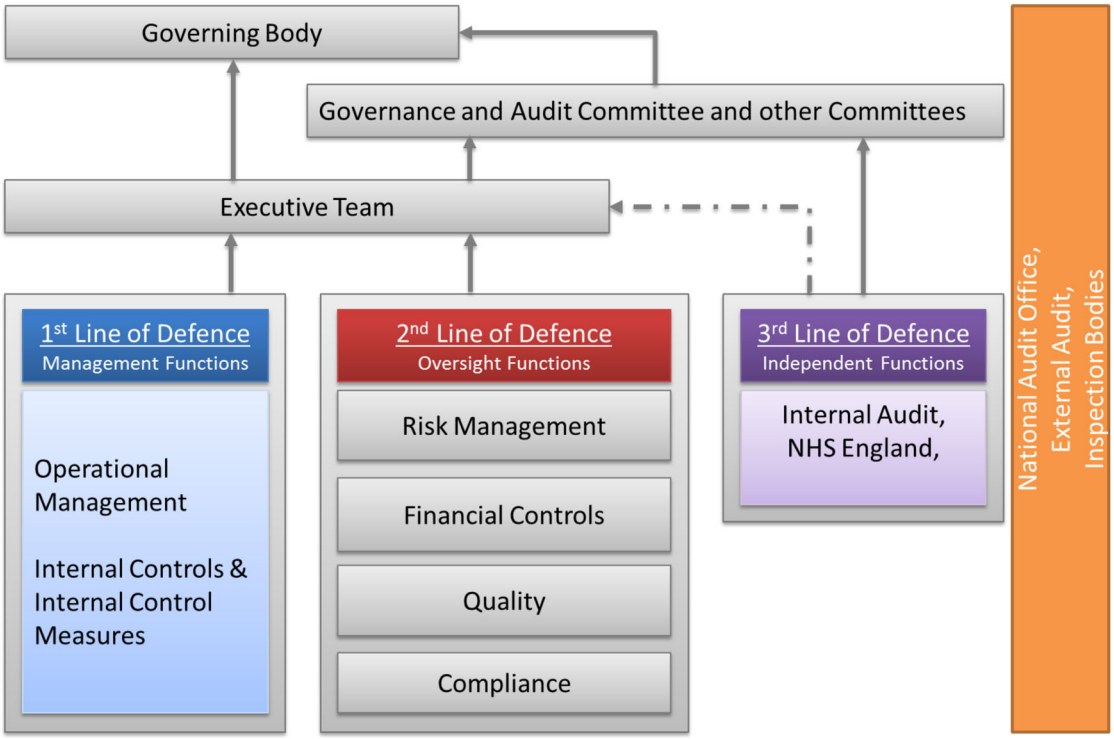
Within the Risk Management Framework, the risk is defined as "the effect of uncertainty on objectives". The components supporting and sustaining risk management across the CCG were refreshed, including the Strategic Objectives and effectiveness arrangements. An essential improvement arrangement was the implementation of DatixWeb – a web-based risk management system by RLDatix, which allows an all-in-one solution that assists in managing and addressing risks, controls, and action plans, simple and easily managed procedures. The risk management system provides a centralised repository for all CCG risks and an overview of the entire risk assessment process, allowing users to see the current risk status quickly. With this system in place, risks are reported quickly, available, accessible, and a live risk register can be produced. This has enhanced the quality of decision-making and aligned business functions across the CCG, resulting in proactive risk identification and assessment culture. The technology forms an integral part of the CCG's system control risk management.

The following are the CCG's risk escalation levels:

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

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

The Treasury Guidance on Assurance Frameworks (2012) defined the Assurance Framework as "a structured means of identifying and mapping the main sources of assurance and co-ordinating them to the best effect". With this definition, the CCG's Governing Body determines the nature and extent of the risks it is willing to take in achieving its Strategic Objectives, referred to as risk appetite. It sets the Strategic Objective and then seeks to gain assurance around the operation of controls and processes to deliver those objectives. It also identifies the leadership and responsibilities for risk management. Assurance is gained through the 'Three Lines of Defence' of the assurance process below:



First Line of Defence – Management Functions

There is strong leadership and commitment to comply with the CCG's Risk Management Policy. All risk leads are responsible for identifying, assessing, managing, and reporting risks to objectives and identifying what assurances are in place to provide Governing Body with confidence that processes and controls are effective. The risk leads are also responsible for putting actions into place to mitigate risks and report activities or circumstance that may give rise to new or changed risk. The Risk Review Group ensures that the necessary processes are in place to achieve compliance with the statutory requirements.

Second Line of Defence – Oversight Functions

The second line of defence is made up of the functions that specialise in risk management or compliance. The Governance and Corporate Affairs team is responsible for facilitating

risk management activity across the CCG. This includes providing training and advice to staff in managing risk, embedding best practise risk management, co-ordinating and reporting risk information to the Governing Body and its committees. The Governance and Audit Committee provide advice to the Governing Body on the status of governance, risk and internal controls and sources of assurance.

Third Line of Defence – Independent Functions
The third line of defence relates to the functions that provide assurance about control system risk management's effectiveness. The assurances are from outside the institution such as Internal Audit, External Audit.

Committee effectiveness

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

The Governance and Audit Committee supports the Governing Body and the Accountable Officer by reviewing the internal controls, the level of assurances to gain confidence about the reliability and quality of these assurances. The scope of the committee's work is defined in the terms of reference, encompassing all the assurance needs of the Governing Body and Accountable Officer. Within this, the Committee has a particular arrangement with the work of Internal Audit and External Audit and Financial Reporting. In December 2020, the Governance and Audit Committee undertook a self-assessment of their effectiveness with a positive outcome covering good practice, objectivity and independence, skill mix to perform it function, effective communication, Internal Auditors and External Auditors and other stakeholders

Capacity to Handle Risk

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

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

Members of the Governing Body have attended specific training in risk management. Risk management training is also mandatory for all managers and staff. As of 30 June 2022, the risk management training compliance for the CCG was 94.12%

Risk Assessment

Risk assessment is the overall process of risk identification, risk analysis and risk evaluation, starting with the CCG setting its strategic objectives to which risks are identified. It is conducted systematically, iteratively and collaboratively, drawing on the knowledge and views of stakeholders to recognise and describe risks that might help or prevent the CCG from achieving its strategic objectives.

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

Corporate risks are monitored and reviewed on a bi-monthly basis by the Risk Review Group. Its outcomes are documented and reported to the Executive Team, Governance and Audit Committee and Governing Body. Any feedback is communicated to the risk leads at the Risk Review Group meeting to improve and assist interaction with those responsible and accountable for risk management activities.

All levels of staff use the Risk Management Policy. It contains the risk scoring matrix and descriptors, which helps staff to ensure that risks are scored consistently so that priority can be given to the risks that could hinder the achievement of objectives. It also details the

process by which risks are managed and escalated to the Corporate Risk Register. The Assurance Framework details the risks that, at a strategic level, could have an impact on achieving the organisation's objectives.

The following table details the strategic objectives of the organisation and the 'primary' risks affecting these, which reflect both the 'in-year' and 'future' risks faced by the CCG.

Strategic Objectives

Codes	Strategic Objectives (SO)
SO1	Living well and preventing ill health To support people to improve their health and wellbeing, and to live well with long term conditions via three enabling approaches to prevention
SO2	Integrated Commissioning for Better Outcomes To improve outcomes through integrated commissioning taking a person-centred, place-based and outcomes-focused approach, working closely together to improve clinical quality, patient experience and affordability, and give equal priority to physical and mental health needs.
SO3	Improving urgent care services To deliver improved urgent and emergency care pathways across our commissioned services for unplanned care.
SO4	Delivering health and care more efficiently and effectively To deliver health and care more efficiently and effectively, and successfully achieve financial and activity targets, including successful delivery of Quality, Innovation, Productivity and Prevention (QIPP) initiatives.
SO5	Data and Technology To define a CCG business strategy that will enable the digital innovation portfolio within the CCG, transitioning from analogue to digital ways of working and conducting business, whilst enabling greater collaboration and integration of services provided to the CCG's population. The digital innovation portfolio that will enable the CCG to develop as an organisation and transform with partners into a single ICS from the current the Hertfordshire and West Essex STP and enabling the emerging strategies of the ICP and PCN's within the STP footprint.
SO6	Workforce To ensure that the CCG recruits, retains and develops staff to ensure the organisation has the capability to successfully deliver its ambitions and objectives, and transition to an Integrated Care System.
SO7	Participation and Engagement To ensure that the public are involved in designing, planning and monitoring the health and care services we commission and are encouraged and supported to take responsibility for their own health and wellbeing.
SO8	Sustainability of General Practice To deliver the NHS Long Term Plan through the reform of the GMS Contract as outlined in "Investment & Evolution" document. This is supported by the Hertfordshire and West Essex Integrated Health and Care Strategy and the Primary Care Strategic Framework & Primary Care Vision document.

Codes	Strategic Objectives (SO)
SO9	COVID-19 Pandemic Covid-19 To maintain a system of internal control, and able to respond as required by NHS E/I to ensure safe and effective services for patients during the pandemic

Corporate Risks at 30 June 2022

SO	Ref	Risk description	Risk score		
			Initial	Current	Target
SO1	F2	If the CCG fails to implement its medium-term initiatives, which are designed to improve patient outcomes, then there is a risk that efficiency and effectiveness improvements will not be delivered, resulting in higher costs and the need to cut other services impacting on the achievement of improved patient outcomes and other objectives.	20	12	12
SO1	M2	IF the Medical Directorate do not deliver their portfolio of improvement/ transformation projects THEN activity and demand on current services will continue to grow (i.e., aging/frail population) RESULTING IN increased demand for services which would mean that the current level of services will be inadequate for the needs of the population and little or no improvement in patient outcomes. This would also likely cause financial pressure for the CCG and/or providers and may result in cuts to services.	16	16	8
	MD1	If the directorate does not have sufficient staff, then we may not be able to deliver all of our portfolio of projects as required which means that some projects maybe delayed resulting in reduced benefits/reduction in potential savings.	12	16	6
	NQ21	If a child's death process is not being reviewed within recommended 6 months period, then there is a risk the CCG will not be compliant with the national guidance resulting in backlog, delay in learning, potential to miss incidents, and impact on parents and carers	15	15	9

SO	Ref	Risk description	Risk score		
			Initial	Current	Target
SO2	NQ2	If there continues to be a shortage of appropriately skilled staff then there is a risk that the CCG will not be able to effectively commission new services or provide existing services potentially resulting in diminished services, poor outcomes for patients and failure to deliver core services.	16	12	8
	NQ17	If the CCG does not implement systems and processes to ensure that any CHC funded clients who are deprived of their liberty are done so lawfully, through the authorisation process Liberty Protection Safeguards (LPS), which will come into force in April 2022 (replacing the Deprivation of Liberty Safeguards (DoLS) following the Mental Capacity (Amendment) Act (2019)). Then there is a risk of eligible clients having their human rights unlawfully breached, leading to patient harm and reputational damage; resulting in the CCG being fined.	12	12	4
	CY1	ENHT Children's community nursing team (CCN) are currently only operating Monday to Friday 9-5pm. This is resulting in a lack of service in the evenings and weekends preventing timely discharge from acute hospitals and increasing footfall through the Children's ED departments. There is an impact across the ICS in terms of equitable service, particularly on discharges from PAH. WE &HV localities operate a 7 day service 8-8. ENH CYP equate to about 40% of attendances/ admissions to PAH, therefore this is impacting on hospital flow.	15	15	6
	NQ1	If East and North Herts NHS Trust fail to address the ongoing quality and safety issues (e.g., sepsis, VTE, IPC), then the quality of care may be compromised potentially RESULTING IN inpatient harm.	20	12	8
	NQ6	If providers for which we are associates to the contract (i.e., Princess Alexandra Hospital (PAH) / Royal Free Hospital (RFH) fail to address quality issues then quality of care may be compromise resulting in harm to patients.	16	12	8

SO	Ref	Risk description	Risk score		
			Initial	Current	Target
	NQ15	IF we don't achieve/make reasonable adjustments in healthcare settings and/or offer regular GP health checks to patients with learning disabilities THEN we may fail to identify serious underlying health conditions potentially RESULTING IN detrimental health outcomes including reduced life expectancy patients with learning disabilities.	20	12	8
	NQ18	If requirements for health checks for adults with severe mental illness is not met, then there are risks of unsafe or poor-quality care for patients, poor patient experience & outcomes resulting in Enforcement Action/ Notice imposed by regulators and Loss of reputation for ENHCCG.	15	15	9
	NQ20	If there is insufficient capacity in the team due to vacancies, redeployment of staff, covering additional covid-19 functions including the ICC and core cells, and the significant volume of care home work such as supporting IPC outbreaks, training and mutual aid requests, then this will impact on core functions and the ability to deliver business as usual within the Nursing and Quality team. Resulting in reduced visibility and identification of quality and safety issues, and potential for negative impact on wellbeing of staff.	20	16	8
	OP3	If there is a pandemic flu/Influenza type disease (pandemic), infectious outbreak or disease including localised legionella or meningitis outbreak or major outbreak of a new or emerging infectious disease then this would cause additional pressure on healthcare services and organisational business continuity issues. Resulting in the increased potential for compromised patient care and safety and organisational business continuity failures	20	16	12
SO4	PMOT2	If external factors cause prices of medicines to increase (for example due to national medicines shortages) then the CCG may overspend on the annual prescribing budget and QIPP targets will not be met resulting in an additional financial burden on the CCG	20	15	12

SO	Ref	Risk description	Risk score		
			Initial	Current	Target
	F21	If activity across all urgent and emergency care settings increased more than planned partly due to the continued effect of COVID 19, then there is a risk of insufficient funding to match the pace in changes to services to meet the required level of increase in both bed capacity and critical care capacity, resulting in delays in care, cancellation of elective admissions, compromising patient experience and safety and increased financial cost.	16	12	9
	F22	If Mental Health activity demand exceeds plan there is a risk that beds are full and there being insufficient capacity resulting in patients having to be placed in expensive private facilities and/or remaining in acute hospital leading to increased cost within acute and CCG Mental Health.	20	16	9
	C&P 23	If there is not a new provider in place when the anti-coagulation service ends at Buntingford and Puckeridge in December 2021, there is a risk that there will be no service in place resulting in an impact on patients care	15	15	15
	C&P 24	If no funding is transferred from ENHT to HCT, following the transfer of some routine skin health activity from ENHT to HCT, this may result in a financial risk for ENHCCG, and the possibility of ENHCCG exceeding its overall commissioning budget.	12	12	6
	FRR4	If there are failures in the management and monitoring of declaration of interest, then there is a risk that undeclared interests would cause potential conflicts, resulting perceived reputation risk and breach of statutory requirements.	15	12	9
SO9	C&P12	If there is a lack of access to dental services, then this will impact on a patient's treatment and care resulting in a potential deterioration of health	16	15	6
	OP5	IF the CCG does not continue to respond to the current COVID-19 (Corona virus) pandemic, there is a risk that delivery of essential services could be compromised resulting in poor outcomes for patients and staff welfare.	15	15	12

SO	Ref	Risk description	Risk score		
			Initial	Current	Target
	PCC6	Phase 2 Recovery Actions IF: Practices do not deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening THEN: This will cause an avalanche of work once the recovery phase has been lifted. RESULTING IN: 1. Delayed waiting times for patients 2. additional capacity pressures	15	12	6
	LM1	Due to significant pressures as a result of COVID-19 and other operational pressures, there is a risk that ENHT Maternity services may not be able to achieve National deliverables, impacting workforce and also patient experience and safety. Key risks include - Increase in stillbirth rates and neonatal deaths - Increase in pre-term babies - A deterioration in workforce and team culture - increase in unit closures and patient diversion	15	15	9

Other sources of assurance

Internal Control Framework

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

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

Internal Audit

The organisation uses an internal audit function to monitor the internal controls in operation to identify areas of weaknesses and make recommendations to rectify them. The system is embedded in the activity of the organisation through an annual Internal Audit Work Plan. RSM currently provides the Internal Audit services for the organisation. The Head of Internal Audit reports independently to the Chair of the Governance and Audit Committee. It

provides objectivity and independent assurance on the effectiveness of its internal control system, including the application of the Risk Management Framework. The annual Head of Internal Audit Opinion provides independent overarching assurance to the organisation.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to have systems in place to satisfy themselves on an annual basis that their registers of interest are accurate and up to date. To do this, the CCG carries out an annual refresh of its declaration of interest register and uses the template audit framework published by NHS E/I to support CCGs.

Data Quality

NHS Digital publishes data quality reports monthly for Admitted Patient Care, Outpatient, A&E/Emergency Care Data Set, Maternity in acute hospitals; these are reviewed by the information team. Any issues that these highlight would be picked up again when the Commissioning Information Groups recommence. The CCG has access to the national Hospital Episode Statistics data, through Mede/Analytics, to undertake bespoke comparative data analysis to be compared alongside any national benchmarking reports such as Right Care.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a Data Security and Protection toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. Risks to data security are managed through a series of management, technical, operational and privacy controls.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that all organisations must complete if they have access to NHS patient data and systems to provide assurance around the controls, they have in place to manage information risk. The toolkit

enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards.

The CCG assessed its position against the DSPT, met all mandatory assertions and submitted the toolkit in June 2022. Policies and processes for the management of information have been agreed at the Information Governance Forum.

We place high importance on ensuring robust information governance systems and processes to help protect patient confidentiality and corporate information. We have established an Information Governance Management Framework and have developed information governance processes and procedures in line with the Information Governance Toolkit. We have ensured that all staff members undertake information governance training annually, which is mandatory and ensures they know their roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. The Chief Finance Officer is the Senior Information Risk Owner, and continues to embed an information risk culture throughout the organisation. One of the Corporate Governance Managers is the Data Protection Officer, in line with the General Data Protection Regulation.

Business Critical Models

The CCG uses activity models that are based on official Government produced information; for example, population demographics, provided by the Office for National Statistics (ONS). It is assumed that the ONS, as a nationally recognised body will have undertaken quality assurance processes with regard to construction of these models.

The CCG currently uses a local risk stratification model that was jointly developed between health and social care and is made available through Mede/Analytics. This model is used to identify a discrete group of patients who are at risk of being admitted to hospital as an emergency, who may be better looked after through local community services. The CCG has developed a model to calculate the elderly frailty index (EFI) using primary care data.

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

Third Party Assurances

The CCG has a contract with Mede/Analytics to provide Business Intelligence support as a Data Processor. As a third-party supplier assurance is provided by satisfactory completion of

the annual Data Security and Protection Toolkit, and they have registered and paid a data protection fee to the Information Commissioners Office (ICO). In addition there is a confidentiality clause in the contract between the CCG and Mede/Analytics and they have been audited by NHS Digital with an assessment of minimal risk of inappropriate exposure and/or access to data provided by NHS Digital. The audit also identified a number of areas of good practice.
The CCG also has a contract with NHS Arden and GEM Commissioning Support Unit (AGEM CSU) to provide Data Services for Commissioning (DSCRO) services. As a third party supplier assurance is provided by satisfactory completion of the Data Security and Protection Toolkit and they are entered on the Data Protection Register with the ICO. Further assurance is provided by the inclusion of a confidentiality clause in the contract between the CCG and AGEM CSU.

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

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

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

Control Issues

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

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

To ensure the Clinical Commissioning Group resources are used economically, efficiently and effectively the CCG has implemented processes, which are described below:

- the CCG has reviewed detailed financial policies, which set out the systems to be adhered to to ensure that resources are used efficiently
- developed and implemented strategic and operational plans, which include an agreed annual budget approved by the Governing Body
- worked closely with providers to review and agree changes to services to best meet need arising from the COVID-19 pandemic
- corporate wide process for the development and review of business cases for investment. Processes include assessment of value for money and contribution to the achievement of CCG objectives
- reports on finance and quality presented on a monthly basis to the Governing Body, with actions identified when performance is off track
- report on identified key financial risks to regular meetings of the Governance and Audit Committee
- implementation of an internal audit programme that is targeted at the strategic risks and key financial control processes
- regular fraud risk assessment undertaken by an independent party, providing recommendations for key actions
- comprehensive suite of Fraud and Bribery policies agreed and in place with local counter fraud specialist delivering an agreed work plan
- requirement as part of mandatory training that all staff undertake counter fraud and bribery training
- training for staff on how to raise concerns under the whistleblowing policy – with the mechanisms being used appropriately
- training for staff to be Speak up Inclusion Champions
- training for more staff to be Mental Health First Aider
- NHS Right Care allows the organisation to compare the amount we spend, the health services we commission and the health of our population against that of other areas in England. These comparisons help the CCG to identify whether our population is receiving high quality, efficient and effective health services
- the NHS Benchmarking Network CCG Functions Project provides comparisons about CCGs, rather than just the services they commission
- regular reporting to the Governing Body on financial planning, in-year performance monitoring and central management costs

Counter fraud arrangements

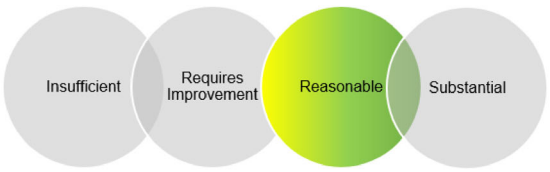
The Clinical Commissioning Group contracts West Midlands Ambulance Service to provide the counter fraud provision by way of a nominated lead local counter fraud specialist (LCFS). The LCFS is accredited by the NHS Counter Fraud Authority and qualified to undertake the duties of that role. A LCFS Annual Report which is received by the Governance and Audit Committee, details all work undertaken in respect of counter fraud activities for the reporting year and measures each task as specified in the NHS Counter Fraud Authority Standards for NHS Commissioners: Fraud, Bribery and Corruption. The LCFS work plan is designed to meet the requirements set out in the Standards and each task is designed to provide compliance with each of the standards described. The LCFS work plan is designed to address the locally and nationally identified fraud risk areas in conjunction with the Chief Finance Officer.

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

HEAD OF INTERNAL AUDIT OPINION

Final Head of Internal Audit Opinion 2022/23

For the 3 months ended 30 June 2022, our Head of Internal Audit Opinion for NHS East and North Hertfordshire Clinical Commissioning Group is as follows:



Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Recovery of Services	Reasonable Assurance
Cyber Security (joint audit with Herts Valleys CCG)	Reasonable Assurance
CCG Change Management	Reasonable Assurance
Financial Planning	Reasonable Assurance

Integrated Care Partnerships	Substantial Assurance
Risk Management and Assurance Framework	Reasonable Assurance
Conflicts of Interest	Reasonable Assurance
Primary Care Networks	Reasonable Assurance

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

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principal objectives have been reviewed.

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

- Governing Body
- Governance and Audit Committee
- Quality Committee
- Internal Audit
- External Audit

Conclusion

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

Dr Jane Halpin
Accountable Officer

Date signed: 11th November 2023

PART 2: STAFF AND REMUNERATION REPORT

The information on pages 83 and 84 is not subject to audit, except for 'payments to past senior managers'.

REMUNERATION COMMITTEE

The members of the Remuneration Committee for the year were as follows. The committee did not sit during Q1 2022/23.

- Linda Farrant – Lay member (Governance and Audit), Chair of the Remuneration Committee
- Dr Ashish Shah – Deputy Clinical Chair
- Dr Dermot O' Riordan – Secondary Care Specialist Doctor

REMUNERATION OF VERY SENIOR MANAGERS

The Accountable Officer of the CCG is paid a salary in excess of £150,000 per annum for the joint post of Accountable Officer of Hertfordshire and West Essex CCGs and ICS and is a shared arrangement between East and North Hertfordshire, Herts Valleys and West Essex CCGs and the ICS. This has been approved by NHS E/I and the national remuneration committee considering senior manager pay and benchmarking was undertaken with similar sized organisations to ensure that salaries are competitive and in line with that of similar systems.

POLICY ON REMUNERATION OF SENIOR MANAGERS (not subject to audit)

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

SENIOR MANAGERS PERFORMANCE RELATED PAY (not subject to audit)

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

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

As of 30 June 2022, there were 9 permanent executive team managers. GPs on the Governing Body are engaged on fixed term contracts:

- Dr Chowdhury [1] (4 year fixed term from 20 February 2019 to 30 June 2022)
- Dr Dixon (4 year fixed term from 1 May 2018 to 30 June 2022)
- Dr Hall (4 year fixed term from 1 April 2017 to 30 June 2022)
- Dr Moodley (4 year fixed term from 1 September 2018 to 30 June 2022)
- Dr O'Riordan (from 29 January 2015 to 30 June 2022)
- Dr Saha (4 year fixed term from 1 October 2018 to 30 June 2022)
- Dr A Shah (4 year fixed term from 10 September 2018 to 30 June 2022)
- Dr R Shah (from 1 May 2019 to 30 June 2022)

Lay members are also employed on fixed term contracts:

- Linda Farrant (1 April 2013 to 30 June 2022)
- Dianne Desmulie (27 November 2014 to 30 June 2022)
- Alison Gardner (1 August 2019 to 30 June 2022)

PAYMENTS TO PAST SENIOR MANAGERS (subject to audit)

There have been no payments to past senior managers.

[1] Dr Chowdhury is an independent GP on the Primary Care Commissioning Committee but is not a member of the Governing Body

OFF-PAYROLL ENGAGEMENTS

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

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

Number of existing engagements as of 30 June 2022	**18**
Of which... the number that have existed:	
for less than one year at time of reporting	5
for between one and two years at time of reporting	3
for between 2 and 3 years at time of reporting	0
for between 3 and 4 years at time of reporting	4
for 4 or more years at time of reporting	6

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

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2022 and 30 June 2022, for more than £245 per day

No of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	4
Of which...	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	4
No. subject to off-payroll legislation and determined as out of scope of IR35	0
The number of engagements re-assessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

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

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2022 and 30 June 2022

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	6
Total no. of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility' during the financial year. This figure must include both on payroll and off-payroll engagements	20

Remuneration for members of the Board - Salaries and allowances April - June 2022

Table 1:Single total figure

Name	Role	Note	2022-23					
			Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000	£	£000	£000	£000	£000
Jane Halpin	Accountable Officer -29.23%	1,2	10-15	0	0	0	0	10-15
Alan Pond	Chief Finance Officer -29.23%	1	10-15	0	0	0	0	10-15
Sharn Elton	Managing Director		30-35	0	0	0	7.5-10	40-45
Jo Burlingham	Interim Director of Operations		25-30	0	0	0	5-7.5	30-35
Elizabeth Disney	Director of Operations (from 6 June 2022) - 29.23%	1	0-5	0	0	0	0-2.5	0-5
Rachel Joyce	Director of Clinical & Professional Services -29.23%	1	10-15	0	0	0	2.5-5	10-15
Jane Kinniburgh	Director of Nursing & Quality -29.23%	1,2	5-10	0	0	0	0	5-10
Avni Shah	Director of Primary Care Transformation -29.23%	1	5-10	0	0	0	2.5-5	10-15
Frances Shattock	Director of Performance & Delivery -29.23%	1	5-10	0	0	0	0-2.5	10-15
Phil Turnock	Chief Digital Officer	2,3	25-30	2700	0	0	0	25-30
Prag Moodley	CCG Chair	4	25-30	0	0	0	£NIL	25-30
Ashish Shah	CCG Deputy Chair	4,6	30-35	0	0	0	£NIL	30-35
Sarah Dixon	GP Board Member	4	10-15	0	0	0	£NIL	10-15
Russell Hall	GP Board Member	5	10-15	0	0	0	0	10-15
Anindita Saha	GP Board Member	4,7	25-30	0	0	0	£NIL	25-30
Rupal Shah	GP Board Member	4,8	15-20	0	0	0	£NIL	15-20
Dianne Desmulie	Lay Member	9	0-5	0	0	0	0	0-5
Linda Farrant	Lay Member	9	0-5	0	0	0	0	0-5
Alison Gardner	Lay Member	9,10	0-5	0	0	0	0	0-5
Dermont O'Riordan	Secondary Care Specialist Doctor	9	0-5	0	0	0	0	0-5

Notes

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

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

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

Note 1- Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the member's remuneration has been apportioned across the ICS and three CCGs and only that relating to East & North Hertfordshire CCG has been disclosed above, based on 29.23% of their total remuneration. For transparency the member's total remuneration across the ICS and Hertfordshire and West Essex CCGs is disclosed in the table below.

Note 2 - Members who chose not to be covered by the pension arrangements during the reporting period.

Note 3 - The taxable benefit relates to the member having a lease car with a taxable benefit as stated. The member has a salary sacrifice arrangement for their vehicle which has the effect of reducing the salary paid during 2022-23.

Note 4 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practioner Pension Scheme". The CCG must make the post non pensionsable on the payroll and submit a GP Solo form with the employer's pension contribution of 14.3% plus an administration levy of 0.08% to the NHS Pension Authority. The salary banding above comprises of gross payment plus employer pension contribution, where applicable.

Note 5 - GP member chose not to be covered by the Practitioner pension arrangements during the reporting period.

Note 6 - The total remuneration for Dr Ashish Shah includes £0-£5,000 relating to a locality workforce lead role.

Note 7 - The total remuneration for Dr Anindita Saha includes £5,000-£10,000 relating to a clinical lead role.

Note 8 - The total remuneration for Dr Rupal Shah includes £0-£5,000 relating to a clinical lead role.

Note 9 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Note 10 - Alison Gardner was also a Lay Member of Herts Valleys CCG Board for the period April - June 2022 for Patient and Public Involvement. The costs disclosed above are recharged by Herts Valleys CCG.

The table below shows the total remuneration for the period April - June 2022 where the Senior Manager has been appointed as a Director in more than one of the Hertfordshire and West Essex CCGs and ICS and where a sharing arrangement existed.

Name	Role	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Jane Halpin	Accountable Officer	40-45	0	0	0	0	40-45
Alan Pond	Chief Finance Officer	30-35	0	0	0	0	30-35
Elizabeth Disney	Director of Operations (from 6 June)	5-10	0	0	0	2.5-5	10-15
Rachel Joyce	Director of Clinical & Professional Services	35-40	0	0	0	7.5-10	40-45
Jane Kinniburgh	Director of Nursing & Quality	30-35	0	0	0	0	30-35
Avni Shah	Director of Primary Care Transformation	30-35	0	0	0	12.5-15	40-45
Frances Shattock	Director of Performance & Delivery	30-35	0	0	0	7.5-10	35-40

Fair Pay disclosure (audited element of remuneration report)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. The total remuneration disclosed in the table below consists of the salary and allowances component only as no performance pay and bonuses were paid.

The banded remuneration of the highest paid director/member in the CCG in the period April - June 2022 when annualised was £135,000-£140,000 (2021-22, £125,000-£130,000). The relationship to the remuneration of the CCG's workforce is disclosed in the table below.

YEAR	25th percentile total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio
2021-22	127,500:33,804	127,500:44,133	127,500:55,064
	3.77	2.89	2.32
2022-23	137,500:33,111	137,500:43,966	137,500:55,064
	4.15	3.13	2.50

In the reporting periods for 2022-23 and 2021-22, no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from the highest paid director to £10,000-£15,000 (2021-22 highest paid director to £10,000-£15,000).
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.

As a number of director posts were shared across the three CCGs and the ICS, for transparency, if the disclosure had been based on total remuneration for those directors the following would then apply.
The banded remuneration of the highest paid director/member in the CCG in the period April - June 2022, when annualised was £170,000-£175,000 (2021-22, £170,000-£175,000). The relationship to the remuneration of the CCG's workforce is disclosed in the table below.

YEAR	25th percentile total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio
2021-22	172,500:33,804	172,500:44,133	172,500:55,064
	5.10	3.91	3.13
2022-23	172,500:33,111	172,500:43,966	172,500:55,064
	5.21	3.92	3.13

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

There has been a 0.84% reduction in respect of the average employees salary and allowances when compared to the previous financial year (2022-23 £48,418:2021-22 £48,822).

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

Table 2: Pension Benefits April – June 2022

Name	Role	Note	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£000
Jane Halpin	ICS Accountable Officer 29.23%	1,2	0	0	0	0	0	0	0	0
Sharn Elton	Managing Director		0-2.5	0	65-70	135-140	1,134	11	1,230	0
Alan Pond	ICS Chief Finance Officer 29.23%	1	0	0	20-25	35-40	380	4	398	0
Jo Burlingham	Interim Director of Operations		0-2.5	0	35-40	65-70	576	5	627	0
Elizabeth Disney	Director of Operations (from 6 June 2022) - 29.23%	1	0-2.5	0-2.5	0-5	0-5	26	0	38	0
Rachel Joyce	ICS Director of Clinical & Professional Services 29.23%	1	0-2.5	0-2.5	15-20	35-40	319	4	352	0
Jane Kinniburgh	ICS Director of Nursing & Quality 29.23%	1,2	0	0	0	0	0	0	0	0
Avni Shah	ICS Director of Primary Care Transformation 29.23%	1	0-2.5	0-2.5	10-15	20-25	174	3	196	0
Frances Shattock	ICS Director of Performance & Delivery 29.23%	1,3	0-2.5	0	0-5	0	8	1	18	0
Phil Turnock	Chief Digital Officer	2	0	0	0	0	0	0	0	0
Prag Moodley	CCG Chair	4	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Ashish Shah	Deputy Clinical Chair	4	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Sarah Dixon	GP Board Member	4	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Russell Hall	GP Board Member	5	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Anindita Saha	GP Board Member	4	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Rupal Shah	GP Board Member	4	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Linda Farrant	Lay Member	6	0	0	0	0	0	0	0	0
Dianne Desmulie	Lay Member	6	0	0	0	0	0	0	0	0
Alison Gardner	Lay Member	6	0	0	0	0	0	0	0	0
Dermot O'Riordan	Lay Member	6	0	0	0	0	0	0	0	0

Notes

The real increase in pension, lump sum and cash equivalent transfer values shown above have been apportioned to reflect the period ending June 2022.

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

Note 1 - Where members have been appointed to the Hertfordshire and West Essex Joint Executive Team (JET), the disclosures above only relate to the CCG's proportion of pension benefits based on 29.23% and apportioned for the period April-June 2022. For transparency the table below shows members total pension benefits across Hertfordshire and West Essex CCGs and ICS for the period.

Note 2 - Members chose not to be covered by the pension arrangements during the reporting period.

Note 3- As a member of the 2015 scheme benefits do not include lump sum payments.

Note 4 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practitioner Pension Scheme". The CCG must make the post non-pensionable on the payroll and for GPs who are members of the Practitioner scheme, submit GP SOLO forms to reflect the employers pension contribution of 14.3% plus 0.08% administration levy to the NHS Pensions Authority .

Note 5 - GP member chose not to be covered by the Practitioner pension arrangements during the reporting period.

Note 6 - As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions.

Note 7 - As part of the changes to public pension schemes, both the 1995 and 2008 Sections of the 1995/2008 Scheme closed on 31 March 2022. All active members of the 1995/2008 Scheme were automatically moved to the 2015 Scheme on 1 April 2022.

Note 8 - NHS employees contribute towards their pension benefits. In 2022/23 contribution rates were 14.5% of salary where the individual earned in excess of £111,377 and 13.5% where the individual earned between £70,631 and £111,377

Note 9 - Cash equivalent transfer values (CETV)

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

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

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be more than just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Note 10 - The real increase in CETV reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

The table below shows the total pension benefits where the Senior Manager was appointed as a Director in more than one of the Hertfordshire and West Essex CCGs and ICS and where a sharing arrangement existed.

Total Pensions Benefits (April - June 2022)

Name	Role	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employer's contribution to stakeholder pension
Jane Halpin	Accountable Officer	0	0	0	0	0	0	0	0
Alan Pond	Chief Finance Officer	0	0	75-80	120-125	1,301	15	1,361	0
Elizabeth Disney	Director of Operations (from 6 June)	0-2.5	0-2.5	10-15	5-10	89	1	130	0
Rachel Joyce	Director of Clinical & Professional Services	0-2.5	0-2.5	50-55	120-125	1,093	14	1,203	0
Jane Kinniburgh	Director of Nursing & Quality	0	0	0	0	0	0	0	0
Avni Shah	Director of Primary Care Transformation	0-2.5	0-2.5	40-45	75-80	595	10	672	0
Frances Shattock	Director of Performance & Delivery	0-2.5	0	5-10	0	29	3	60	0

EAST & NORTH HERTFORDSHIRE CCG

Remuneration for members of the Board - Salaries and allowances in 2021-22 RESTATED*

Table 1:Single total figure (Subject to Audit)

			2021-22					
Name	Role	Note	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000	£	£000	£000	£000	£000
Jane Halpin	Accountable Officer -29.23%	1,3	50-55	0	0	0	0	50-55
Beverley Flowers	Acting Accountable Officer (from 1 November 2021-31 March 22) - 29.23%	1,2	15-20	0	0	0	5-7.5	20-25
Alan Pond	Chief Finance Officer -29.23%	1	40-45	0	0	0	17.5-20	55-60
Sharn Elton	Managing Director		125-130	0	0	0	52.5-55	180-185
Jo Burlingham	Interim Director of Operations		105-110	0	0	0	45-47.5	150-155
Rachel Joyce	Director of Clinical & Professional Services -29.23%	1	40-45	0	0	0	12.5-15	55-60
Jane Kinniburgh	Director of Nursing & Quality -29.23%	1,3	35-40	0	0	0	0	35-40
Avni Shah	Director of Primary Care Transformation -29.23%	1	35-40	0	0	0	20-22.5	55-60
Frances Shattock	Director of Performance & Delivery -29.23%	1	35-40	0	0	0	7.5-10	40-45
Phil Turnock	Chief Digital Officer	3,4	105-110	2,000	0	0	0	110-115
Prag Moodley	CCG Chair	5	115-120	0	0	0	£NIL	115-120
Ashish Shah	CCG Deputy Chair	5,6	120-125	0	0	0	£NIL	120-125
Tara Belcher	GP Board Member (to 31 October 2021)	5	30-35	0	0	0	£NIL	30-35
Sarah Dixon	GP Board Member	5	55-60	0	0	0	£NIL	55-60
Russell Hall	GP Board Member	9	50-55	0	0	0	0	50-55
Anindita Saha	GP Board Member	5,7	100-105	0	0	0	£NIL	100-105
Rupal Shah	GP Board Member	5,8	65-70	0	0	0	£NIL	65-70
Dianne Desmulie	Lay Member	10	10-15	0	0	0	0	10-15
Linda Farrant	Lay Member	10	15-20	0	0	0	0	15-20
Alison Gardner	Lay Member	10,11	10-15	0	0	0	0	10-15
Dermont O'Riordan	Secondary Care Specialist Doctor	10	10-15	0	0	0	0	10-15

* The 2021-22 Table 1 has been restated to reflect the pension figures for Alan Pond without adjusting for pension share.

Notes

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

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

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

Note 1- Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the member's remuneration has been apportioned across the ICS and three CCGs and only that relating to East & North Hertfordshire CCG has been disclosed above, based on 29.23% of their total remuneration. For transparency the member's total remuneration across the ICS and Hertfordshire and West Essex CCGs is disclosed in the table below.

Note 2 - In addition to being the Director of Integration and Systems Transformation for the CCG and ICS, Beverley Flowers was also Acting Accountable Officer for the period 1 November 2021 - 31 March 2022. The remuneration disclosed above relates only to the Acting Accountable Officer role. Total remuneration is shown in the table below.

Note 3 - Jane Halpin, Jane Kinniburgh and Phil Turnock are not members of the NHS pension scheme.

Note 4 - The taxable benefit relates to the member having a lease car and the excess amount that is taxable for the reimbursement of mileage incurred on official duties.

Note 5 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practioner Pension Scheme". The CCG must make the post non pensionsable on the payroll and submit a GP Solo form with the employer's pension contribution of 14.3% plus an administration levy of 0.08% to the NHS Pension Authority. The salary banding above comprises of gross payment plus employer pension contribution, where applicable.

Note 6 - The total remuneration for Dr Ashish Shah includes £5,000-£10,000 relating to a locality workforce lead role.

Note 7 - The total remuneration for Dr Anindita Saha includes £35,000-£40,000 relating to a clinical lead role.

Note 8 - The total remuneration for Dr Rupal Shah includes £5,000-£10,000 relating to a clinical lead role.

Note 9 - The GP is not a member of the Practitioner pension scheme

Note 10 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Note 11 - Alison Gardner was also a Lay Member of Herts Valleys CCG Board in 2021/22 for Patient and Public Involvement. The costs disclosed above are recharged by Herts Valleys CCG.

The table below shows the total remuneration where the Senior Manager has been appointed as a Director in more than one of the Hertfordshire and West Essex CCGs and ICS and where a sharing arrangement exists.

Name	Role	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000
Jane Halpin	Accountable Officer	170-175	0	0	0	0	170-175
Alan Pond	Chief Finance Officer	135-140	0	0	0	60-62.5	195-200
Rachel Joyce	Director of Clinical & Professional Services	140-145	0	0	0	42.5-45	185-190
Jane Kinniburgh	Director of Nursing & Quality	125-130	0	0	0	0	125-130
Avni Shah	Director of Primary Care Transformation	125-130	0	0	0	75-77.5	200-205
Frances Shattock	Director of Performance & Delivery	125-130	0	0	0	27.5-30	150-155
Beverley Flowers	Acting Accountable Officer (from 1 November 2021) Director of Integration & Systems Transformation	145-150	0	0	0	42.5-45	185-190

Fair Pay disclosure (audited element of remuneration report)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. The total remuneration disclosed in the table below consists of the salary and allowances component only as no performance pay and bonuses were paid.

The banded remuneration of the highest paid director/member in the CCG in the financial year 2021-22 was £125,000-£130,000 (2020-21, £125,000-£130,000). The relationship to the remuneration of the CCG's workforce is disclosed in the table below.

YEAR	25th percentile total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio
2021-22	127,500:33,804	127,500:44,133	127,500:55,064
	3.77	2.89	2.32
2020-21	127,500:32,933	127,500:42,685	127,500:53,459
	3.87	2.99	2.39

In 2021-22 and 2020-21, no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from the highest paid director to £12,514 (2020-21 highest paid director-£19,342).

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.

As a number of director posts were shared across the three CCGs and the ICS, for transparency, if the disclosure had been based on total remuneration for those directors the following disclosure would then apply.

The banded remuneration of the highest paid director/member in the CCG in the financial year 2021-22 was £170,000-£175,000 (2020-21, £170,000-£175,000). The relationship to the remuneration of the CCG's workforce is disclosed in the table below.

YEAR	25th percentile total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio
2021-22	172,500:33,804	172,500:44,133	172,500:55,064
	5.10	3.91	3.13
2020-21	172,500:32,933	172,500:42,685	172,500:53,459
	5.24	4.04	3.23

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

There has been a 2.77% increase from the previous financial year in respect of the average employees salary and allowances (2021-22, £48,822 :2020-21, £47,505) due to an increase in staff recharged to the CCG and a 3% staff pay increase, excluding directors.

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

EAST AND NORTH HERTFORDSHIRE CCG

Table 2: Pensions Benefits (Subject to Audit) RESTATED*

Table 2: Pension Benefits

Name	Role	Note	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£000
Relating to the period 1 April 2021 to 31 March 2022										
Jane Halpin	ICS Accountable Officer 29.23%	1,2	0	0	0	0	0	0	0	0
Beverley Flowers	29.23%	1	0-2.5	0-2.5	15-20	25-30	267	5	287	0
Sharn Elton	Managing Director		2.5-5	2.5-5	60-65	130-135	1,052	58	1,134	0
Alan Pond	ICS Chief Finance Officer 29.23%	1	0-2.5	0-2.5	20-25	30-35	353	19	380	0
Jo Burlingham	Interim Director of Operations		2.5-5	0-2.5	30-35	65-70	521	38	576	0
Rachel Joyce	ICS Director of Clinical & Professional Services 29.23%	1	0-2.5	0-2.5	10-15	30-35	296	16	319	0
Jane Kinniburgh	ICS Director of Nursing & Quality 29.23%	1,2	0	0	0	0	0	0	0	0
Avni Shah	ICS Director of Primary Care Transformation 29.23%	1	0-2.5	0-2.5	10-15	20-25	152	16	174	0
Frances Shattock	ICS Director of Performance & Delivery 29.23%	1	0-2.5	0	0-5	0	1	3	8	0
Phil Turnock	Chief Digital Officer	2	0	0	0	0	0	0	0	0
Prag Moodley	CCG Chair	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Ashish Shah	Deputy Clinical Chair	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Tara Belcher	GP Board Member (to 31 October 2021)	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Sarah Dixon	GP Board Member	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Russell Hall	GP Board Member	6	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Anindita Saha	GP Board Member	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Rupal Shah	GP Board Member	3	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL	£NIL
Linda Farrant	Lay Member	4	0	0	0	0	0	0	0	0
Dianne Desmulie	Lay Member	4	0	0	0	0	0	0	0	0
Alison Gardner	Lay Member	4,5	0	0	0	0	0	0	0	0
Dermot O'Riordan	Lay Member	4	0	0	0	0	0	0	0	0

* The 2021-22 Table 2 has been restated to reflect the pension figures for Alan Pond without adjusting for pension share.

Notes

Note 1 - Where members have been appointed to the Hertfordshire and West Essex Joint Executive Team (JET), the disclosures above only relate to the CCG's proportion of pension benefits based on 29.23%. For transparency the table below shows members total pension benefits across Hertfordshire and West Essex CCGs and ICS.

Note 2 - Jane Halpin, Jane Kinniburgh and Phil Turnock are not members of the NHS pension scheme.

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

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

Note 5 - Alison Gardner was also a Lay Member of Herts Valleys CCG Board in 2021/22 for Patient and Public Involvement.

Note 6 - The GP is not a member of the Practitioner pension scheme.

Note 7 - NHS employees contribute towards their pension benefits. In 2021/22 contribution rates were 14.5% of salary where the individual earned in excess of £111,377 and 13.5% where the individual earned between £70,631 and £111,377.

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

Note 8 - Cash equivalent transfer values (CETV)

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.
The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be more than just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.
CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

The table below shows the total pension benefits where the Senior Manager was appointed as a Director in more than one of the Hertfordshire and West Essex CCGs and ICS and where a sharing arrangement existed.

Name	Role	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
Jane Halpin	Accountable Officer	0	0	0	0	0	0	0	0
Beverley Flowers	Acting Accountable Officer (from 1 November 2021-31 March 22) Director of Integration & Systems Transformation	2.5-5	0-2.5	50-55	95-100	913	45	982	0
Alan Pond	Chief Finance Officer	2.5-5	0-2.5	75-80	115-120	1209	66	1301	0
Rachel Joyce	Director of Clinical & Professional Services	2.5-5	0-2.5	50-55	110-115	1013	54	1093	0
Jane Kinniburgh	Director of Nursing & Quality	0	0	0	0	0	0	0	0
Avni Shah	Director of Primary Care Transformation	2.5-5	5-7.5	35-40	70-75	519	55	595	0
Frances Shattock	Director of Performance & Delivery	0-2.5	0	0-5	0	2	9	29	0

EXPENDITURE ON CONSULTANCY (NOT SUBJECT TO AUDIT)

The total spend on consultants in 2022/23 is shown on within the accounts from page 119

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

There are no exit packages for the three months to 30 June 2022 and for the previous 2021-22 financial year.

STAFF REPORT

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

Trade Union Facility Time

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

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

Activities can be, for example, taking part in:

- branch, area or regional meetings of the union where the business of the union is under discussion

- meetings of official policy making bodies such as the executive committee or annual conference
- meetings with full time officers to discuss issues relevant to the workplace.

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

Table 7: Relevant union officials

Number of employees who were relevant union officials during 2021/22	Full-time equivalent employee number
2	2

Table 8: Percentage of time spent on facility time

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

Table 9: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£1,134.08
Total pay bill	£4,071,598.24
Percentage of the total pay bill spent on facility time	0.03%

Table 10: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	22.84%

About our CCG staff

As at 31 January 2022, East and North Hertfordshire CCG employed a total of 332 staff (288.67 full time equivalents). These figures include all governing body members and 7 staff on external secondment to partnership organisations.

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

Agenda for Change Band	Headcount	FTE
8a	43	39.78
8b	34	32.19
8c	9	8.40
8d	17	16.60
9	1	1
VSM[16]	27	11.67
Medical & Dental (M&D)	5	4.33

Equality and Diversity

The Equality Act 2010: The Public Sector Equality Duty

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

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

Throughout 2021/22, East and North Hertfordshire CCG's engagement approach was fully cognisant of this duty and it will continue to promote equality of opportunity for the population of east and north Hertfordshire in the context of all its commissioning engagement activities in the future.

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

The CCG met statutory responsibilities around data publication and will meet the NHS requirements in using the NHS Equality Delivery System (EDS2) and the Workforce Race Equality Standard (WRES) as tools to enable us to review our equality and diversity work and identify where improvements can be made.

NHS Workforce Race Equality Standards (WRES)

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

The CCG's profile for staff-declared ethnicity appears in the table below (at 31 March 2022).

Ethnic Origin	Count	%
A White - British	205	62%
B White - Irish	8	2%
C White - Any other White background	21	6%
D Mixed - White & Black Caribbean	2	1%
E Mixed - White & Black African	1	0%
F Mixed - White & Asian	2	1%
G Mixed - Any other mixed background	1	0%
GD Mixed - Chinese & White	1	0%
GF Mixed - Other/Unspecified	1	0%
H Asian or Asian British - Indian	32	10%
J Asian or Asian British - Pakistani	6	2%
K Asian or Asian British - Bangladeshi	4	1%
L Asian or Asian British - Any other Asian background	5	2%
LE Asian Sri Lankan	1	0%
LH Asian British	1	0%

M Black or Black British - Caribbean	9	3%
N Black or Black British - African	15	5%
P Black or Black British - Any other Black background	1	0%
R Chinese	3	1%
S Any Other Ethnic Group	3	1%
Unspecified	6	2%
Z Not Stated	4	1%
Grand Total	332	100%

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

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

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

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

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

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

Disability

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

At 31 March 2022, 92.06% of staff have declared they have no disability, with 2.94% declaring a disability and the remaining 5.00% undeclared.

Gender Profile

Gender Profile – overall workforce (at 31 March 2022)

Gender	%
Female	64
Male	36

% gender by pay band (at 31 March 2022)

Band	Female	Female%	Male	Male %
Band 3		0%	1	100%
Band 4	24	89%	3	11%
Band 5	24	50%	24	50%
Band 6	29	64%	16	36%
Band 7	49	65%	26	35%
Band 8 - Range A	38	88%	5	12%
Band 8 - Range B	17	50%	17	50%
Band 8 - Range C	4	44%	5	56%

Band 8 - Range D	9	53%	8	47%
Band 9	1	100%		0%
M&D	5	100%		0%
VSM	14	52%	13	48%
Grand Total	**214**	**100%**	**118**	**100%**

Gender breakdown (as at 31 March 2022)

Governing Body members (covers VSM pay framework grades)			
Male		**Female**	
Headcount	%	Headcount	%
13	41	19	59
Bands 8a and above			
Male		**Female**	
Headcount	%	Headcount	%
35	33	69	66
All other bands (band 7 and below)			
Male		**Female**	
Headcount	%	Headcount	%
70	36	126	64

Gender pay gap reporting regulations

All public sector organisations in England employing 250 or more staff are required to publish gender pay gap information annually, both on their website and on the designated government website at **www.gov.uk/genderpaygap**. East and North

Hertfordshire is one of the few CCGs nationally which is required to publish this information, as most CCGs employ fewer than 250 members of staff. This information is reported on an annual basis.

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

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

East and North Hertfordshire CCG employs more women than men, with women making up approximately 64% of the workforce.

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

On 31 March 2021 (the latest available data) the mean gender pay gap was 6.47% which is a significant reduction on the 2020 figure of 25.65%.

The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle salary. We believe this is a more representative measure of the pay gap because it is not affected by outliers – a few individuals at the top or bottom of the range. On 31 March 2021 (the latest available data) the median gender pay gap was -0.57 %. This means that typically women are paid 0.57% more in the CCG than men.

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

Religion and beliefs

The declared religion or belief of CCG staff at 31 March 2022 appears in the table below:

Religious Belief	Count	%
Atheism	48	14%
Buddhism	1	0%
Christianity	126	38%
Hinduism	14	4%
I do not wish to disclose my religion/belief	88	27%
Islam	10	3%
Jainism	4	1%
Judaism	1	0%
Other	20	6%
Sikhism	5	2%
Unspecified	15	5%
Grand Total	**332**	**100%**

Sexual Orientation

The declared sexual orientation of CGG staff at 31 March 2022 appears in the table below:

Sexual Orientation	Count	%
Bisexual	2	1%
Gay or Lesbian	2	1%
Heterosexual or Straight	249	75%
Not stated (person asked but declined to provide a response)	62	19%
Other sexual orientation not listed	3	1%

Undecided	1	0%
Unspecified	13	4%

Sickness Absence Data

Sickness absence data relating to the year 2021/22 extracted from ESR, this information is reported on an annual basis:

Total days lost:	2255 days (equivalent calendar days)
Total absence (FTE)	2255 days out of a total of 105,814 available FTE days
Average absence per employee:	7.78 days (average of total days lost by CCG employee headcount)
Of total days lost, long term absence episodes:	26 (taken from ESR)
Long term days total:	1504.8 days (included in total days lost)

The CCG's sickness absence rate for 2021/22 was 2.13%

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

COVID-19 related absence was recorded separately to general sickness absence in accordance with government guidelines. In addition, where sickness absence has been extended due to COVID-19, consideration has been given to the impact of this on

sickness levels, for example where an operation has been delayed and has resulted in the staff member's absence being longer than the norm.

Staff turnover

Overall rate
17.01%

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

EMPLOYEE BENEFITS (SUBJECT TO AUDIT)

Employee benefits and staff numbers (subject to audit)

Employee benefits	2022-23 (3 months to 30 June) Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	3,351	3,145	206
Social security costs	367	366	1
Employer Contributions to NHS Pension scheme	559	558	1
Other pension costs	2	2	0
Apprenticeship Levy	14	14	0
Termination benefits	0	0	0
Total employee benefits expenditure	**4,293**	**4,085**	**208**

Employee benefits	2021-22 Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	13,505	12,350	1,155
Social security costs	1,361	1,334	27
Employer Contributions to NHS Pension scheme	2,466	2,441	25
Other pension costs	6	6	0
Apprenticeship Levy	58	58	0
Termination benefits	0	0	0
Total employee benefits expenditure	**17,396**	**16,189**	**1,207**

Average number of people employed (subject to audit)

	2022-23 (3 months to 30 June) Total Number	Permanently employed Number	Other Number
Total for CCG	**267.7**	**252.6**	**15.1**

	2021-22 Total Number	Permanently employed Number	Other Number
Total for CCG	269.3	254.7	14.6

HR shared service model

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

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

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

Health and safety

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

During 2022/23 additional staff Mental Health First Aiders have been recruited and training is planned to take place during quarter two, existing first aiders refreshed their training virtually to ensure their skills were up to date. The CCG ensured compliance with The Health and Safety (Display Screen Equipment) Regulations 1992 by issuing additional guidance to staff to reduce the risk of developing related health problems, particularly while working from home. The CCG also continued to enable staff to reclaim the costs of any equipment bought to enable effective working from home following a DSE assessment

Employee consultation and communications

Joint Partnership Forum

Staff Survey

The 2021 NHS National Staff Survey has demonstrated that there has been significant improvement in the following areas:

- Staff feeling involved in deciding changes that affect work
- Last experience of harassment/bulling abuse reported
- Staff having opportunities to show initiative frequently in my role
- Staff feeling they would be secure in raising concerns about unsafe clinical practice
- Staff being able to make improvements happen in their area of work

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

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

PART THREE: PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

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

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

Opinion on financial statements

We have audited the financial statements of NHS East and North Hertfordshire Clinical Commissioning Group (the CCG) for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as interpreted and adapted by the 2022-23 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2022-23.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS East and North Hertfordshire CCG as at 30 June 2022 and of its net expenditure for the period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2022-23; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for opinion on financial statements

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

Emphasis of matter – basis of preparation of financial statements

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

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

Conclusions relating to going concern

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

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

Opinion on regularity

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

Basis for opinion on regularity

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

Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report described in that report as having been audited.

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

Matters on which we are required to report by exception

We are required to report to you if, in our opinion, we identify any significant weaknesses in the arrangements that have been made by the CCG for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

We have completed our work on the CCG's arrangements. We have nothing to report in this regard.

Other matters on which we report by exception

We are required to report to you if:

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

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Our procedures included the following:

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

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

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Governing Body;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- in addressing the risk of fraud in expenditure recognition, testing the accounting treatment of an increased sample of payments around the period end; testing an increased sample of accruals to supporting evidence to confirm a liability existed at period end; testing an increased sample of accruals to post period payments or other supporting evidence to verify their accuracy; testing the expenditure recognised with healthcare providers to agreed contracts and their performance against conditions.

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

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

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

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

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

We have undertaken our work in accordance with the Code of Audit Practice issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in January 2023.

Auditor's other responsibilities

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

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

Certificate

We certify that we have completed the audit of the accounts of insert name Clinical Commissioning Group for the period ended 30 June 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Members of the Board of NHS Hertfordshire and West Essex Integrated Care Board, as a body, in respect of NHS East and North Hertfordshire CCG, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph

43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015.

Our audit work has been undertaken so that we might state to the Members of the Board those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the Members of the Board of NHS Hertfordshire and West Essex Integrated Care Board, as a body, for our audit work, this report, or for the opinions we have formed.

Lisa Blake

Key Audit Partner

For and on behalf of BDO LLP, local auditor

Ipswich, UK

16 November

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

Statement of Comprehensive Net Expenditure for the year ended 30 June 2022

	Note	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Revenue from contracts with customers	2	(2,697)	(12,131)
Other operating income	2	(58)	(212)
Total operating income		**(2,755)**	(12,343)
Staff costs	3	4,293	17,396
Purchase of goods and services	4	232,085	926,242
Depreciation	4	311	972
Provision expense	4	0	868
Other Operating Expenditure	4	123	482
Total operating expenditure		**236,812**	945,960
Net Operating Expenditure		**234,057**	933,617
Finance expense		**1**	0
Net expenditure for the year		**234,058**	933,617
Total Comprehensive Expenditure for the year ended 30 June 2022		**234,058**	933,617

The notes on pages 123 to 125 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000	31 March 2022 £'000
Non-current assets:			
Property, plant and equipment	6	1,426	1,663
Right-of-use assets		341	0
Trade and other receivables	7	215	229
Total non-current assets		**1,982**	1,892
Current assets:			
Trade and other receivables	7	5,257	6,531
Cash	8	4,065	640
Total current assets		**9,322**	7,171
Total assets		**11,304**	9,063
Current liabilities			
Trade and other payables	9	(50,997)	(60,179)
Lease Liabilities		(277)	0
Provisions		(308)	(452)
Total current liabilities		**(51,582)**	(60,631)
Total Assets less Current Liabilities		**(40,278)**	(51,568)
Non-current liabilities			
Lease Liabilities		(68)	0
Provisions		(282)	(282)
Total non-current liabilities		**(350)**	(282)
Assets less Liabilities		**(40,628)**	(51,850)
Financed by Taxpayers' Equity			
General fund		(40,628)	(51,850)
Total taxpayers' equity:		**(40,628)**	(51,850)

The notes on pages 123 to 125 form part of this statement

The financial statements on pages 119 to 122 were approved by the Audit and Risk Committee (on behalf of the Governing Body) on 9th November and signed on its behalf by:

Jane Halpin
Accountable Officer

16th November 2023

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

	General fund £'000
Changes in taxpayers' equity for 2022-23 (3 months to 30 June)	
Balance at 1 April 2022	**(51,850)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23 (3 months to 30 June)	
Net operating expenditure for the financial year	(234,058)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year including balance brought forward from previous year	**(285,908)**
Net funding	245,280
Balance at 30 June 2022	**(40,628)**

	General fund £'000
Changes in taxpayers' equity for 2021-22	
Balance at 1 April 2021	(44,767)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22	
Net operating expenditure for the financial year	(933,617)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year including balance brought forward from previous year	(978,384)
Net funding	926,534
Balance at 31 March 2022	(51,850)

The notes on pages 123 to 125 form part of this statement

Statement of Cash Flows for the year ended 30 June 2022

	Note	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(234,058)	(933,617)
Depreciation	4	311	972
Decrease in trade & other receivables	7	1,287	3,202
(Decrease)/increase in trade & other payables	10	(9,182)	2,769
Provisions utilised		(144)	(377)
Increase in provisions		0	868
Net Cash Outflow used in Operating Activities		**(241,786)**	(926,183)
Cash Flows from Investing Activities			
Payments for property, plant and equipment		0	(219)
Net Cash Outflow used in Investing Activities		**0**	(219)
Net Cash Outflow before Financing		**(241,786)**	(926,402)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		245,280	926,534
Repayment of lease liabilities		(69)	0
Net Cash Inflow from Financing Activities		**245,211**	926,534
Net Increase in Cash	9	**3,425**	132
Cash at the Beginning of the Financial Year		**640**	508
Cash at the End of the Financial Year		**4,065**	640

The notes on pages 123 to 125 form part of this statement

Notes to the financial statements

Foreword

NHS East and North Hertfordshire CCG has changed its reporting period from 31 March to 30 June due to an establishment order by NHS England dissolving the CCG on 30 June 2022. These accounts have therefore been prepared for the three months to 30 June 2022. The comparators in the accounts are for the twelve months to 31 March 2022 and are therefore not entirely comparable.

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities transferred to NHS Hertfordshire and West Essex ICB.

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.

When CCGs ceased to exist on 1 July 2022, the services continued to be provided (using the same assets, by another public sector entity) by ICBs. Accordingly, the financial statements for this CCG for 3 months ending 30 June 2022 have been prepared on a Going Concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

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

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

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

(3) Equipment Services.

(4) Intermediate Care Services.

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

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

1.4 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The CCG is of the opinion that there are no critical judgements and key sources of estimation uncertainty that will materially affect these financial statements.

Notes to the financial statements

1.5 **Revenue**

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

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

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

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

1.6.2 **Retirement Benefit Costs**

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

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

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

1.7 **Other Expenses**

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

1.8 **Property, Plant & Equipment**

1.8.1 **Recognition**

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

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

1.8.2 **Valuation**

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

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

1.8.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.9 **Depreciation and Impairments**

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

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

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

1.10 **Cash**

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

1.11 **Financial Liabilities**

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

1.12 **Adoption of new standard**

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

Under IFRS 16 the CCG will recognise a right-of-use asset representing the CCG'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 CCG will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the CCG will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The CCG has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the tax payers equity 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 CCG has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The CCG has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value (less than £5,000).
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the CCG recognised £414k of right-of-use assets and lease liabilities of £414k. The weighted average incremental borrowing rate applied at 1 April 2022 was 0.95% and on adoption of IFRS 16 there was no impact to tax payers' equity.

2 Other Operating Revenue

	2022-23 (3 months to 30 June) Total £'000	2021-22 Total £'000
Revenue from contracts with customers		
Non-patient care services to other bodies	2,683	11,870
Other revenue	14	261
Total Income from sale of goods and services	2,697	12,131
Other operating income		
Non cash apprenticeship training grants revenue	(1)	20
Other non contract revenue	59	192
Total Other operating income	58	212
Total Operating Income	**2,755**	12,343

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

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

2022-23 (3 months to 30 June)	Non-patient care services to other bodies £'000	Other Contract Income £'000	Total £'000
Source of Revenue			
NHS	2,682	0	2,682
Non NHS	1	14	15
Total	**2,683**	**14**	**2,697**

2021-22	Non-patient care services to other bodies £'000	Other Contract Income £'000	Total £'000
Source of Revenue			
NHS	11,861	0	11,861
Non NHS	9	261	270
Total	**11,870**	**261**	**12,131**

3. Employee benefits

3.1 Employee benefits	2022-23 (3 months to 30 June) Total £'000	2021-22 Total £'000
Salaries and wages	3,351	13,505
Social security costs	367	1,361
Employer Contributions to NHS Pension scheme	559	2,466
Other pension costs	2	6
Apprenticeship Levy	14	58
Gross employee benefits expenditure	**4,293**	**17,396**

3.2 Ill health retirements

Ill health retirement costs are met by the NHS Pension Scheme and are not included in table 3.1 above. There was no such cost for the three months to 30 June 2022 (2021-22 £nil).

3.3 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

4. Operating expenses

	2022-23 (3 months to 30 June) Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	143	651
Services from foundation trusts	46,022	163,531
Services from other NHS trusts	116,836	437,622
Services from other WGA bodies	0	1
Purchase of healthcare from non-NHS bodies	21,674	112,824
Purchase of social care	3,899	14,959
Prescribing costs	20,787	85,834
GPMS/APMS and PCTMS	19,975	96,822
Supplies and services – clinical	3	40
Supplies and services – general	571	1,605
Consultancy services	(42)	286
Establishment	1,821	9,423
Transport	63	345
Premises	400	1,626
Audit fees (Note 1)	74	71
Other non statutory audit expenditure		
· Other services	3	13
Other professional fees (Note 2)	30	299
Legal Fees	(4)	114
Education and training	(169)	156
Non cash apprenticeship training grants	(1)	20
Total Purchase of goods and services	**232,085**	926,242
Depreciation		
Depreciation (Note 3)	311	972
Total Depreciation	**311**	972
Provision expense		
Provisions	0	868
Total Provision expense	**0**	868
Other Operating Expenditure		
Chair and Non Executive Members	46	185
Expected credit (gain) on receivables	(0)	(2)
Other expenditure	77	299
Total Other Operating Expenditure	**123**	482
Total operating expenses	**232,519**	928,564

Note 1

Audit fee is shown inclusive of VAT and the net amount was £62k (2021-22 £59k).

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

Note 2

Other professional fees includes the sum of £21k for Internal Audit Fees (2021-22 £42k). Internal audit fees is shown net of VAT.

Note 3

This relates to depreciation of £238k for Property, Plant and Equipment and £73k for Right-of-Use asset.

5 Better Payment Practice Code

Measure of compliance	2022-23 (3 months to 30 June) Number	2022-23 (3 months to 30 June) £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	6,141	68,936	23,522	259,654
Total Non-NHS Trade Invoices paid within target	6,001	67,149	23,294	257,750
Percentage of Non-NHS Trade invoices paid within target	97.72%	97.41%	99.03%	99.27%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	185	157,194	655	603,069
Total NHS Trade Invoices Paid within target	185	157,194	647	602,906
Percentage of NHS Trade Invoices paid within target	100.00%	100.00%	98.78%	99.97%

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

6 Property, plant and equipment

2022-23 (3 months to 30 June)	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2022	4,112	597	4,709
Additions purchased	0	0	0
Disposals other than by sale	(590)	0	(590)
Cost/Valuation at 30 June 2022	**3,522**	**597**	**4,119**
Depreciation 1 April 2022	2,636	410	3,046
Disposals other than by sale	(590)	0	(590)
Charged during the year	207	31	238
Depreciation at 30 June 2022	**2,253**	**441**	**2,694**
Net Book Value at 30 June 2022	**1,269**	**156**	**1,425**
Purchased	1,269	157	1,426
Total at 30 June 2022	**1,269**	**157**	**1,426**
Asset financing:			
Owned	1,269	157	1,426
Total at 30 June 2022	**1,269**	**157**	**1,426**

The CCG did not hold any revaluation reserve balance for property, plant & equipment in 2022-23 (3 months to 30 June) and 2021-22.

7 Trade and other receivables	Current 30 June 2022 £'000	Non-current 30 June 2022 £'000	Current 31 March 2022 £'000	Non-current 31 March 2022 £'000
NHS receivables: Revenue	1,107	0	2,832	0
NHS prepayments	106	0	0	0
NHS accrued income	0	0	0	0
Non-NHS and Other WGA receivables: Revenue	192	0	314	0
Non-NHS and Other WGA prepayments	3,400	215	3,274	229
Non-NHS and Other WGA accrued income	0	0	0	0
VAT	423	0	92	0
Other receivables and accruals	29	0	19	0
Total Trade and Other Receivables	**5,257**	**215**	**6,531**	**229**
Total current and non current	**5,472**		**6,760**	

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

8 Cash

	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Balance at 1 April	640	508
Net change in year	3,425	132
Balance at 30 June	**4,065**	**640**
Made up of:		
Cash with the Government Banking Service	4,065	640
Balance at 30 June	**4,065**	**640**

There were no patients' monies held by the clinical commissioning group in 2022-23 (3 months to 30 June) and 2021-22.

9 Trade and other payables	Current 30 June 2022 £'000	Current 31 March 2022 £'000
NHS payables: revenue	287	481
NHS accruals	7,057	458
NHS deferred income	0	0
Non-NHS and Other WGA payables: Revenue	4,903	8,799
Non-NHS and Other WGA accruals	36,270	47,287
Non-NHS and Other WGA deferred income	448	18
Social security costs	252	239
Tax	217	218
Other payables and accruals	1,563	2,679
Total Trade and Other Payables	**50,997**	**60,179**
Total current and non-current	**50,997**	**60,179**

Other payables include £741k (£247k employees and £494k GP Practices) outstanding pension contributions at 30 June 2022 (£1,052k: £268k employees and £784 GP Practices - 31 March 2022).

10 Financial instruments

10.1 Financial risk management

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

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

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

Because the majority of the CCG's revenue comes from parliamentary funding, the CCG has low exposure to credit risk.

10.1.2 Liquidity risk

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

10.2 Financial liabilities

	Financial Liabilities measured at amortised cost 30 June 2022 £'000	Financial Liabilities measured at amortised cost 31 March 2022 £'000
Trade and other payables with NHSE bodies	353	265
Trade and other payables with other DHSC group bodies	7,419	1,061
Trade and other payables with external bodies	42,654	58,378
Total at 30 June	**50,426**	59,704

11 Operating segments

The CCG considers they have only one segment for the three months to 30 June 2022 and 2021-22: Commissioning of healthcare services

	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Commissioning of healthcare services	**234,058**	933,617

12 Pooled budgets

The clinical commissioning group has entered into a pooled budget with Hertfordshire County Council, Herts Valleys Clinical Commissioning Group, and Cambridgeshire and Peterborough Clinical Commissioning Group. The pool is hosted by Hertfordshire County Council.

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

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

2022-23 (3 months to 30 June)	**Mental Health, Learning Disabilities & CAMHS**		**Equipment Service**		**Intermediate Care**		**Protection of Social Care Services**		**All pooled funds**
	Total Pooled-Budget	**CCG** (Note)	**Total Pooled-Budget**	**CCG**	**Total Pooled-Budget**	**CCG**	**Total Pooled-Budget**	**CCG**	**Total CCG Contribution**
	2022-23 (3 months to 30 June) £000	**2022-23 (3 months to 30 June) £000**	**2022-23 (3 months to 30 June) £000**	**2022-23 (3 months to 30 June) £000**	**2022-23 (3 months to 30 June) £000**	**2022-23 (3 months to 30 June) £000**	**2022-23 (3 months to 30 June) £000**	**2022-23 (3 months to 30 June) £000**	**2022-23 (3 months to 30 June) £000**
Contribution	99,141	25,217	2,024	487	1,648	611	6,820	4,003	30,318
Expenditure	99,162	25,217	1,883	455	1,648	611	5,425	4,003	30,286
Total Variance	(21)	0	141	32	0	0	1,395	0	32

Note

The contribution of the CCG also included £22,912k paid directly to Hertfordshire Partnership NHS Foundation Trust. This was in compliance with the revised financial regime instigated by NHS England as a result of the Covid-19 pandemic, which simplified cashflows to NHS providers. This is consistent with last year but prior to that, the payment was made to Hertfordshire County Council.

2021-22	Mental Health, Learning Disabilities & CAMHS		Equipment Service		Intermediate Care		Protection of Social Care Services		All pooled funds
	Total Pooled-Budget	CCG	Total Pooled-Budget	CCG	Total Pooled-Budget	CCG	Total Pooled-Budget	CCG	Total CCG Contribution
	2021-22 £000	2021-22 £000	2021-22 £000	2021-22 £000	2021-22 £000	2021-22 £000	2021-22 £000	2021-22 £000	2021-22 £000
Contribution	387,834	98,596	5,956	1,428	6,176	2,258	26,015	15,358	117,640
Expenditure	388,688	99,027	6,587	1,580	6,176	2,258	21,383	15,358	118,223
Total Variance	(854)	(431)	(631)	(152)	0	0	4,632	0	(583)

13 Related party transactions

Details of related party transactions with individuals are as follows:

During the period, other than that declared below, none of the Department of Health and Social Care Ministers, clinical commissioning group Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the CCG.

Following their appointment to the Hertfordshire & West Essex Joint Executive Team (JET), the following Governing Body members are also Board members of Herts Valleys and West Essex CCGs:

Jane Halpin
Alan Pond
Rachel Joyce
Jane Kinniburgh
Avni Shah
Frances Shattock

A number of local GPs were members of the CCG's Governing Body. Details of payments made by the CCG to their practices and related parties disclosed by the GPs and other Governing Body members were as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Chells Surgery - Dr. R Hall	459	0	0	0
King George Surgery - Dr. A Saha	741	0	0	0
South Street Surgery - Dr. S Dixon	571	0	0	0
Stanmore Medical Group - Dr. P Moodley	1,182	0	0	0
Wrafton House Surgery - Dr. A Shah	294	0	0	0
The following are payments made in the normal course of business to GP Federations of which GP practices are shareholders:				
Ephedra Healthcare Limited - Dr. A Shah	284	0	0	0
Stort Valley Health Care Limited - Dr. S Dixon	9	0	0	0
Payments were also made to the following Primary Care Networks of which GP practices are members:				
Hatfield PCN - Dr. A Shah	220	0	0	0
Stevenage South PCN - Dr. A Saha	397	0	0	0
Stevenage North PCN - Dr. R Hall & Dr. P Moodley	237	0	0	0
Stort Valley & Villages PCN - Dr. S Dixon	335	0	0	0

The Department of Health and Social Care is regarded as a related party. During the period the CCG has had a number of material transactions with entities for which the Department is regarded as the parent organisation. The CCG has adopted a disclosure level of £1.25million and the most significant related parties are listed below. In addition, the CCG had a number of material transactions with other local government bodies. Where appropriate, these entities have also been reflected in the list below:

East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Hertfordshire Community NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
North Middlesex University Hospital NHS Trust
The Princess Alexandra Hospital NHS Trust
Royal Free London NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Hertfordshire County Council

2021-22 comparators are shown on the following page.

13a Related party transactions (2021-22)

Details of related party transactions with individuals are as follows:

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

Following their appointment to the Hertfordshire & West Essex Joint Executive Team (JET), the following Governing Body members are also Board members of Herts Valleys and West Essex CCGs:

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Alan Pond
Rachel Joyce
Jane Kinniburgh
Avni Shah
Frances Shattock

A number of local GPs were members of the CCG's Governing Body. Details of payments made by the CCG to their practices and related parties disclosed by the GPs and other Governing Body members were as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Chells Surgery - Dr. R Hall	1,849	0	4	0
King George Surgery - Dr. A Saha	2,965	0	14	0
Portmill Surgery - Dr. T Belcher	2,025	0	0	0
South Street Surgery - Dr. S Dixon	2,380	0	0	0
Stanmore Medical Group - Dr. P Moodley	5,891	0	82	0
Wrafton House Surgery - Dr. A Shah	1,166	0	1	0

The following payments were made to the organisation below where the spouse of a GP Governing Body Member is a Partner in that organisation:

Mills & Reeves	11	0	1	0

The following are payments made in the normal course of business to GP Federations of which GP practices are shareholders:

12 Point Care Limited	3,736	0	156	0
Ephedra Healthcare Limited	621	0	84	0
Stort Valley Health Care Limited	1,697	0	14	0

The Department of Health and Social Care is regarded as a related party. During the year the CCG has had a number of material transactions with entities for which the Department is regarded as the parent organisation. The CCG has adopted a disclosure level of £5million and the most significant related parties are listed below. In addition, the CCG had a number of material transactions with other local government bodies. Where appropriate, these entities have also been reflected in the list below:

East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Hertfordshire Community NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
North Middlesex University Hospital NHS Trust
The Princess Alexandra Hospital NHS Trust
Royal Free London NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Hertfordshire County Council

14 Events after the end of the reporting period

Following the issue of an establishment order by NHS England, the CCG was dissolved on 30 June 2022. On 1 July 2022 the assets, liabilities and operations transferred to NHS Hertfordshire and West Essex ICB.

15 Financial performance targets

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

	2022-23 (3 months to 30 June)	**2022-23 (3 months to 30 June)**	2021-22	2021-22
	Target	**Performance**	Target	Performance
	£'000	**£'000**	£'000	£'000
Expenditure not to exceed income	239,361	236,813	946,311	946,179
Capital resource use does not exceed the amount specified in Directions	0	0	219	219
Revenue resource use does not exceed the amount specified in Directions	236,606	234,058	933,749	933,617
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	2,866	2,866	12,005	11,194

Accessibility Report

Filename: 06K_ENHCCG_ANNUAL_REPORT_AND_ACCOUNTS_2022_23___signatures_removed_for_website.pdf

Report created by: [Enter personal and organization information through the Preferences > Identity dialog.]
Organization:

Summary

The checker found problems which may prevent the document from being fully accessible.

- Needs manual check: 1
- Passed manually: 1
- Failed manually: 0
- Skipped: 1
- Passed: 12
- Failed: 17

Detailed Report

Document

Rule Name	Status	Description
Accessibility permission flag	Passed	Accessibility permission flag must be set
Image-only PDF	Passed	Document is not image-only PDF
Tagged PDF	Failed	Document is tagged PDF
Logical Reading Order	Needs manual check	Document structure provides a logical reading order
Primary language	Passed	Text language is specified
Title	Passed	Document title is showing in title bar
Bookmarks	Failed	Bookmarks are present in large documents
Color contrast	Passed manually	Document has appropriate color contrast

Page Content

Rule Name	Status	Description
Tagged content	Failed	All page content is tagged
Tagged annotations	Passed	All annotations are tagged
Tab order	Failed	Tab order is consistent with structure order
Character encoding	Failed	Reliable character encoding is provided
Tagged multimedia	Passed	All multimedia objects are tagged
Screen flicker	Passed	Page will not cause screen flicker
Scripts	Passed	No inaccessible scripts
Timed responses	Passed	Page does not require timed responses
Navigation links	Passed	Navigation links are not repetitive

Forms

Rule Name	Status	Description
Tagged form fields	Passed	All form fields are tagged
Field descriptions	Passed	All form fields have description

Alternate Text

Rule Name	Status	Description
Figures alternate text	Failed	Figures require alternate text
Nested alternate text	Failed	Alternate text that will never be read
Associated with content	Failed	Alternate text must be associated with some content
Hides annotation	Failed	Alternate text should not hide annotation
Other elements alternate text	Failed	Other elements that require alternate text

Tables

Rule Name	Status	Description
Rows	Failed	TR must be a child of Table, THead, TBody, or TFoot
TH and TD	Failed	TH and TD must be children of TR

Headers	Failed	Tables should have headers
Regularity	Failed	Tables must contain the same number of columns in each row and rows in each column
Summary	Skipped	Tables must have a summary

Lists

Rule Name	Status	Description
List items	Failed	LI must be a child of L
Lbl and LBody	Failed	Lbl and LBody must be children of LI

Headings

Rule Name	Status	Description
Appropriate nesting	Failed	Appropriate nesting

Back to Top