NHS
East and North Hertfordshire
Clinical Commissioning Group

# ANNUAL REPORT AND ACCOUNTS

# 2021/22

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**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**
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NHS East and North Hertfordshire
Clinical Commissioning Group (CCG)

# PERFORMANCE REPORT

Dr Jane Halpin
Accountable Officer

**Date signed: 21 June 2022**

# PERFORMANCE REPORT: OVERVIEW OF PERFORMANCE

This section contains a summary of our performance as an organisation during 2021/22 plus a flavour of the work we do. You can read more about our work at: www.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 2021/22.

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.**

TYPES OF COMISSIONING

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.

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

- as the ***lead commissioner***, where our CCG has the biggest share of activity and holds the contract, allowing other commissioners to be associates to the contract. Examples of this include contracts with East and North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust.

- as an ***associate commissioner***, where another commissioner has the biggest share of activity and holds the contract, allowing East and North Hertfordshire CCG to be a party to the contract. Examples of this include contracts with Princess Alexandra Hospital NHS Trust, Royal Free London NHS Foundation Trust and Cambridge University Hospitals NHS Foundation Trust.

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

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

We have strong governance arrangements in place to oversee the delivery of the priorities for patient care identified in the CCG's operational plan. We work together with other organisations in our local health and social care system to achieve these priorities, where appropriate. For example, the Urgent Care Network involves representatives from across health and social care. 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** (HCT). 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 2021/22 – 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 |

| | |
|---|---|
| Herts Urgent Care (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 2021/22 can be found from page 99.

# 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

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

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

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

The continuing impact of the pandemic has inevitably affected the performance of our health system against some of the key national standards. This resulted in longer waiting times for diagnosis, treatments delivered in different ways or interrupted or stopped on the grounds of clinical safety, and some follow-up care being disrupted. As is usual in our annual report, you will be able to read more about how our hospitals have performed and the particular challenges facing them in each target area.  Further details can be found from page 39.

## Transition to an Integrated Care Board (ICB)

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

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

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

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

## Caring for our staff

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

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

## Delivering services differently

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

A new 'Shared Care Record' has also started rolling out in Hertfordshire and west Essex to increase the information available to support joined-up direct care. The aim of the Shared Care Record is to allow health and care professionals access to a real-time summary of information from within a patient record. This information is used safely and securely to support patients as they move between different parts of the NHS and social care. GP

practices within east and north Hertfordshire and Princess Alexandra Hospital are in the first phase of roll-out along with our provider of NHS111 services and the two community providers that work across the county. Usage of the shared system is rapidly increasing with more than 1,000 clinicians accessing a record in February 2022. Over the next 12-18 months, more providers will be connected in stages including mental health providers, acute trusts, and local authorities within the ICS. We will also be able to connect to similar systems in neighbouring areas, for example hospital trusts in London.

Clinicians at West Hertfordshire Hospitals NHS Trust (WHHT) who set up the UK's first 'virtual COVID hospital' to care for local patients were also named Respiratory Team of The Year by the British Medical Journal in 2021. The virtual ward model is in widespread use in Hertfordshire and west Essex for respiratory conditions and heart disease, also enabling many thousands of patients to be closely monitored in the comfort of their own homes and access care when they need it.

The reaction to virtual wards from both patients and staff has been very positive. The wards help to prevent people being admitted to hospital because their symptoms have gone unchecked and is also helping people leave hospital more quickly to finish their recovery at home.

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

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

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

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

## Protecting and supporting vulnerable communities

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

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

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

HertsHelp provides an independent information and advice service, acting as a gateway to voluntary services in Hertfordshire as well as running the Crisis Intervention Service. They can link people to the Hospital and Community Navigation Service, Community Help Hertfordshire for volunteer support, Hertswise dementia support and independent advocacy services. HertsHelp is open 7 days a week, from 8am to 8pm on weekdays and 10am to 4pm on weekends.

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

We have also extended the Community Help Hertfordshire delivery model, which unifies the CVS organisations across Hertfordshire under one joint umbrella with a new focus on recovery. People who have received support will be proactively contacted and offered help to rebuild their mental and physical wellbeing and to get them engaged with their local community.

## COVID vaccinations

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

The co-ordination of the vaccination programme has required quick thinking, flexibility and determination in order to rapidly respond to the demands that new variants and changes in Joint Committee on Vaccination and Immunisation (JCVI) guidance have made on the delivery model. This year our vaccinations teams in the CCGs, community trusts, GP practices and hospitals have offered vaccinations to all adults and children over the age of 5. The model has adapted from booked appointments for eligible cohorts to walk-in sessions for everyone and the logistics of this have been managed smoothly by staff. The reaction of our teams to the overnight expansion of the COVID booster programme is to be commended and has no doubt protected many people from serious effects of the Omicron variant. Our residents have responded remarkably to the vaccination programme and I would thank every individual for coming forward to protect themselves.

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

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

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

Our council partners in the Watford and Hatfield areas have led initiatives to encourage people from Portuguese, Brazilian and eastern European communities to come forward for their vaccine. The teams have built strong relationships within the local community among people who were initially extremely reluctant to engage with the vaccine programme. By arranging local pop-up clinics with interpreters; providing translated materials and communicating through trusted community and business leaders, there's been a positive response to vaccine uptake. Many people have also registered with a local GP for the first time.

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

This year we have also dedicated efforts to supporting those who are pregnant to have their vaccination following a change to the guidance. Expert online panels were convened to answer public questions on fertility, pregnancy and breastfeeding and our Local Maternity and Neonatal Network has tirelessly promoted the benefits of having the vaccination to the parents they engage with.

## Pressures and challenges facing our system

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

As is usually the case during winter, our hospitals have been planning how they might rapidly increase their critical care capacity if required to do so. This surge planning is supported by the CCGs who also ensure that hospitals are enabled to work together to manage ambulances arriving at emergency departments when a particular acute trust is under immense pressure. We work closely with the region's ambulance service to drive up performance. You can read more about this in the detailed performance information on page 39.

This year, at the request of NHS E/I, a 'super surge' hub was planned at Lister Hospital to support trusts across the east of England. Thankfully as the pressure of the Omicron wave eased, the need for these additional beds was withdrawn.

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

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

A number of other changes have taken place this year in order to make best use of the available clinical staff including closing the urgent care centre at the New QEII Hospital overnight where it was very underused, and transferring those staff to work in the busy Lister emergency department. In the coming year, the minor injuries unit at St Albans City Hospital will also transform into an integrated care hub following its emergency closure during the peak of the pandemic's first wave to allow staff to be redeployed. A public consultation ran during 2021 to make decisions on the centre's future. Work also continues to improve the emergency department at Lister, including more effective triage when patients first arrive, expanding the assessment space for adults and separately for children, moving x-ray facilities much closer to the emergency department and providing a dedicated space for patients who need mental health support.

In the longer term, Princess Alexandra Hospital NHS Trust and West Hertfordshire Hospitals NHS Trust will be replacing their current facilities with either new or refurbished buildings. Plans are still to receive funding sign off from central government, but we expect there to be significant progress on developing plans over the coming year. Alongside getting the best clinical outcomes for patients, each trust will have a focus on sustainability and on creating holistic environments which integrate the latest technology.

## Managing waiting lists for routine care

At the time this report is published, the current planning guidance – which sets out national NHS priorities for local systems to deliver - has set an ambitious goal that in order to reduce waiting times for patients, around 30% more planned routine activity will take place by 2024/25 than was being delivered pre-pandemic.

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

Ensuring people have tests and receive a diagnosis in a timely way is a key support to this programme of work and also to improving care for diseases like cancer. Our performance on diagnosing cancer has been impacted by the pandemic and our local hospitals haven't met a number of the cancer target waiting times during 2021/22, we are working hard to improve care along the whole pathway. Encouraging people to come forward for cancer screening is an important part of our health promotion and prevention work, with examples of how promotion to patients can improve uptake being seen in West Essex CCG's cervical screening campaign.

To help as many patients have the diagnostic tests they need as quickly as possible, we

have increased opening hours into the evening and at weekends and used mobile scanning units and spare capacity in other centres to help see more patients.

A community diagnostic centre (CDC) is being planned for the New QEII Hospital in Welwyn Garden City which will be open 12 hours a day, 7 days a week for MRI, CT, x-ray and ultrasound scans, with other more complex diagnostic tests for heart and gastroenterology conditions following at a later date. We hope to have further CDCs in place across our area in the coming years subject to agreement by NHS E/I.

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

## Mental health recovery

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

Mental health service providers across the local health and care system have worked together to better understand this demand and to invest in additional capacity. As a result, waiting times for mental health services in Hertfordshire are generally in line with or better than current national averages, including almost all referrals for 'talking therapies' starting their treatment within six weeks.

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

Key investments and developments include:

- More investment in and expansion of early intervention services
- Introducing Mental Health Support Teams in schools
- A new 24-hour crisis support service
- Identifying people at risk of an eating disorder earlier and increasing capacity to treat them

- An extra £7million to reduce waiting times in primary and community mental health services

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

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

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

## Improving access to primary care

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

Practices have remained open throughout the pandemic, offering patients telephone and online appointments, with face-to-face consultations available for those who need them. This was in line with national requirements to keep patients safe, whilst COVID infection rates were high and before the vaccination programme was widespread. Practices have continued to manage their patients' care alongside delivering the COVID vaccination programme.

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

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

telephone systems is often a cause of frustration for patients and practice staff alike.

### Conclusion

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

# THE CCG'S WORK IN 2021/22

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

# PRIMARY CARE

**What are Primary Care Networks?**

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

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

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 and Restoration

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

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

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

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

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

During 2021/22 GP practices have continued delivering a total triage system which was first implemented according to NHSE/I guidance produced in April 2020. This has meant that every patient contacting the practice first provides some information on the reasons for contact and is triaged before making an appointment. Total triage has continued to be important in reducing avoidable footfall in practices and protect patients and staff from the risks of infection. Assessment by a healthcare professional over the telephone or online, has enabled many patients to be offered advice and potentially a prescription or referral without the need for a face-to-face appointment where clinically appropriate.

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

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

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

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

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

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

The overall demand on primary care services has risen substantially as patients present with concerns that they haven't addressed during the pandemic, long-term conditions requiring monitoring and stabilisation, help whilst waiting on hospital waiting lists for surgical procedures and of course presenting for COVID vaccination. All of this led to increased demand on the use of telephone lines which were already over-subscribed and could not cope with the pre-Covid demand in many practices. Most practices across Hertfordshire have not have the advanced telephony systems to cope with this new level of demand. We know that one of the most common complaints about GP services from patients is not being able to get through on the phone. We are part-way through an exciting project to replace outdated analogue telephony systems with new digital cloud-based systems that feature important enhancements such as much greater (or even infinite) line capacity, call back and queue waiting functionality. The programme is currently expected to run until March 2023. These new systems also enable call volumes and wait times to be monitored during the day to enable practices to adjust the number of staff taking calls according to the demand.

This increased demand is also reflected in GP appointment data collected by NHS Digital[1], the total number of appointments attended across Hertfordshire and West Essex in November 2021 rose to 656,553 an increase of 102,178 compared to November 2019 representing an overall 18% increase.

East & North Herts increase = 44,351 (18.7%)

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

General practice continued to deliver Extended access appointments during the year; these services provide general practice appointments weekday evenings, weekends and bank holidays. The total number of appointments available are detailed below by CCG per month but also gives the committee the expected appointments over the coming winter to support patients in the community.

[1] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice#latest-statistics

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

## Winter Access Fund Programme

On 14 October 2021 NHS England and Improvement launched "*Our plan for improving access for patients and supporting general practice*" making available £250 million to support primary care and same day urgent care during the challenging winter period. The allocation available for the Hertfordshire and West Essex ICS was £6.16m for the five months November 2021 to March 2022, of which £2.41m was allocated to ENHCCG.

The two main uses of the fund are to:

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

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

In line with the guiding principles for restoration in primary care and the plans underway to improve access, the ICS plan submitted to NHS E/I following engagement with the LMC, primary care and clinical leads included: additional on the day capacity; accelerating training for the Community Pharmacy Consultation Service; supporting communications and engagement; advanced telephony and piloting in-hours triage.

In addition, the ICS plan included all 135 practices, including all 50 ENHCCG practices for support through tailored practice visits which were completed in March 2022. The aim of the practice visits is to have practice owned access plan which will include actions for practices to improve or sign post them to the appropriate resource such as:

- support on recruitment for all staff through Primary Care Careers
- short term estates support
- advanced telephony support

[2] Appointments in General Practice - NHS Digital

- maximising the use of online consultations and opportunities to integrate within the practice model
- access to training especially telephone consultation for admin staff
- reinvigorating PPGs.

Nationally a further £5m for improving security arrangements in General Practice is also being rolled out.

## Community Pharmacist Consultation Service

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

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

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

There are 50 ENHCCG practices trained and 27 currently using the service with the remaining practices either received training but are not live or a training date is being identified.

## Digital / IT

Following the disruptive impact of the pandemic in 2020, this last year has been one of more gradual change. As the nation has begun to recover, Primary Care has been opening up and returning to a new normal. The main focus of activity has been around the various vaccination efforts and our role has been to support and help practices and PCNs to begin to deliver face to face patient care again.

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

We have been piloting new functionality to allow practice staff to work remotely from the main practice building to ensure practices can operate in a more agile way. This virtual

solution gives people the opportunity to work if self-isolating or outside of hours to support a better work life balance.

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

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

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

## Workforce Development

Hertfordshire and West Essex (HWE) ICS receives funding, predominantly from NHS England and Improvement (NHSE/I) and Health Education England (HEE), to support Primary Care Workforce recruitment and retention across the ICS. In 2021/22 this will amount to £3.7m which includes a share by an equivalent share capitation for NHS East and North Herts CCG of £1.4m.. Some of this funding supports specific small initiatives; however, there are a number of major funding streams:

| | ENHCCG Capitated Equivalent | ICS |
|---|---|---|
| NHSE/I Training Hub Infrastructure: | £116k | £296k |
| HEE Training Hub Infrastructure: | £122k | £314k |
| GP/GPN New to Practice Fellowship Scheme: | £530k | £1,357k |
| Primary Care Flexible Staff Pool: | £47k | £120k |
| Local GP Retention Fund: | £117k | £300k |
| Supporting Mentors Scheme: | £78k | £200k |
| International GP Recruitment: | £254k | £650k |

| | | |
|---|---|---|
| GPN/AHP CPD[3] | £67k | £172k |
| GPN/CARE Programme[4]: | £62k | £158k |

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

Other Local Initiatives presented below;

| **NHS East and North Herts CCG Scheme** | **21-22 Expenditure and Commitments (£'000)** |
|---|---|
| Local Training Hubs | 169 |
| GP Education Leads | 38 |
| Reception And Clerical Training | 221 |
| Other General Primary Care Training | 93 |
| Nurse Education Leads | 69 |
| Practice resilience | 40 |
| £1k personal Training Budget | 72 |
| Infrastructure and Resilience | 55 |
| PCN Leadership Payment | 405 |
| **Other Local and Primary Care Transformation Workforce Spend** | **1,162** |

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

**Workforce Numbers**

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

| 2021/22 | | | | | | |
|---|---|---|---|---|---|---|
| Workforce Group | Baseline (Q4 20/21) | Q1 21/22 Target/ (Actual) | Q2 21/22 Target/ (Actual) | Q3 21/22 Target/ (Actual) | Q4 21/22 Target/ (Actual) | Year end change Target/ (Actual) |
| GPs (excluding Registrars) | 693 | 698 (701) | 702 (698) | 706 (707 – M8) | 710 (710) | 17 (17) |
| Registered Nursing Staff | 312 | 321 (306) | 330 (303) | 339 (310 – M8) | 348 (312) | 36 (0) |
| Other staff providing Direct Patient Care (ARRS) | 273 | 341 (280) | 374 (286) | 407 (415) | 440 (415*) | 134 (142) |
| Other Practice Staff (Admin) | 1642 | 1634 (1629) | 1627 (1648) | 1619 (1687 – M8) | 1612 (1721*) | -23 (45) |

*Please note the NHS Digital NWRS data[5] is dependent upon accurate and timely reporting by practices, there is work underway to improve reporting across the system

[5] https://app.powerbi.com/view?r=eyJrIjoiYTM4ZTA3NGItMTM2Mi00NzAwLWEyY2QtNDgyZDkxOTk3MmFlIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

## Health Education England Procurement – ICS Training Hub

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

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

Procurement for ICS training hubs was launched by HEE on 18th October 2021 for a 3-year contract with a potential to extend for a further 2 years. The value per annum for HWE was proposed to be £310,000. HWE ICS put in a bid as the training hub is essential to the future delivery model of primary care workforce across HWE working in partnership across system and place. The ICS was successful in the procurement and has been awarded the contract. This funding together with NHSE/I funding will allow us to build on the learning to date and restructure the primary care managerial workforce functions at system level to improve delivery and remove overlap.

## Workplan Highlights

Following a mini procurement process, the ICS contracted with the National Association of Sessional GPs (NASGP) for the provision of a Flexible GP Pool for two years. This was launched on 1st October 2021. By the end of the fourth month, 75 practices had registered and 24 clinicians were accessing the funded offer. 353 sessions had been booked through the platform. NASGP also provide the same service across the rest of Essex and have been tying in with Primary Care Careers (PCC), an organisation that provides recruitment support to practices and PCNs. West Essex CCG have used PCC for a number of years and in 2020/21 the training hubs funded PCC recruitment support for PCNs. In the current year, this service has been extended to all GP practices.

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

All training and development opportunities are published on the training hub website alongside a range of resources for the primary care workforce[6]

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

## Covid-19 Response and Wellbeing in Primary Care

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

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

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

In the survey, we had also asked how we could genuinely thank staff and identify other areas to support primary care colleagues. Part of the response to this was for each CCG to host an annual event to celebrate the success of primary care in 21/22. The first of these events took place in Herts Valleys on 6th October 2021. The next steps beyond those initially identified included linking to the NHS Leadership Academy in the East of England to explore new leadership, lifelong learning and talent management opportunities for general practice.

## Premises

2021/22 was a busy year for the CCG's premises team and whilst the pandemic may have temporarily slowed things down, work to secure or develop new premises has been completed, some are on existing sites and further business cases have been approved for new premises with more to follow.

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

- After many years of searching for land options, Dolphin House, Ware were thrilled to move into their purpose built new premises in April 2021. The capital cost of the project was privately funded with professional fees funded under ETTF.

- Major reconfiguration and improvements to a wing at Stanmore Road Health Centre which had stood vacant for a couple of years are expected to be completed in June 2022. ETTF will fund the entirety of the capital and fees.

- Puckeridge and Standon Surgery involves an extension which will double the size of the existing premises. The capital was part funded by ETTF and the practice with all professional fees met by the ETTF programme.

- The Kitwood Unit at the hospital known as Herts and Essex, Bishops Stortford, has been underutilised since it was built several years ago. 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. The ETTF funded the capital cost and all professional fees.

Projects not funded by ETTF have also completed such as:

- High Street Surgery at Cheshunt, where the private landlord funded the capital to significantly increase the surgery premises. The CCG funded the professional fees

- Hailey View Surgery in Hoddesdon in agreement with their private landlord funded an improvement scheme in return for a longer lease with the practice

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

- Full Business Case approval was given to Wallace House to relocate their surgery premises into the town centre development scheme at Bircherley Green. The capital is funded by the landlord, with fees and revenue met by the CCG

- Full Business Case approval was given to South Street to relocate part of their business to a new build at Stortford Fields. The capital is funded by the landlord, with fees and revenue met by the CCG. This project was approved in conjunction with the project at Herts and Essex Hospital

- Spring House in Welwyn Garden City also received support and funding for additional porta cabins as an interim solution whilst a longer-term premises plan is developed; the longer-term plan being hindered by lack of land with the appropriate land use classification.

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

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

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

- Support small fund and grant schemes via NHSE national funding under the Winter Access Fund as well as CCG funds

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

# Primary Care Covid Response

## Vaccination Programme

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

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

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

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

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

## COVID Immunisation Programme for children aged over 5

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

## Seasonal Flu Vaccination

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

Challenges remain with the children's cohorts, with 2- to 3-year-olds at 47.7%. Furthermore, the extended school-age programme has had a slower start, as a result of the COVID programme for 12- to 15-year-olds being in place. Across Hertfordshire and west Essex, HCT and EPUT have plans to accelerate the school aged flu vaccination programme and are looking to extend this to 5- to 11-year-olds. Improved uptake in particularly vulnerable groups such as those living in care homes has been particularly successful with 90% of this population having received the Flu vaccine. Pregnant women remain a key focus area with 44% of people who are currently pregnant having been vaccinated.

A roving model with local community trusts is currently in place to support flu and COVID vaccination for care home staff and outstanding care home residents. All providers are committed to delivering the national trajectory[7] for their staff and where appropriate, those they care for.

## Respiratory Hubs

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

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

Practices were incentivised through the Consolidated Funding Framework to enable practices to safely see patients within their own surgery throughout the Pandemic.

## Oximetry at Home

When the rates of Covid-19 infections began increasing, NHSE offered CCGs free Adult Pulse Oximeters to share with surgeries, care homes, out of hours services and hospitals. These were to be used under supervision, prioritising people at greatest risk of COVID-19, and assessing for alternative diagnoses before remote monitoring of deterioration with COVID-19.

We learnt that monitoring blood oxygen levels is the most accurate way of keeping an eye on patient's progress when they had symptoms of COVID-19: patients most at risk of poor outcomes are best identified by oxygen levels. The use of oximetry to monitor and identify 'silent hypoxia' and rapid patient deterioration at home is recommended for this group. The service was designed to support patients in primary and community health settings, but could also be used for patients who were at an early stage of the disease and sent home from A&E or discharged following short hospital admissions, following assessment using the total triage model and a plan put in place using pulse oximetry.

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

All 3 CCGs within Hertfordshire and West Essex ICS supported the practices to offer Oximetry at Home service, pulse oximeters were given to practices from the supply offered by NHSE. Pathway conversations took place with local Community and Acute Trusts and then shared with general practice.

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

In order to help with the recommendation of 24/7 coverage, ENHCCG had a practice run model, each Practice have their own process, linking in with Out of Hours Doctors and 111

for evenings and weekends with some guidance, then transfer care back to GPs on weekdays-Mondays.

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

## Blood Pressure at Home

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

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

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

Since the scheme started the number of people who have submitted home blood pressure readings each month has increased steadily. The data shows that the number of people submitting home readings has increase by approximately 50% since April 2021.

Additional funding has been secured for the ICS to purchase further monitors and cuffs.

## Initial Accommodation Centres (IAC)

Initial accommodation Centres provide short-term housing for asylum seekers who need accommodation urgently before their support applications have been fully assessed and longer-term accommodation can be arranged by the Home Office. The amount of time people stay in initial accommodation can vary.

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

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

# Primary Care Network Directed Enhanced Service (PCNDES)

## NHSE PCN Plans for 21/22 and 22/23

In August 2021, NHSE published the plans for the PCN DES for the remainder of 2021/22 and 22/23, to take effect from 1st October 2021. These plans emphasised that the COVID-19 pandemic has clearly demonstrated the value and effectiveness of the PCN model as a basis for local partnership working. The previously anticipated new PCN DES service requirements and majority of Investment and Impact Fund (IIF) incentives had been deferred until October 2021. The IIF is a financial incentive scheme, focusing on resourcing high quality care in areas where PCNs can contribute significantly towards Improving health and saving, improving the quality of care for people with multiple morbidities and helping to make the NHS more sustainable.

The updated plans confirmed that in addition to existing service requirements (early cancer diagnosis, Enhanced Care for Care Homes) and limited IIF indicators, there has been a gradual introduction of new service requirements (CVD, health inequalities, anticipatory care, personalised care) and a significant increase in IIF indicators to promote PCN service improvement goals from the Long-Term plan. As previously set out, the IIF will be worth £150m to PCNs for 2021/22 and £225m for 2022/23 and the indicators will compliment QOF indicators.

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

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

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

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

## Temporary changes from December 2021

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

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

Extension to the deadlines associated with tackling neighbourhood health inequalities requirement; with the area of focus to be identified by 28th February 2022 and the ICS agreed an extension to agreeing a plan to 30th April 2022. All PCNs submitted plans by this date, although some plans required further refinement.

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

## Additional Role Reimbursement (ARR) Scheme

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

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

ENHCCG have 146 ARRS roles in place, the most popular scheme roles include Clinical Pharmacists, Care Co-ordinators, Social Prescribing Link Workers and First Contact Physiotherapists.

The end of year ambitions for 196 recruited roles were optimistic, having undoubtedly been impacted by the additional pressures in General Practices, especially from December onwards.

## PCN Development Fund

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

Support development and maturity of PCNs including enhancing integration

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

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

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

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

# SUMMARY OF PERFORMANCE 2021/22

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

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

## A&E four hour operational standard

There is a national requirement that 95% of patients attending A&E are treated, admitted or transferred within 4 hours of arrival. Over 2021/22 the total number of A&E

attendances increased from 2020/21 and rose above pre-Covid levels for the majority of months putting further pressure on A&E departments and flow through the system.

Performance at both East and North Hertfordshire NHS Trust and Princess Alexandra Hospital NHS Trust followed the national trend and continued below standard with providers achieving 73.97% and 67.84% respectively. Overall CCG performance which includes all CCG patients across all providers was 65.91%

| Treated / Admitted / Transferred in under 4 Hours | Target | Q1 | Q2 | Q3 | Q4 | 2021/22 |
|---|---|---|---|---|---|---|
| ENHT | 95% | 81.69% | 72.53% | 69.47% | 69.78% | 73.97% |
| PAH | 95% | 73.80% | 67.35% | 62.07% | 69.05% | 67.84% |

Focused work streams continued in response to increased pressures with the aim to improve patient assessment, flow and discharge:

- A&E services continued to be reconfigured and split into COVID and non-COVID pathways at peak times to create better flow;
- To support the significant challenges to staffing, the UCC at the New QEII Hospital was closed overnight with clinical staff redeployed to the Lister Hospital to support demand;
- Work continued across the system to provide alternatives to admissions including community-based streaming of COVID patients and expansion of community support for sub-acute COVID patients including virtual ward and remote monitoring with rapid access to acute advice. These services have also been expanded to non-COVID patients;
- Implementation of the ambulance handover action plan - improving pathways and minimising time taken for ambulance handovers. The East and North system were part of a number of ambulance initiatives including the National Ambulance Handover Programme;
- Increased use of alternative urgent care pathways for same day emergency care, including ambulatory emergency care, frailty and surgical assessment;
- Continued roll out of 'Think 111 First' now called 'Further Faster' to encourage the use of the NHS 111 service as a means of accessing A&E or alternative service where A&E was not the appropriate choice;
- Implementation of professional standards and escalation protocols;
- Surge and escalation planning across the ICS including use of mutual aid as appropriate;
- Implementation of COVID Oximetry at Home models and implementation of COVID virtual wards to maximise available capacity;

- Continued development of the Princess Alexandra Hospital 'out of hospital care model', implementation of the REACT frailty service, new build assessment and ambulatory care wards/service and Care Co-ordination Centre to facilitate better use of alternative care pathways.

## Response times to ambulance calls

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

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

The East of England Ambulance Trust has had a challenging year with the continued high demand on services in 2021/22. C1 to C4 standards were not met for the year, and performance has deteriorated quarter on quarter in all categories until Q4 which saw a slight improvement in C1 and C2 and C3 categories.

| EEAST Ambulance Response | Target | Q1 | Q2 | Q3 | Q4 | 2021/22 |
|---|---|---|---|---|---|---|
| **C1 People with life threatening injuries and illness** | **<7 minutes** | **6:57** | **8:39** | **10:35** | **9:36** | **8:49** |
| **C2 Emergency calls** | **<18 minutes** | **26:16** | **41:43** | **55:50** | **51:58** | **41:54** |
| **C3 Urgent calls** | **<120 minutes** | **170:13** | **306:34** | **418:27** | **403:22** | **306:32** |
| **C4 Less urgent calls** | **<180 minutes** | **211:13** | **452:59** | **497:12** | **521:56** | **382:02** |

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

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

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

# Waiting times for cancer treatment

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

### Two-week waits

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

### 28 day Faster Diagnosis Standards (FDS)

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

### 31 days

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

## 62 days

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

**East and North Hertfordshire NHS Trust**

East and North Hertfordshire NHS Trust was able to continue to provide a timely cancer service throughout 2021/22 and performed very well against all cancer standards. Cancer referrals throughout the year have been consistently above pre-pandemic levels as patients with unidentified need from the first year of the pandemic have been referred on urgent cancer pathways.

Both '2 week wait' urgent cancer GP referrals and breast symptom referrals continued to meet standard for 2021/22. 31 day performance also achieved standard for all pathways; with the exception of subsequent surgery, due to decreased theatre capacity at peak times of pressure.

Performance against 62-days to first definitive treatment was maintained well until Q4 2021/22 when performance was impacted by the Omicron variant.

Performance against the 62 days following screening referral fell below standard, however screening programmes have been paused over the pandemic and numbers going through the service throughout 2021/22 continue to be very low.

Work has been ongoing between the trust and CCG to continue to improve cancer pathways, with action plans in place by specialty. The CCG has a Cancer Steering Group which discusses issues of performance against the national cancer waiting standards, national guidance and reviews and agrees ways in which cancer pathways can be improved.

**Princess Alexandra Hospital NHS Trust**

In contrast, performance at Princess Alexandra Hospital fell below standard in the majority of areas in 2021/22 with the impact of COVID-19 on staffing and capacity affecting cancer pathways.

62 day performance was particularly challenged through a combination of high referrals and the Covid-19 impact on workforce and operating capacity. A wide ranging recovery plan has been agreed with the Trust and a dedicated cancer recovery oversight regime is in place.

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

The table below shows cancer performance at CCG level which is for ENHCCG patients attending any hospital. With the majority of CCG patients attending ENHT and PAH, the performance at these providers has a significant impact on CCG performance.

**Table: Cancer waiting times for all CCG patients** [8]

| Cancer Waiting Times at CCG level | | Target | Q1 | Q2 | Q3 | Q4 | 2021/22 |
|---|---|---|---|---|---|---|---|
| **Two Week Waits** | Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP | **93%** | **93.26%** | **90.07%** | **88.94%** | **86.65%** | **89.63%** |
| | Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) | **93%** | **89.98%** | **94.64%** | **91.47%** | **81.80%** | **89.42%** |
| **31 Day Waits** | Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers | **96%** | **97.77%** | **94.37%** | **95.66%** | **95.35%** | **95.75%** |
| | Maximum 31-day wait for subsequent treatment where that treatment is surgery | **94%** | **91.06%** | **88.32%** | **90.52%** | **90.48%** | **90.02%** |
| | Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime | **98%** | **100%** | **98.76%** | **100%** | **97.95%** | **99.16%** |
| | Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy | **94%** | **96.62%** | **97.82%** | **99.20%** | **97.84%** | **97.85%** |
| **62 Day Waits** | Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer | **85%** | **82.19%** | **80.41%** | **81.07%** | **74.76%** | **79.50%** |
| | Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers | **90%** | **82.89%** | **78%** | **68.09%** | **76.79%** | **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%** | **87.38%** | **84.87%** | **85.98%** | **75.76%** | **83.08%** |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **28 Day Faster Diagnosis Standard (FDS)** | A maximum 28-day wait from urgent GP referral to be diagnosed with, or have cancer ruled out, all 2ww referrals | **75%** | **73.68%** | **71.84%** | **71.47%** | **67.58%** | **71.06%** |
| | A maximum 28-day wait from urgent GP referral to be diagnosed with, or have cancer ruled out, breast symptom 2ww referrals | **75%** | **81.42%** | **83%** | **84.96%** | **78.09%** | **81.90%** |
| | A maximum 28-day wait from screening referral to be diagnosed with, or have cancer ruled out | **75%** | **46.35%** | **50.46%** | **36.23%** | **57.41%** | **47.41%** |

# Referral to Treatment Times (RTT)

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

The table below [9] details the RTT performance for East and North Hertfordshire CCG patients for 2021/22.

| RTT Waiting Times | | Target | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|
| **18 Weeks** | Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral | **92%** | **64.57%** | **62.13%** | **59.43%** | **56.67%** |

This standard has not been met for East and North Hertfordshire CCG patients during 2021/22 with both ENHT and PAH below standard, achieving 60.70% and 50.00% respectively at year end.

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

Clinicians have reviewed all patients on their elective waiting lists and risk-stratified patients according to clinical need in line with the national Risk Stratification programme[10]; patients have been booked and treated in order of clinical priority. Independent sector

[9] Data shown is a 'snapshot' from month 3 of each quarter

[10] https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/

capacity has been utilised for elective pathways where possible throughout the year, with NHS capacity being increased at peak times of pressure. Work is also underway across the ICS to jointly review demand and capacity and agree mutual aid where possible.

Moving into 2022/23, recovery plans and trajectories will be focused on restoring activity to 30% above pre-COVID levels by 2024/25 in line with the National Elective Recovery Plan, together with reducing the length of time that patients are waiting for treatment. The CCG has worked with providers to manage demand on services by reviewing pathways such as advice and guidance and triage services.

## Diagnostics

Under the NHS Constitution there is a performance standard related to patients access to diagnostic testing; the standard being that 99% of tests are undertaken less than 6 weeks from request.

The table below [2] details the Diagnostic performance for East and North Hertfordshire CCG patients for 2021/22.

| Diagnostic Waiting Times | | Target | Q1 | Q2 | Q3 | Q4 | 2021/22 |
|---|---|---|---|---|---|---|---|
| **6 Weeks** | Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request | **99%** | **70.31%** | **65.16%** | **59.20%** | **60.32%** | **63.74%** |

COVID-19 pressures and reduced staffing together with increased referral rates have impacted diagnostic services at ENHT with performance deteriorating throughout the year. The Trust was further impacted by the replacement of a CT scanner and a national / regional lack of Echocardiography capacity. All patients on the diagnostic waiting list have been reviewed and risk-stratified according to clinical need in line with the national Risk Stratification programme; patients have been booked and treated in order of clinical priority.

Demand and capacity plans are in place in line with the ambitions set out in the National Elective Plan to increase activity and reduce waiting times. Plans for the Community Diagnostic Centre programme will increase diagnostic capacity and improve access.

## Upcoming changes to Key Performance Standards

**Access Standards**

Following a national review, changes to standards in mental health services, cancer care, elective care and urgent and emergency care started to be field tested at a selection of sites across England. Revised standards were originally expected to come in during spring 2020, but the programme of work has been delayed due to COVID-19. NHS England and Improvement have sought views on the proposed recommendations[11] for urgent and emergency care standards which will inform final recommendations and guidance for 2022/23.

## NHS Oversight Framework

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

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

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

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

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

NHS E/I has a legal duty to annually assess the performance of each CCG. From 2015-2020 this was managed first under the auspices of the CCG Improvement and Assessment Framework, and for 2019/20 the NHS Oversight Framework. This provided an approach

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

whereby NHS E/I provided each CCG with an overall assessment rating using the CQC rating terminology of 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

For 2020/21, a simplified approach to the annual assessment of CCG performance was taken as a result of the differential and continued impact of Covid-19. It provided scope to take account of the different circumstances and challenges CCGs faced in managing recovery across the phases of the NHS response to Covid-19 and focused on CCG contributions to local delivery of the overall system recovery plan. A narrative assessment, based on performance, leadership and finance, replaced the ratings system previously used for CCGs.

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

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

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

Further details of the assessment methodology can be found on the **NHS E/I** website.

# ENSURING QUALITY

## The work of our nursing and quality team

Quality continues to be a leading priority for ENHCCG. One of our strategic objectives for 2021-22 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 2021-22 we have looked at the inclusion of new ways of scrutinising quality with regard to our CCG processes and commissioned services and which utilised technology more creatively as part of our overall approach. The following analysis reflects our ratings available for the CCG at the following sources on the NHS website:

Data on speciality treatments **myNHS (www.nhs.uk)**

Data on services **myNHS (www.nhs.uk)**

In addition to the above the team has:

- continued to monitor quality, patient experience and patient safety of our providers through regular partnership meetings and undertaken risk-based quality assurance visits (including virtual) where required. Monitoring arrangements have also included partnership exercises and reviews to establish service resilience and provide assurances with regards to COVID-19 restoration and recovery

- monitored and reviewed data from a number of sources, including the Quality Alert System (QAS), to ensure early themes around a potential decline in quality are identified and appropriate action taken as quickly as possible. QAS is a direct way for GPs and practice staff to alert healthcare providers and the CCG of any concerns

- maintained a robust Quality Committee which 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

- worked in partnership with providers and other commissioners to ensure quality priorities are aligned to the current and future health needs of the local population. This has been particularly key with the impact of COVID-19

- developed plans and secured dedicated resources to enhance the monitoring arrangements of quality within primary care.

- reviewed complaint themes and trends from our main providers. '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. 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.

**Maintaining quality during the COVID-19 pandemic**

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

**Patient Safety**

**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 2021/22 ENHCCG were notified of 212 SIs in total; this compares with 215 SIs notified to the CCG in 2020/21. 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**

‘Never Events’ are particular types of serious incidents which 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 2021/22, five Never Events were reported by organisations where East and North Hertfordshire CCG is the host commissioner; all occurred at East and North Hertfordshire NHS Trust. The details of the incidents are as follows:

| Organisation | Type of Never Event | Detail | Level of harm sustained |
|---|---|---|---|
| East and North Hertfordshire NHS Trust | Wrong site surgery | Patient had a wrong site procedure undertaken | Low harm |

| | | | |
|---|---|---|---|
| East and North Hertfordshire NHS Trust | Wrong site surgery | Patient had a wrong site injection administered | Moderate harm |
| East and North Hertfordshire NHS Trust | Wrong site surgery | Patient had a wrong site biopsy taken | Low harm |
| East and North Hertfordshire NHS Trust | Retained foreign object | Patient had a retained dressing following a procedure | Moderate harm |
| East and North Hertfordshire NHS Trust | Wrong site surgery | Patient had an incorrect incision during surgery. | Low harm |

For each of the first two Never Events the investigations have been completed and the reports have been reviewed by the CCG's SI panel. The CCG is assured that the actions put in place by the provider relating to the processes in place, equipment used, and training and education of staff, are robust and will prevent a future incident of a similar nature as long as the actions are embedded. This will be reviewed by the CCG during our routine programme of quality assurance visits.

The remaining three Never Events currently remain under investigation at the time of writing the report.

## Infection Prevention and Control (IPC)

During 2021/22, IPC activity was dominated by the pandemic response. However, where possible some other core functions were re-established. The ICS IPC team has therefore achieved the following:

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

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

## National Patient Safety Strategy

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

Implementation of the Patient Safety Specialist role within the CCG and across the local system

Establishment of a Patient Safety Specialist Network for all Patient Safety Specialists across Hertfordshire and West Essex

The roll out of the national patient safety training for all staff within the CCG

Participated in national workshops looking at how the patient safety strategy can be implemented within primary care

Ongoing work to support our local Medical Examiner Offices with the roll out of the Medical Examiner system for community deaths, following successful implementation for deaths occurring in our acute hospitals.

Supported areas of COVID 19 recovery, including working with our acute providers to ensure there is a robust process across our local system for undertaking harm reviews for those patients that have waited significantly longer than usual on the waiting lists, with consistent reporting of harm review outcomes and learning.

Kept our Quality Committee, Primary Care Commissioning Committee and Governing Body updated with national timelines and local implementation throughout the year.

## Patient Experience

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.

The CCG received 248 complaints and MP enquiries in 2021/22, compared to 164 in 2020/21. Of these 39 were investigated by the CCG; 18 formal complaints and 21 MP enquiries. The remaining 209 were passed to providers or other CCGs for investigation and response.

The top themes for complaints this year were: funding, quality of GP provision and communication. The PHSO requested additional information for 1 ENHCCG complaint during 2021/22; they have since confirmed that they will not be formally investigating the case.

The CCG received 368 PALS enquiries during 2021/22; this is an increase compared to the previous year when there were 329. Key themes include enquiries or concerns regarding Covid-19 vaccination, and queries regarding funding decisions made within the CCG.

In the last reporting year, the CCG focussed on providing timely responses to the large number of queries, including those regarding the provision of covid-19 vaccinations for different cohorts of patients, and ensuring that responses to patients and other stakeholders were not delayed due to pandemic related factors. Going forward into the coming year, the focus will be on ensuring our functions, policies and processes are aligned with our fellow CCGs across Hertfordshire and West Essex as we move into the ICB as well as ensuring appropriate collection of demographic data from complainants and patients as part of the wider health inequalities workstream

## Healthwatch Hertfordshire

The Nursing and Quality Team has worked closely with Healthwatch Hertfordshire and worked with colleagues within the CCG to improve services based on feedback received from patients contacting Healthwatch Hertfordshire.

The CCG has undertaking 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**

Worked with colleagues across the LMNS to ensure implementation of local plans to deliver Better Births, the report of the national maternity review. This includes offering every woman a personalised care and support plan.

Seeking assurance regarding the progress against the 7 immediate and essential actions laid out in the national Ockenden report. This relates to findings from the review looking into the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital Trust, following a letter from bereaved families.

Joined regular meetings with East and North Herts Trust to seek assurance regarding the safety of maternity services during times of extreme pressure.

**Primary Care**

Supported practices in key areas of quality and safety, undertaking risk-based quality visits where appropriate – both in person and virtually.

Supported practices to understand the new monitoring approach from CQC by sharing information and presentation at a Practice Manager Forum.

Targeted support for practices undergoing CQC inspection, including undertaking mock-inspections.

Helped practices to identify learning and improvements following the publication of the annual GP Patient Survey (2021), including identifying good practice and sharing as part of the Winter Access Fund visits.

Supported practices with IPC measures, developing guidance and checklists, and undertaking support visits to offer advice and support to help practices become 'COVID-secure'

Supported PCNs with ongoing running of PCN vaccination sites and supporting with quality visits to ensure a safe service with good patient experience is maintained.

**Care Homes**

• Effectively managed the widespread COVID 19 outbreaks and the highly transmissible Omicron variant in care homes and supported living through daily outbreak management cell led by the CCG in collaboration with HCC, PHE, CQC, HCT, HPFT and HCPA.

• Ensured safe IPC practices in care homes, supported living and domiciliary care providers through train the trainer teaching sessions of donning and doffing and virtual IPC session for care homes during outbreaks. Also developed an IPC crib sheet used by visiting professional to provide IPC assurances on homes that are in outbreak.

• Developed the multi-agency observational tool used by visiting GPs, district nurses and ECHPs to evaluate patient safety in care homes during outbreaks. Information shared is used to priorities QAV whilst routine monitoring remains paused.

• Completed a multi-disciplinary deep dive into care homes and now working with HCC and other multi -agencies to develop a system approach towards hospital avoidance and high standards of care in care homes

• Launched a system wide network/forum with all enhanced health in care homes providers to drive the quality of care and empower staff working withing care homes.

• Worked collaboratively with HCC ensuring safe transition of care homes following the deadline set by the government for staff to be vaccinated as a condition of deployment in care homes.

• Supported delivery of an ambitious vaccination programme in care homes which saw most of the residents fully boosted ahead of the Omicron variant.

**Quality and Safety Assurance**

Established regular virtual meetings with our main providers to discuss key COVID-related quality related risks, issues and mitigation

Attended provider internal meetings and reviewed provider internal committee papers where available to seek assurance regarding key quality matters

Established new ways of working to monitor services remotely including virtual visits

Worked with other stakeholders including Healthwatch to obtain patient feedback regarding health and social care services during the pandemic

**Workforce**

Continued to be actively involved with the ICS workforce programme, looking at ways of attracting, recruiting and retaining staff in the Hertfordshire health and social care sectors. This has included work to ensure we have the right levels and skills of staff for the future

# 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 and West Essex are able to make a full and positive contribution to society.

Our ICS Director of Nursing and Quality and Associate Director of Adult Safeguarding are both members of the 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 Teams have played a valuable role in Hertfordshire and West Essex to enable our partners to promote the culture of continuous improvement within their organisations as well as the CCGs by:

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

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

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

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

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

- We worked with partnership agencies to support care homes and care providers to monitor quality and management of risk with the CCG chairing the HSAB Strategic Quality Improvement Group in Herts and the Care Home Hub now renamed Provider Hub led by the CCG in West Essex to drive forward a robust action plan

which focuses on quality assurance processes, shared learning and responding to areas of concern.

- As part of the HSAB we chair the Safeguarding Adult Review subgroup and have led the development of a trauma and resilience framework to support panel members. Represented the CCG in a number of domestic abuse work streams in response to the Domestic Abuse Bill including the development of a Strategy for 2022 – 2025 which was published January 2022 and the future development of the Independent Domestic Violence Advocate Service. We also chair the Quality and Innovation sub-group of the Domestic Abuse Partnership Board. One of the objectives of this sub-group is to identify learning ensuring that it is shared and implemented by partners.

- We worked with private providers to ensure safeguarding processes were in place for migrants seeking asylum and for those coming from Afghanistan. We sought assurance that hotel staff within Quarantine Hotels had received appropriate safeguarding training to enable them to support this vulnerable cohort of people. The team supported CCG staff in managing complex cases through individual case discussions and group supervision. Support and guidance were also given for colleagues in providers and primary care managing complex cases through individual case discussions and interventions

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

## Safeguarding children

The CCG is committed to safeguarding and promoting the welfare of children. The responsibilities for safeguarding are a statutory requirement supported in legislation. The Children Acts 1989 and 2004, and Children and Social Work Act 2017 places a duty on local authorities to promote and safeguard the welfare of children in need in their area. The Act makes the child's welfare paramount. Section 27 imposes a duty on health bodies to cooperate with a local authority to support children and families. The duties are further clarified within Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019[12], which sets out how all NHS organisations, including those they may contract, should fulfil their responsibilities.

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

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

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

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

**Safeguarding Support to Primary Care**

The CCG Safeguarding Children Primary Care team continues to support and offer expert safeguarding advice to GP Practices throughout the COVID-19 pandemic. A bespoke practice support tool underpins this activity in addition to an updated safeguarding template incorporated within the supporting documentation used for CCG quality visits.

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

The team offer training both within GP Practices and through more formal conferences arranged on a biannual basis in conjunction with the Bedfordshire and Hertfordshire Local Medical Committee (LMC). Currently these are being offered virtually with very good attendance rates and positive evaluations. Many GPs are reporting this method of delivery is preferred, enabling them to attend at a time that suits their current unpredicted work demands. There are also numerous CCG led safeguarding workshops and conferences available to Primary Care professionals and additionally the Hertfordshire Safeguarding Children Partnership offer extensive training opportunities, many of which are free of charge.

Learning from local reviews has resulted in changes and improvements to safeguarding practices within Primary Care to include enhanced information sharing processes. Following an audit reviewing the quality of returned information requests to Children's Services, an automated electronic form has been created to facilitate accurate, timely information sharing. This has recently been embedded within Primary Care electronic patient record systems enabling auto-population of much of the required information, vastly reducing the time taken to share this vital information. A training webinar was held in Q4 21/22 to provide an overview and demonstration to Primary Care colleagues of this improved process. A 'gold standard' template has also been produced to support staff with the completion of these requests for information.

Primary Care representation continues at Hertfordshire Safeguarding Children Partnership (HSCP) and Hertfordshire Adult Safeguarding Board (HSAB) subgroups to include Audit and Performance, Child Death Overview Panel and Domestic Abuse Quality and Innovation groups. The team contributes to relevant task and finish groups and workstreams arising from these subgroups and additionally participates in regular HSCP multi-agency audits, providing requested Primary Care information and presenting associated learning from these activities to their colleagues.

The biennial Safeguarding Children and Adult audit was completed in 2020 by 77% of GP Practices in West Essex. Practices who either did not submit an audit, or identified areas requiring additional support are being offered a practice visit by Safeguarding team. An audit of the GP child protection case conference reports submitted to Children's Services has been completed. Identified learning will be addressed to achieve compliance, with standards set. The report and action plan has been shared with GP practices for comment. Discussions are planned with Primary Care to consider options moving forward.

**Safeguarding Support to Secondary Care**

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

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

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

gaps and improving practice following national and local reviews.

**Looked after children** (LAC)

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

The Hertfordshire IHA's compliance initial reduction in Q1 -Q2 2021 due to impact of pandemic, has increased to 85% compliance.

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

The Designated CLA team contribute to the Partnership including a working group to establish an Exploitation hub. The partnership group - Vulnerable Adolescent Strategic Group (formerly SAAG) will be able to identify hot spots of activity and risk by sharing data from all services/providers. This will enable development of targeted strategies to reduce child sexual/criminal exploitation and associated risks that present to young people.

The Designated CLA team have audited records of children who have declined a statutory Health assessment over the last 18 months. Recommendations on how the refusal process may be improved by working with some children currently in care as well as some care leavers to develop an understanding of why young people refuse as well as use their skills to develop some more user-friendly information around the process.

The NICE Quality Standard on Foetal Alcohol Spectrum Disorder (FASD) has yet to be published. As it is known that FASD affects many CLA the designated team have been doing some preliminary work. The team were lucky to secure national experts for an afternoon session to raise awareness of FASD across the partnership. Following this the Designated team are contributing to a round table exercise being run to share knowledge and expertise of others who have commissioned / work in FASD services with a view to contributing to a business case for a local service.

Dental access for routine appointments for CLA has proved increasingly difficult over the last 2 years and current data suggests that the number of children in care with a dental check in the last year is 52%. The designated team are working with local dental commissioners to improve this over the next year. This is a national problem, and a regional workshop has taken place with a further follow up meeting in February.

During the last year the number of children coming into care has increased with the number from Hertfordshire currently 1015. This number has been impacted by an increase

in UASC coming into Hertfordshire although numbers remain consistent at around 85 as the age of becoming CLA is usually around 16 -18yrs.

There has been an increased requirement for Tier 4 beds[13] where the demand has exceeded availability the Designated team have been sighted on concerns and attended meetings where appropriate.

The Designated CLA team have been involved with creating a survey to establish the impact of trauma on professionals working with and those that have experienced trauma first hand. The survey findings will contribute to the Trauma Informed Practice strategy work that is taking place by Hertfordshire County Council for implementation across the partnership.

**Separated Migrant Children (formally Unaccompanied Asylum-Seeking Children)**

HWE safeguarding teams contributed to support children and young people who arrived in Hertfordshire and West Essex in 2021. Harlow continues to see a significant number of Separated Migrant Children[14] placed in semi-independent accommodation which has had a direct impact on the capacity of the local paediatricians to complete the Initial Health Assessments within timescales. The service forms part of the Essex Child and Family Wellbeing Service. A solution has been agreed that should increase the IHA capacity within the service.

**Asylum Contingency Accommodation**

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

**Child Deaths**

Hertfordshire Child Death Overview Panel (CDOP) reviewed 33 retrospective cases for April 2020- March 2021, this is lower than previous years. Potential reasons for the decrease in completed reviews include difficulties in obtaining information from other agencies who were new to the electronic database (eCDOP) and moving to virtual CDOP meetings because of the Covid-19 pandemic with the associated technical difficulties impacting on the process.

The CCG facilitated two development workshops for Child Death Overview Panel (CDOP) members exploring the impact of the changes introduced by Working Together 2018

[13] Tier 4 are specialised services that provide assessment and treatment for children and young people with emotional, behavioural or mental health difficulties.
[14] Formerly known as unaccompanied asylum-seeking children or UASC.

Section 5 Child Death Reviews. The workshop was an opportunity for members of Hertfordshire Safeguarding Children Partnership (HSCP) Child Death Overview Panel (CDOP) to review the working of the panel; taking into consideration membership, roles and responsibilities and business as usual following the introduction of eCDOP, to ensure the statutory function of the panel was discharged and child deaths reviewed within statutory time frames. A further workshop is planned to ensure the equity of service for unexpected and expected deaths across the County, this will be supported by an integrated protocol.

The CCG have worked closely with QES (electronic child death recording system provider) to facilitate a virtual seminar for Named GPs in the completion of child death reporting forms to enable support to be offered to the wider system. This has led to increased participation in the use of the virtual platform.

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

**Section 11 and NHS England and Improvement Safeguarding Assurance Tool (SAT)**

The 3 CCGs submitted the safeguarding assurance tool to NHSE in November /December 2021.

## Improving the health of people with a learning disability

- A new national **LeDeR (Learning from Lives and Deaths)** policy was introduced in March 2021. Locally, the LeDeR 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. An Annual Healthcheck preparation tool has been further promoted by the Learning Disability Nursing Service to increase the quality of completed checks and embed a collaborative approach. The national target for Annual Health Check delivery is 75%.

  The official year end national data is usually published in June for the preceding year. Monthly data from NHS Digital released for April 2021 – February 2022 shows

cumulatively that ENHCCG completed 1677 annual health checks and HVCCG completed 1941 annual health checks[15].

- The **STOMP/STAMP programme[16]** to address over-medication of people with a learning disability or autism with psychotropic medications was restarted after a pause due to the pandemic. The STOMP nurse continues to support reductions of medications and work has begun on 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 have continued in a virtual adapted format for both community and inpatient settings. 6-8 week monitoring visits of specialist LD hospitals have returned to on-site formats. Host commissioner responsibilities continue, overseeing community and inpatient specialist LD hospital services in the Hertfordshire footprint.

- Safe and Wellbeing reviews[17] have taken place for inpatients in specialist learning disability/autism beds as of 31st October 2021. With ICS panel review of findings in February 2022, and learning feeding to the national team by the end of March 2022.

# 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.

[15] Learning Disabilities Health Check Scheme - NHS Digital
[16] https://www.england.nhs.uk/learning-disabilities/improving-health/stamp/
[17] https://www.england.nhs.uk/learning-disabilities/care/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/

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

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

- Life expectancy for 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.

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

- Starting well
- Developing well

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

- Living and working well
- Ageing well

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

## 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[19] 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.

[19] **Better Care Funds**

- 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.

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

The current Hertfordshire Health and Wellbeing Strategy can be viewed here: **https://www.hertfordshire.gov.uk/media-library/documents/about-the-council/partnerships/health-and-wellbeing-board/hertfordshire-health-and-wellbeing- strategy-2016-–-2020.pdf**

Hertfordshire Health and Wellbeing Board is currently consulting on a new health and wellbeing strategy which is expected to be launched in June 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[20] 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 will also address capacity issues in the BAME sector which has suffered Voluntary,

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

Community, Faith and Social Enterprise Sector (VCFSE) funding cuts disproportionately in the last 10 years.

- A BAME carers project with Carers in Herts is also funded out of NHSCT monies and will commence in June, addressing cultural competence in carers' breaks and building on the 'urgent short breaks on prescription project' funded in all 4 localities, designed to address a quick response to carers who have not had a break for over a year and may present to primary care in need.
- A digital inclusion project (Staying Connected) commenced 1 February, with a worker employing a CSR approach to the acquisition of kit (already received 50 dongles from Tescos, and donations of tablets from other companies, HCC and others) which is cleansed by volunteers and can be socially prescribed to people whose wellbeing will be significantly improved by access to the internet. Volunteers also provide with motivation and support to use.
- A winter small grants process (with Hertfordshire County C and the ten District Councils) to distribute £75k of NHSCT funding to 33 projects, which helped with digital exclusion, social isolation and ensuring maximising of volunteer capacity. Additional funding was levered from Districts (£9k), from Mental Health commissioners (£11k) and HCC (£14k food and fuel poverty monies). This will be repeated next winter.
- NHSCT monies also funded two pilot posts supporting adolescents in crisis (one at WHHT and one at ENHT) before admission/in hospital/after hospital attendance with social prescribing to link them into support on their return home. Both workers are now in post.
- The CCG worked with ENHT, Carers in Herts and Community Development Herts to develop the NHSE funded "Mind the Gap" Sickle Cell Zoom carers' support group for the 135 families affected across Herts, seeing it as an exemplar for outreach to marginalised groups.
- The CCG led on work with HCC to develop proposals for a new joint strategic commissioning board for Health Creation and the VCFSE Sector, designed to ensure the ICS treats the VCFSE as a key partner in 'health creation'. This has been supported by heightened collaboration within the sector, including a presentation by key players to 70+ elected members in February of what had been achieved during COVID-19, which presented details of the 130,000 calls taken by HertsHelp in one year and the thousands of interventions by organisations across the county. The board will ensure this improved integration is maintained and built upon. Key themes will be the focus on "No Wrong Door" approach (to ensure access for those most in need through HertsHelp and the social prescribing system) as well as ensuring Family Carers and Volunteering are always considered in the commissioning of the VCFSE.

**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.

• During the COVID-19 vaccination programme the CCG have worked with a group called Afro GP Herts & Beds to help promote pop-up clinics targeting the BAME population, using their networks for distribution. Clinics have been well attended.

**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**[21].

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.

# PATIENT AND PUBLIC ENGAGEMENT

In 2021/22, the continued response to COVID-19, and the impact of the virus on the way that NHS services were delivered, meant there was a lot of work to do to assist the public to get health and wellbeing help when they needed it. Our communications and engagement team also focused on helping residents to access information about the COVID vaccination programme and testing.

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

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

(PLNs)[22]. 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.

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. Some of this joint work is covered in this section. We have also contributed to internal audits, highlighted opportunities to take part in research and insight work, and have consulted on health-related strategies such as for friend and family carers, mental health and dementia.

Regular engagement with volunteer members and other stakeholders[23] has helped us to reflect on engagement practices and make improvements to our approaches.

"I am the Lay Member for Patient and Public Involvement on the CCG's Governing Body, so I attend many workshops and committees and take part in as wide a range of patient engagement events as possible.

I undertake the same role in Herts Valleys CCG and being involved in both organisations means I have many opportunities to help to ensure that both organisations meet their ambitions in terms of engagement and communications. The joint working arrangements with West Essex CCG to transition to the Integrated Care Board (ICB) are great to see as they demonstrate meaningful collaboration in action.

I love getting involved in the work ('involve me and I will understand!') and this year has mainly meant virtual engagement on a range of matters. I go to patient network meetings, CCG and ICS webinars about health and care topics, and take part in activities where my involvement can give our Governing Body an assurance that we're meeting our statutory requirements to involve and engage different groups of people.

As we navigate a third year of responding to COVID-19, we are transitioning to integrated care systems being formally established. This includes the component parts such as ICBs.

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

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

There are some fantastic ways of doing things in CCGs that we can bring into the future, as well as adopting inventive and accessible ways to involve and engage the people we commission services for. In particular, I am aware that there are many lessons we can learn from our engagement with the public during the vaccination programme. These lessons should help to refocus and re-energise our work to reduce health inequalities across the entire ICS.

Thank you to everyone involved in patient and public involvement work for another unprecedented year; our volunteer patient representatives continue to be valuable 'critical friends' and advocates alike in their roles, supporting our efforts to great effect. Their enthusiasm and commitment remains so important to us.

As we work towards COVID-19 system recovery and a formal integrated system in Hertfordshire and west Essex, I am confident that we can harness the best of existing practice along with learning from the extraordinary period we have just been through – and embrace the opportunities of the new arrangements. ”

***Alison Gardner,***
***Lay member for Patient and Public Involvement***

# What we've been doing

**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. These are some examples of the key work we've supported.

<u>Community Diagnostic Hub</u>

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.

NHS E/I has mandated that all areas need to implement a community diagnostic centre model to increase the capacity of elective (planned) diagnostic services and move some diagnostics 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.

A patient involvement representative works principally with East and North Hertfordshire NHS Trust (ENHT) to add insight and feedback during the development of plans. To help expand people's understanding of the Hub programme, the Patient Network Quality group are kept informed about its progress, with the opportunity to raise questions and ideas at meetings that can be taken back to those working on the programme.

E&NH Falls and Frailty Care Coordination Centre

The East and North Hertfordshire Health and Care Partnership (HCP) is designing and developing a single point of access and care co-ordination centre for patients identified as frail, or recovering from or at risk of falls, to navigate the health and social system.

The engagement team brought five volunteer patient involvement members on board, so that the project benefits from a co-production approach to the design of the centre. These members live with frailty or have cared for someone who is frail. Working with the Project Manager, the members had an initial informal introduction session to learn about this work, its benefits, and the part they could play in its design. At the time of writing, the project is still in progress.

Procurement of online and video consultations in Primary Care

As part of an ICS 'Digital First' programme, an online consultation procurement process has been set up with a view to give GP practices choice in the product they use for patients. This has included determining technical and clinical needs with input from technical staff, clinicians and patients through the practice PPGs and the CCGs patient networks.

Engagement colleagues in the three CCGs gave feedback on a questionnaire designed to gather feedback on access and tools currently used, like eConsult. These went to patients, GPs and other Practice staff across the ICS. A patient involvement representative is also connected to this programme of work.

Access to Primary Care Services

We have supported work across the ICS to listen to patient and public feedback on GP access and to manage growing expectations about provision of face-to-face appointments

as we emerged from the second wave of the pandemic. Communications and engagement teams have worked with primary care commissioners to support GP practices in providing reassurance around continued use of telephone consultations as well as e-Consult forms as the best route into general practice. We have prepared supporting materials to help people understand the practical and safety rational behind this approach.

In October 2021, Hertfordshire CCGs took part in the County Council Health Scrutiny 'GP access topic group' to explain the challenges faced by general practice in meeting rising patient demand and work to improve access. This resulted in recommendations by the topic group members to return for further discussion with CCGs.

In November, the three CCGs held an engagement event for patients on the topic of GP access, chaired by Hertfordshire Healthwatch. This allowed patients to hear from GPs and vice versa to achieve greater mutual understanding. About 70 patient involvement representatives attended. Many said they would join future sessions and wanted to be contacted about other matters too.

These conversations with public representatives and patients have provided valuable insight and highlighted key priorities for patients including getting through to practices on the telephone and the quality of information on practice websites.

As an immediate response we have worked on a variety of communications including social media, messages for GP websites, media work and a video to help educate, inform and reassure patients. These have covered topics such as telephone triage, infection control and the wider professional team, such as pharmacists and physiotherapists, who add to the support for patients within practices.

To provide lasting solutions, communications and engagement teams are working with primary care teams to support general practice teams to improve their communication with patients. This includes communications and engagement advice and training, support to improve practice websites and helping practices develop new channels of communication with patients such as social media.

Mount Vernon Cancer Centre Review

We have continued to support the Mount Vernon Cancer Centre (MVCC) review which started in 2019, led by NHS E/I. In 2021, expressions of interests were made to the governments New Hospital Programme to redevelop Watford, Hemel Hempstead and St Albans hospitals, and to build a new cancer centre at the preferred option of a redeveloped Watford General Hospital. There are also options being explored to have a networked radiotherapy unit at either Lister Hospital in Stevenage, or Luton and Dunstable Hospital.

We have helped promote several patient and public involvement opportunities renby NHS E/I and supported the associated Patient Reference Group to improve representation from

the eastern most part of the county. Involving patients, carers and local people is continuing as proposals are developed, and this will include a consultation on options.

Princess Alexandra Hospital New Build Plan

An engagement programme continued into 2021/22, gauging more views on the plans for a new Princess Alexandra Hospital in Harlow, to serve our Stort Valley and Upper Lea Valley communities. We hosted meetings between two Patient Locality Networks and those leading the new-build project, so that patient representatives could give direct feedback in a meaningful way. More announcements are expected in 2022 about the progress of this hospital programme, and we're committed to continuing to promote public engagement in the project.

Changes to the local delivery of care and supporting GP practices

Our expertise is used to help GP practices to engage on proposals for change, such as when a practice is considering moving premises, merging with other practices, changing or ending a service, is going through a change of ownership, or is considering closing branch surgeries.

We work with Contracts, Primary Care, and Nursing and Quality team colleagues on these processes to help ensure the patient voice is heard, and feedback acted upon in a timely manner, with decisions made at the most appropriate part of any process.

**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 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, around 160 people have benefited from these sessions since April 2021, thanks to marketing and stakeholder relation work.

A work programme for 2021 was produced, focusing on:

- recruiting more volunteer presenters, and supporting volunteers in their role
- improving marketing, and growing stakeholder relationships to lead to more sessions
- primary care network (PCN) level sessions

- introducing specific sessions for audiences with learning disabilities.

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 in quarter four
- 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 are piloting making the presentation suitable for people with learning disabilities
- we are working with Herts Valley and West Essex CCGs to begin planning an extension to the programme and therefore its reach across our ICS area
- relationships are being 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. Across a six-month period in 2021, we looked at survey results from 135 respondents and discovered that after attending a session:

- more than double the number of patients felt confident about recognising symptoms (33% pre session to 80% post session)
- 81% of attendees felt confident about going to their GP within a week of symptoms appearing
- more than 95% of attendees would change their lifestyle to avoid cancer
- 75% of attendees found the presentation very useful and informative
- 97% of attendees said they would now take part in future cancer screening.

We have now made links with Lincolnshire and Great Yarmouth and Waveney systems, which are interested in the programme.

Our ambition is now to complete the implementation of Cancel Out Cancer in the other ICS CCGs, set up the first face-to-face Learning Disability-friendly presentation, set up new mechanisms to ‘keep in touch’ with participants, and work closely with a new nursing role which focuses on screening. The government’s 10-Year Cancer Plan for England, the consultation for which was announced in early 2022, is also likely to inform the priorities

for improving patient experience and detection of cancer, and campaigns such as Cancel Out Cancer can play a big part in that.

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

## The public and patient perspective

**Patient volunteer representative Justin Jewitt supports the CCG and the ICS in a range of ways. He sits on the CCG's Cancer Steering Group, helps lead the Cancel Out Cancel programme, chairs the patient rep-led Patient Network Quality, and currently represents the patient voice about Community Diagnostic Hubs, and the virtual consultation programme for GP services.**

"With the creation of CCGs in 2013, there was a real opportunity to get the patient voice heard at the highest level in the new organisation. I volunteered to join my local Patient Participation Group (democracy begins at the lowest level) and then got invited to represent the PPG at the next level up, the locality network then onto the CCG Quality Committee, chairing the Patient Network Quality committee and I'm a member of various groups, such as the CCG's Cancer Steering Group and the Primary Care Network equivalent.

Everyone does want to hear the patient voice at all levels in the NHS; however do they all listen to what we say? Do patients say something that is constructive and helpful? I hope the answer to those two questions, from my part, is 'yes' and 'yes'. Acting as a critical friend is quite a valuable skill that I do not always manage to practice; however I have got the voice of patients into many decision areas over the past eight or nine years.

I try and represent people from the widest range of age, gender, ethnicity, faith and experience and encourage everyone I meet or communicate with to speak up for all patients. Speaking up for patients has been even more positive during the pandemic because everyone meets virtually, enabling patients like me to attend more meetings across a variety of subjects but with no travel or formal meeting location issues.

In 2021/22 as well my involvement in different CCG groups, I have been involved in setting up a new Facebook page for a PPG which now has nearly 200 members regularly sharing health news. I have also supported my own surgery to start up a PPG, and participated in the procurement programme for the next generation of virtual consults in GP surgeries and the development of the new Community Diagnostic Hub coming soon to the area."

I am still as excited to take part in any CCG event now as on my first day. Its super to be part of a wonderful service for everyone and be part of the influence for positive change in the NHS.

***Justin Jewitt***

# Activity and planning with CCG teams and external stakeholders

**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 is working in shadow form until July 2022. This has involved establishing a Community Assembly, and two sessions have been held, hosting different cohorts of stakeholders.

The Assembly's purpose and objectives are being 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.

Assemblies are proposed to be held four times a year, and a five-year strategy for the partnership including visions and values which were agreed in early 2022.

**Involving patient and public representatives**

In 2021/22, Patient Locality Network (PLN) members contributed hundreds of collective hours to NHS-focused work, including helping us link into communities, and 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, including quarterly patient involvement representative meetings and webinars. 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 want to explore inclusive and sustainable solutions that can help everyone stay connected.

The Health Involvement Network is an example of how we can connect with people away from formal meeting structures. The 'closed' Facebook group is underutilised, however, and as part of planning for the Integrated Care Board engagement structure, a reset is needed to create a meaningful place for virtual public involvement.

We opted to upgrade the ad-hoc updates to Patient Locality Network members to a monthly newsletter for members, following feedback from a communications survey sent to all members in June. We receive positive feedback for keeping in touch beyond the meeting cycle and evolving a network which is more than just a meeting place. They also bring a great deal of value thanks to volunteering for communication-related activities such as feedback on surveys, winter booklets, leaflets, and campaigns.

Our volunteers are made aware of training workshops and online information from trusted organisations as the Kings Fund, as well as local organisations. NHS E/I also provides a suite of opportunities for patient voice representatives which we promote to volunteers. The engagement team have run webinars to help keep volunteers informed

For the second year running, we ran an informal evening event online close to Christmas where participants reflected on the year's events. It gave us a chance to thank everyone for the commitments they make and in the spirit of the festive season, we also ran a short quiz.

**Responding to insight and research**

The CCG has responded to, and supported, Healthwatch Hertfordshire's continued research and insight work during the pandemic. This has included highlighting a range of Healthwatch surveys about different experiences during the pandemic, such as capturing the views of people from Black, Asian or other ethnic backgrounds on accessing NHS services.

All engagement opportunities are shared with not only the Patient Locality Network (PLN) but also through all the CCG's communications channels. Healthwatch's research and insight reports set out some key considerations and actions for the CCG and other organisations. For instance, improving stakeholder engagement to help identify military veterans in our area and promoting the benefits of identifying yourself as a veteran to the NHS.

# You said, we did

Here are a few highlights of the ways we have responded to feedback to help make a difference. You can also see some of our work on our website at: **www.enhertsccg.nhs.uk/get-involved**

| Project | You Said | We Did/Are Doing |
|---|---|---|
| Engagement about the COVID-19 pandemic response and access to services | We want to support the CCG in sharing information about vaccination, testing, access to services, and to have the chance to influence messages through feedback | Our Patient Locality Network (PLN) shares information about a range of COVID-related help and guidance for communities, including vaccinations, community safety (e.g. 'hands-face-space'), and access to support.<br><br>PLN members take part in webinars about communications to take messages back to their communities about access to services, the system response to the pandemic, and staying healthy. They also receive regular updates, and, and can access Local Resilience Forum newsletters.<br><br>The Communications team have involved PLN members in the Integrated Care System-wide project to support GP practices, helping improve public understanding of ways to use GP services as well as suitable NHS alternatives |
| Supporting PPGs and their GP practices with membership and diversification | We need more people to join, and we need a range of members | We created local content for Patient Participation Awareness Week (31 May- 6 June) including promoting PPGs, using quotes from PPG members and thanks from health leaders for the work and dedication of PPG members.<br><br>We are working across the ICS to develop more support for PPGs and GP practices, to exchange best practice and explore schemes for patient involvement with Healthwatch Herts, practice managers and patient rep organisations. |

| Project | You Said | We Did/Are Doing |
|---|---|---|
| Primary Care Network (PCN) engagement | PPGs can have a meaningful role at PCN level to help foster community engagement and collaboration | We set up a webinar with a PPG and PCN patient volunteer lead from a Berkshire CCG, who shared his experiences and best practice tips for Patient Locality Network members.<br><br>Engagement with PCNs is routinely discussed at PLN meetings and there is an open invite for them to get in contact with us for advice, including putting reps in touch with others who are making good progress in this area.<br><br>We also advise PLN members on how PPGs in their networks can get better connected. |
| Improving awareness about cancer screening and symptoms | We need to improve patient confidence around screening appointments and encourage them to come forward with concerns about possible symptoms | We increased the number of public Cancel Out Cancer sessions available and introduced volunteer training to increase capacity.<br><br>We routinely support cancer campaigns such as World Cancer Day, and NHS 'Just' and 'Help Us Help You' campaigns.<br><br>A cancer-focused communications group was set up in April 2021 at ICS level to collaborate on different programmes. The network has helped our CCG to develop our Cancel Out Cancer programme with support from other colleagues and promote and collaborate on other initiatives. |

## 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 2021/22, the CCG has continued to be involved in, or engaged with, many groups including:

- local authority Health and Wellbeing Boards
- the Hertfordshire 'Local Resilience Forum' and its COVID-19 response 'cells'
- 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

An extended Communications and Engagement Strategy was agreed by the joint CCGs' Board in November to take into account the work that needed to continue as a result of the COVID-19 pandemic response, and the transition to Integrated Care Board (ICB) status. The key priorities for the year ahead consider that:

- Hertfordshire and West Essex's three CCGs are transitioning into the new ICB
- the communications teams in the three CCGs are working together more closely than ever as the process of becoming one team continues
- a new, ICS-focused communications and engagement strategy covering Hertfordshire and west Essex will need to be developed to reflect and support the priorities of the new ICB.

Notwithstanding some aims and ambitions referenced in this section, these are some of the key engagement activities which will continue through the transition period:

- Using co-production and engagement methods to ensure patient and public views are central to the development and transformation of services
- Continuing to 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.
- Helping stakeholders and the public to navigate the changes in health and social care services (direct and indirect) brought about by the COVID pandemic
- Leading engagement activity to help the public to access information on the COVID-19 and flu vaccination programmes to support take-up, help to protect the population's health during the winter 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.
- Maintaining stakeholder confidence in health services throughout the transition process.

**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, particularly in the challenging circumstances we have faced this year. 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 delivers IT services to the five Member Organisations of the HBL Partnership and in April 2022 WECCG (for Corporate Services) will become the latest NHS organisation to join the Partnership.

As with the previous year, 2021/22 has been dominated by Covid-19 and we have continued to support our member organisations in their incredible responses to the pandemic, which in recent months has again increased due to the Omicron variant.

In HBL ICT, we are very proud of our achievements in 2021/22, introducing new services and technologies at scale and pace and adapting our support model to meet the changing demands of our member organisations. This year we have published our new Business and Digital Strategy which sets out our vision and operational plan for the next five years, embracing collaborative technologies, automation through robotics and enhancing our communication channels to make us more responsive and accessible.

In this year, we have undergone a very successful organisational change programme across the Shared Service, to ensure that we are current and relevant to meet the digital requirements of our member organisations, and this will position us well to be able to rapidly respond as required.

Looking ahead, we know that 2022/23 will be equally as busy and challenging, not least in supporting our member organisations in their continued responses to Covid, but in enabling the Clinical Commissioning Groups to digitally transition to the emerging Hertfordshire and West Essex (HWE) & Bedfordshire, Luton, and Milton Keynes (BLMK) Integrated Care Boards.

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 financial year 2020/21, HBL ICT met the control total specified by the Partnership Board, based upon roll-over block contract regime, incorporating inflation and cost improvement targets, resulting in a small surplus at the financial year end. Despite the unavailability of capital budgets, HBLICT managed to maintain its current infrastructure without any further use of external funds. This was done mainly through the realisation of efficiencies from active investments previously deployed.

During 2021/22, we maintained excellent control of our financial resources and met our planned control total. A further development has been the partnership agreement to adopt 'Activity Based Costing' as a method of apportioning service charges, which will come into force in 2022/23.

## 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.

In December 2021, all NHS organisations had to respond and manage the Log4j vulnerability. For the past two months HBL has been proactively managing and monitoring the vulnerability and although there may be some instances, there is no evidence that the vulnerable versions being present, and we have subsequently been working with our 3rd party vendors to patch all identified instances with no impact to service. In addition, we have put in place extra controls and restrictions on our firewalls and monitoring systems to ensure any potential suspicious activities are blocked. Plus, as part of our recent restructure in HBL, we have introduced two additional Cyber Security Technicians to further increase our proactive security monitoring capability and defences.

## Development and Innovation

Development and innovation is fundamental to the 5 year HBL business and digital strategy which was approved and published in 2021. The following are the key developments that has been introduced this year:

1. **Integrated Network through SDWAN** – designing the network solution for the partnership that will improve system performance by separating out clinical and internet traffic at sites. This will be a key deliverable as we start to consume more cloud-based services.

2. **Office 365 Migration (N365)** – deployment of the new officer 365 platform to all users replacing the legacy Office 2010.

3. **Migration off of Unsupported Operating Systems** – All end user devices migrated to the latest operating systems, with planning migration to Win11.

4. **Development of Bespoke Applications** – development of a new Antibiotics app for mobile devices

5. **Virtual Desktop Infrastructure (VDI)** – development and deployment of a new VDI platform for Primary Care which provides clinicians with access to core clinical systems and is key to support business continuity in Practices during the Pandemic.

6. **Virtual Smartcards** - Toward the end of the year work has started on trialling the use of Virtual Smart Cards. VSC's in conjunction with VDI allow us to enable any device as a platform to access clinical systems at short notice without the user having a physical smartcard in their presence.

7. **Primary Care On-Line and Video Consultations** - supported the further rollout of Online Consultations to practices across the CCG by enhancing the tools that were available in April by adding additional functionality to the AccuRx suite. Practices can now send structured Questionnaires tailored to specific cohorts of patients; SMS functionality was also procured using the integrated toolbar to create a seamless environment.

8. **Service Desk Virtual Agent** – In December we introduced the virtual agent (Chatbot) to further enhance the Service Desk interface making support more available and build of the 'Live Chat support channel which is now the preferred channel for contacting the Service Desk.

# PREPARING FOR EMERGENCIES

The CCG has a responsibility in law to be fully prepared and able to respond effectively in the event of an incident which challenges the capacity or capability of the local health system.

In 2021/22 we remained fully compliant with all nine areas of **NHS England and Improvement's Core Standards for Emergency Preparedness, Resilience and Response (EPRR).**

## COVID-19

### Background

The NHS continues to respond to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China and which has now been detected in more than 100 locations internationally, including the United Kingdom. The virus has been named

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

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

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

**Clinical Commissioning Groups (CCGs) Role in the Response**

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

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

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

- Strategic: CCG Executive Team (ENHCCG), Senior Management Team (WECCG) and Incident Management Team (HVCCG)

- Tactical: Incident Coordination Centres

- Operational: Cells/key work programmes.

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

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

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

The CCGs internal governance structures developed have supported them to:

- Engage at the Hertfordshire and Essex Strategic Co-ordinating Groups to represent their populations from a strategic multi-agency health perspective
- Engage at the Hertfordshire and Essex Tactical Co-ordinating Groups to ensure involvement at a local level with joint working from their local county or area systems

- Continue to engage with the Hertfordshire and Essex Directors of Public Health on the Health Protection Outbreak Board

- Provide updates about CCG and system progress to their respective governing bodies through the reporting routes established

- Continue to work with NHSE/I for situational awareness and reporting

- Chair Hertfordshire and Essex-wide meetings with the other commissioners and providers on the health TCGs to provide a tactical health response

- The CCGs also work as part of the Hertfordshire and Essex communications cell to plan and deliver COVID communications for the public, staff and stakeholders.

**Mass vaccination and outbreak cells**

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

Due to the increased number of outbreaks and clusters occurring after the initial influx of reports an Outbreak Cell was formed with standard templates for action cards and reporting documents circulated to General Practice, in addition to duty managers and the ICCs internally. Roles and responsibilities and escalation frameworks were included on IMT agendas to ensure all members of outbreak IMT calls were clear on reporting requirements and had an understanding of what needed to be done by each organisation.

**Debriefing and Recovery**

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

**Workforce**

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

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

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

**Concurrent Incidents**

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

- Fuel Crisis
- Afghanistan Refugees - Managed Quarantine Services Hotels
- Beckon Dickson Medical Supplies Disruption
- Death of Prince Phillip (Operation Bridges)
- EU end of Transition

**The Immediate Future**

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

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

# SUSTAINABLE DEVELOPMENT

**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. During 2020/21 the CCG pledged not to purchase single use plastics.

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 | 2021-2022 |
|---|---|---|---|---|
| CCG Net Internal Area of Charter House (m2) | 1,730 | 1,796 | 1,796 | 1,796 |
| Number of staff (Whole Time Equivalent) | 286 | 282 | 286 | 289 |
| Average floor space per staff member (m2) | 6.04 | 6.37 | 6.25 | 6.21 |

**Total Energy Cost (All Energy Supplies)**

NHS East and North Hertfordshire CCG spent £ 77,220 on energy in 2021-22

**Energy used (consumption in kWh)[24]**

| | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | kg CO2e (21-22)[25] |
|---|---|---|---|---|---|---|---|
| **Gas (natural) consumed** | 623,464 | 497,344 | 409,945 | 452,162 | 238,173 | 294,752 | 53987 |
| **Electricity consumed** | 575,969 | 620,989 | 352,221 | 351,077 | 314,680 | 313,035 | 66467 |

[24] 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.

[25] https://www.gov.uk/government/publications/greenhouse-gas-reporting-conversion-factors-2021

**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 material production | 17-18 | kg CO2e (17-18) | 18-19 | kg CO2e (18-19) | 19-20 | kg CO2e (19-20) | 20-21 | kg CO2e (20-21) [26] | 21-22 | kg CO2e (20-21) [27] |
|---|---|---|---|---|---|---|---|---|---|---|
| **Paper spend £)** | 2,783 | | 3,308 | | 2,829 | | 630 [28] | | 876 | |
| **Paper products used (Tonnes)** | 4.19 | 3,890 | 5.00 | 4,778 | 3.94 | 3,753 | 0.78 | 717 | 2.286 | 2102 |

**Travel**

NHS East and North Hertfordshire CCG spent £6106 on business travel costs in 2021-22. This is a substantial decrease on the £18,538 spent in 2020-21. This spend has substantially reduced compared to previous years due to the majority of CCG staff working from home and meeting virtually wherever possible. 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.

[26] Greenhouse gas reporting: conversion factors 2020 - GOV.UK (www.gov.uk)
[27] Greenhouse gas reporting: conversion factors 2021 - GOV.UK (www.gov.uk)
[28] Decrease due to most CCG staff working predominantly from home from 2020/21

| 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)<br><br>Estimated using figures for the average car of unknown fuel type, see here. |
|---|---|---|---|---|---|
| 2015-16 | 19 | 251,159 | 248 | 1,013 | 75,569 |
| 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 |

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

**Waste Disposal and Recycling**

| | 2017-18 | 2018-19 | 2019-20 | 2020-21 | [7]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 |

The CCGs ICT provider, HBLICT recycles all ICT waste in a cost neutral agreement, however a breakdown of total waste for ENHCCG was not available for 2021/22.

**Water and Sewage Cost**

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

**Key Initiatives 2021/22**

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. Our health and safety arrangements were reviewed and the risks assessed, which continue to be monitored. A number of Covid-19 protection arrangements have continued to a number of sustainable positives, which support lowering the organisation's carbon footprint including:

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

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

• Previously occasional cycling and walking for business and commuting purposes: maintaining social-distancing. Sustainable/active travel option: reducing carbon emissions and improving air quality; promoting better health and wellbeing.

• Reducing occupation levels in office areas by encouraging working from home: maintaining social distancing parameters. Reduced business travel and commuting: cutting carbon emissions and improving air quality. Reducing impact of seasonal hot and / or cold weather / heat waves: lowering need for supplemental mechanical heating, ventilation and cooling – cutting carbon from power consumption.

• Major reduction in circulation of printed matter – papers, reports and so on: minimises virus transfer risk. Reduction in use of natural resources and associated carbon emissions.

CCG staff members continue to enjoy the benefits of the government's 'cycle to work' scheme, although of course the bicycles can be used outside of work activities too. This allows staff to purchase a bike and cycle safety equipment as a tax-free benefit and as a

salary sacrifice scheme. The scheme contributes supports the organisation’s reduction in carbon emissions whilst promoting physical activity as part of a health and wellbeing strategy.

# REVIEW OF FINANCIAL PERFORMANCE

# REVIEW OF FINANCIAL PERFORMANCE

## SUMMARY

East and North Hertfordshire CCG's Annual Accounts 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 2021/22. The duties, their relevance in 2021/22 and the performance of East and North Hertfordshire CCG in 2021/22 are set out in the following table.

Further details are provided in of the accounts from page 179 of this Annual Report.

| Duty [and section of 2012 Act] | Relevance in 2021/22 | Achievement |
|---|---|---|
| Expenditure does not exceed sums allotted to the CCG plus other income received [223H(1)] | Applicable | ✓ **£132k underspend in - year (Cumulative underspend of £18.983m)** |
| Capital resource use does not exceed the amount specified in Directions [223I(2)] | Not applicable; no specified matters in 2021/22 | |
| Revenue resource use does not exceed the amount specified in Directions [223I(3)] | Applicable | ✓ **£132k underspend in - year (Cumulative underspend of £18.983m)** |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions [223J(1)] | Applicable | ✓ **Breakeven** |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions [223J(2)] | Not applicable; no specified matters in 2021/22 | |
| Revenue administration resource use does not exceed the amount specified in Directions [223J(3)] | Applicable | ✓ **Underspend £811k** |

# FUNDING ALLOCATED TO THE CCG

In response to COVID-19 pandemic, NHS E/I put in place a temporary financial regime in which CCG allocations were initially issued to cover the first half of the year called H1 (1st April - 30th September 2021). Another tranche of allocation for the second half was issued for H2 (1st October 2021 – 31st March 2022).

For both halves of the year, allocations were made in line with NHS E/I's assumptions on expected costs, including those related to responding to the COVID pandemic and to support the restoration of services, with the intention that all health systems would achieve financial balance. The simplified arrangement for payment and contracting with providers introduced in 2020/21 was retained.

These temporary financial arrangements effectively simplified CCG financial management and allowed greater focus on system partnerships to manage overall resources. Systems were issued with funding envelopes comprising funding for NHS providers equivalent in nature to a block value, prospective top-up payments and a system-wide COVID funding envelope. A summary of the framework adopted in 2021/22 for the two halves of the year is as shown in the table below.

| Category | Planning guidance assumptions. Months 1 to 6 2021-22 (H1) and months 7-12 2021-22 (H2) |
|---|---|
| Allocations and Budgets | Financial envelope for HEW ICS provided by NHSE/I. The CCGs allocation within this has been set against NHSE/I estimations of budgets required. Top ups are provided throughout the ICS for growth and COVID-19 expenditure to achieve break even positions. Financial performance will be measured against a break even control total H2 funding envelope was based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of the pay award, and increased efficiency requirement. |
| Contracting and Commissioning | Contracting and commissioning stood down. No invoicing for NHS Non-Contracted Activity (NCAs) |
| NHS providers | Block payments above £500k continue. Ability to adjust these payments to recognised newly commissioned services not in the baseline in 2019/20. Requirement to top up mental health providers to achieve MHIS. Providers supported within the overall ICS financial envelope. |
| Independent Sector | Commissioning returned to CCGs working with main providers |
| Non-NHS providers | Expectation that support to providers is phased out and normal activity resumes |
| Primary Care | Additional requirements of Care Home DES and Additional Roles Reimbursement Scheme have been included in the CCGs baseline budgets |
| Efficiencies and QIPP | Expectation that a level of efficiency will be delivered, although no formal efficiency reporting |

## CCG ALLOCATION

The total allocation received by the CCG for the 2021/22 financial year was £952.6m including

- £7.584m for the Hospital Discharge Programme;
- £5.177m for COVID-19 reimbursement;
- £18.851m being the brought forward cumulative underspend. The CCG was not authorised to spend this brought forward funding.

# NHS EAST AND NORTH HERTFORDSHIRE CCG 2021/22 EXPENDITURE

An analysis of 2021/22 net expenditure shows that the majority of the CCG expenditure relates to services commissioned with NHS Acute Providers (48%), Primary Care Services (excl. prescribing) (12%), Mental health Services (12%), Prescribing (9%) Community Health Services (8%) and Continuing Healthcare (4%) as shown in the table below.

| | Annual Budget (£'000) | Forecast Outturn (£'000) | Annual Variance (£'000) | Spend % of total % |
|---|---|---|---|---|
| **Allocation** | **952,600** | **952,600** | **0** | |
| NHS Contracts - Acute | 454,273 | 453,966 | (307) | 48% |
| Non-NHS Providers - Acute | 23,733 | 23,780 | 46 | 2% |
| Mental Health Services | 111,231 | 111,286 | 55 | 12% |
| Community Health Services | 76,026 | 76,153 | 127 | 8% |
| Better Care Fund | 14,992 | 14,989 | (3) | 2% |
| Continuing Care Services | 39,457 | 38,392 | (1,066) | 4% |
| Prescribing | 85,637 | 83,323 | (2,314) | 9% |
| Primary Care Services (Excl. Prescribing) | 115,931 | 120,184 | 4,253 | 12% |
| Other Programme Services | 331 | 350 | 19 | 0% |
| **Total Programme Expenditure** | **921,612** | **922,423** | **811** | |
| Running Cost | 12,005 | 11,194 | (811) | 1% |
| **Total CCG Expenditure** | **933,617** | **933,617** | **(0)** | **100%** |
| **Total CCG in year** | | | | |
| Cumulative underspend brought forward | 18,983 | 0 | (18,983) | |
| **Total (including cumulative underspend)** | **952,600** | **933,617** | **(18,983)** | |

The cumulative underspend of £18.983m will be carried forward into 2022/23.

# HOSPITAL DISCHARGE PROGRAMME AND COVID-19 FINANCIAL SUPPORT

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

In response to the COVID-19 pandemic and the need to ensure hospital beds were available to those who needed them most, the government introduced new hospital discharge arrangements based on the expanding of Discharge to Assess (DTA) model. Health and Care systems were financially supported by NHSEI under the Hospital Discharge Programme (HDP) to ensure people who no longer needed to stay in hospital were discharged safely from hospital to the most appropriate place and continued to receive the care and support they needed after they left hospital. Any expenditure incurred by the system under this programme representing the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to six weeks following discharge from hospital was

re-imbursed by NHSEI. The programme ensured Social Care needs assessments and NHS Continuing Healthcare (NHS CHC) assessments of eligibility were made in a community setting and did not take place during the acute hospital inpatient stay (Discharge to Assess).

With this financial support in place, the CCG responded to a significant rise in hospital discharge activity. Some of the expanded services included assessment, discharge home to assess, therapy at home, mainstream homecare, rehabilitation beds, discharge to assess beds and complex care.

For the financial year 2021/22, the total amount spent by the CCG under the Hospital Discharge Programme was £7.584m.

In addition to the HDP, COVID-19 funding was made available to support the CCG in responding to increased costs arising as a result of our response to the pandemic. Areas of funding support included:

- Remote management of patients/non-patient activities
- Support of stay at home
- NHS 111 additional capacity
- Backfill for higher sickness absence
- Primary Care consumables
- Bank holiday opening of GP Practices
- Digital support to GP Practices

For the financial year 2021/22, the total amount spent and reimbursed under COVID-19 financial support was £5.177m.

# MENTAL HEALTH INVESTMENT STANDARD

A very important requirement in the 2021/22 planning guidance related to the Mental Health Investment Standard (MHIS), under which all CCGs were required to increase their spending on mental health services by at least the percentage increase in the CCG's programme allocation growth. In 2021/22 the CCG's programme allocation growth was 4.27%. However, during the year the CCG received additional funding to manage the impact of a higher NHS staff pay award. The adjusted MHIS target after allowing for this increase was a growth in expenditure of 4.89%.

In addition, the CCG received non recurrent allocations such as Department for Work and Pensions funding for Improved access to psychological therapies and other national funding such as for service development (£2.540m) and from the Spending Review (£2.633m).

The CCG targeted the increased investment at delivering the Mental Health Five Year Forward View and other national priorities. This included investment in:

- Continued expansion and growth in both community and specialist perinatal mental health services e.g., increasing access to women who can access the service
- Expansion of IAPT services to people with Long Term Conditions, such as diabetes, respiratory and MSK. Development of Long Covid pathways.
- Embedding the 24/7 CAMHS Crisis helpline
- Crisis resolution and home treatment team
- Early intervention in psychosis – support for people in the "At Risk Mental State" group
- Adult eating disorders day treatment unit
- Individual placement and supports (employment support)
- Annual physical health check for adults with serious mental illness
- Improving the therapeutic offer in inpatient care to support a reduction in length of stay and better outcomes
- Core 24 standard for psychiatric liaison
- GP health checks and vaccination rates for the people on the GP LD register
- Increased focus on delivering the nationally set trajectory for the reduction of Out of Area Placements to zero
- Commitment as a system to reducing the number of suicides across Hertfordshire and maintain effective suicide bereavement support services

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

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

CCGs are required to calculate if their spending met the Mental Health Investment Standard and to publish a formal declaration on this, i.e. whether in 2021/22 East and North Hertfordshire CCG's spending on mental health services increased by at least 4.89%.

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

| Description | £000 unless stated otherwise |
|---|---|
| 2021/22 Mental health spending | 113,423 |
| Less spending on Learning disability and dementia | (25,771) |
| Less spending covered by allocations received | (6,142) |
| 2021/22 spending funded by general allocation | 81,510 |

| | |
|---|---|
| 2020/21 spending funded by general allocation* | 77,689 |
| Increase in spending | 3,821 |
| | |
| Increase in spending (%) | 4.92% |
| | |
| **Has the Mental Health Investment Standard been met?** | **Yes** |

** In 2021-22, a re-categorization exercise took place the net effect of which resulted in an increase in the spending reported under MHIS. For 2020-21, the previously published MHIS spending was £75,455k.*

# FUTURE FINANCIAL STRATEGY

East and North Hertfordshire CCG has a strong underlying financial level of performance and has met its revenue Control Total every year since inception. At the end of 2021/22 the CCG delivered an in-year breakeven financial position which maintained the cumulative underspend of £18.851m, well above the standard national requirement (1% of its allocation).

In recognition of the impact of the COVID-19 pandemic, NHS E/Ihas maintained the same financial framework introduced in the second half of 2020-21. The thrust of this framework is to encourage more system joint working and financial risk management. The financial planning guidance for 2022/23 has now reverted to an annual planning focus.

The Financial Envelope for Hertfordshire and West Essex (HWE) ICS has been provided by NHS E/I, comprising adjusted CCG allocations, system top-ups and COVID-19 fixed allocations, based on those provided in the second half of 2021/22 with allowance for inflation and policy priorities.

The requirement for the CCG to continue to increase funding within Mental Health in line with their allocation growth continues. East and North Herts CCG is planning to meet the Mental Health Investment Standards (MHIS)

Commissioning of Independent Sector services has now been returned to CCGs however CCGs and providers will need to work together to effectively utilise total available capacity across the NHS and Independent Sector in a way that enables significant reduction in waiting lists and waiting times, whilst prioritising those with greatest need.

For the year 2022/23, the CCG is planning to deliver a breakeven financial position and to meet all of its statutory financial duties.

During 2022/23, following the passage of the Health and Care Bill through Parliament, CCGs will be abolished, and their functions transferred to newly created Integrated Care Boards (ICBs). On establishment of the Hertfordshire and West Essex ICB, it will receive the balance of the year's financial allocation that would have been made available to this CCG and will review its plans for the remaining year.

# FINANCIAL RISKS

The ongoing and long-term impact of the COVID pandemic will continue to be managed for the foreseeable future and it is probable that some of the increased spend attributed to COVID may become recurrent needing a recurrent funding source.

The notification in the 2022-23 planning guidance that the hospital discharge funding support will cease at the end of March 2022 presents an immediate funding risk both to the CCG and the System in managing capacity and funding going forward. Existing collaborative effort between System partners are being strengthened to ensure people continue to leave hospital when they no longer need to be there, using the right discharge pathway with an emphasis on home first, contributing to more efficient use of beds and improved outcomes for people.

Continuing Healthcare is a volatile area of spend and there has been an increase in the cost of care packages as the requirement for infection prevention and control (including limiting the number of homes staff can work in) has led to increased costs to the providers which they have had to pass on to CCGs. Additionally, the increase in National Living Wage is significantly above the inflation funding received by the CCG. The CCG will continue to monitor expenditure to ensure any financial risk is managed.

The planning guidance and funding allocation requires each system to deliver efficiency savings of at least 1.1%. With the Hertfordshire and West Essex System being overfunded compared to a national fair share formula, there is an additional 0.8% efficiency requirement of the System. The process of identifying efficiency schemes is ongoing however there is a risk of under-delivery against planned level.

In order to mitigate these risks, East and North Hertfordshire CCG is fully engaged with the ICS finance community to manage all emerging risks both at individual organisation level and at a system level.

# 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.

# ACCOUNTABILITY REPORT

Dr Jane Halpin
Accountable Officer

**Date signed: 21 June 2022**

# 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 31 March 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 2021/22, 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 April 2021 to the date this report was signed (21 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 138 provides details of the membership of the Remuneration Committee.

The Governance Statement, from page 111 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: 21 June 2022**

# 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.

As at 31 March 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 8th July 2021 to publish and present the annual report and audited accounts for the year ending 2020-21;
- Having a published and clear complaints process;
- Complying with the Freedom of Information Act 2000;
- Providing information to NHS 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 is detailed below:

## 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[29]

**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.

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

[29] The Governing Body, Renumeration Committee and Primary Care Commissioning Committee met in Common with Herts Valleys CCG and West Essex CCG for most of 2021/22

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 2021/22

Members' attendance records are detailed in the following table:

| | | Public | Private | Workshops |
|---|---|---|---|---|
| **Number of meetings held during 2021/22** | | **3** | **2** | **5** |
| **Name:** | **Title/Locality:** | **Attendance:** | | |
| Dr Prag Moodley | Chair, Clinical Lead | 3 | 2 | 5 |
| Dr Ashish Shah | Deputy Clinical Chair | 3 | 2 | 5 |
| Dr Sarah Dixon | GP Representative - Stort Valley and Villages | 3 | 2 | 5 |
| Dr Russell Hall | GP Representative – Stevenage and Interim Governing Body Member for Lower Lea Valley | 2 | 1 | 5 |
| Dr Rini Saha | GP Representative – Stevenage | 3 | 0 | 5 |
| Dr Rupal Shah | GP Representative – Upper Lea Valley | 3 | 2 | 4 |
| Dr Dermot O'Riordan | Secondary Care Consultant | 3 | 0 | 5 |
| Linda Farrant | Lay Member – Governance and Audit | 3 | 2 | 5 |
| Alison Gardner | Lay Member – Patient and Public Involvement | 3 | 1 | 4 |
| Dianne Desmulie | Lay Member – Primary Care | 3 | 1 | 5 |

| | | | | |
|---|---|---|---|---|
| Dr Jane Halpin | Chief Executive (Accountable Officer) | 3 | 2 | 1 |
| Sharn Elton | Managing Director | 2 | 2 | 5 |
| Dr Rachel Joyce | Director of Clinical and Professional Services | 3 | 1 | 3 |
| Alan Pond | Chief Finance Officer | 3 | 2 | 5 |
| Jane Kinniburgh | Director of Nursing and Quality | 3 | 1 | 5 |
| Avni Shah | Director of Primary Care Transformation | 3 | 2 | 4 |
| Phil Turnock | Chief Digital Officer | 3 | 2 | 4 |

**Governance and Audit Committee**

| **Number of meetings held during 2021-22** | **5** |
|---|---|
| **Title:** | **Attendance:** |
| *Lay Member, Governance and Audit | 5/5 |
| Lay Member, Public and Patient Engagement | 5/5 |
| Deputy Chair, GP Lead, Welwyn and Hatfield, Prescribing Lead | 5/5 |

* Chair of Governance and Audit Committee

**Primary Care Commissioning Committee**

| **Number of meetings held during 2021-22** | 3 |
|---|---|
| **Title/Locality** | |
| *Lay Member - Primary Care Commissioning | 3/3 |
| Lay Member – Patient and Public Involvement | 2/3 |
| Lay Member – Governance and Audit | 3/3 |
| Managing Director | 2/3 |
| Chief Finance Officer | 3/3 |
| Director of Primary Care Transformation H&WE ICS & CCGs | 3/3 |
| Director of Nursing & Quality | 1/3 |
| Independent GP Member | 3/3 |
| GP Lead, North Herts | 2/3 |
| GP Lead, Stevenage | 3/3 |
| GP Lead, Stevenage | 2/3 |
| Deputy Chair, GP Lead, Welwyn and Hatfield, Prescribing Lead | 2/3 |

* Chair of Primary Care Commissioning Committee

**Quality Committee**

| Number of meetings held during 2021-22 | 4 |
|---|---|
| **Title/Locality:** | **Attendance:** |
| *Lay Member – Governance and Audit | 3/4 |
| Director of Nursing and Quality | 3/4 |
| Clinical GP Lead - Stort Valley and Villages | 4/4 |
| Clinical GP Lead – Stevenage and Interim Governing Body Member for Lower Lea Valley | 4/4 |
| Clinical GP Lead – Stevenage | 0/4 |
| Patient representative from the Patient Quality Network | 4/4 |
| Lay Member - Patient and Public Participation | 4/4 |
| Associate Director of Quality and Patient Experience | 4/4 |
| Consultant in Public Health | 3/4 |

* Chair of Quality Committee

**Remuneration Committee**

| Number of meetings held during 2021-22 | 2 |
|---|---|
| **Title/Locality:** | **Attendance:** |
| *CCG Lay Member - Governance and Audit | 2/2 |
| Deputy Chair, GP Lead, Welwyn and Hatfield, Prescribing Lead | 2/2 |
| Secondary Care Specialist Doctor | 2/2 |

* 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.

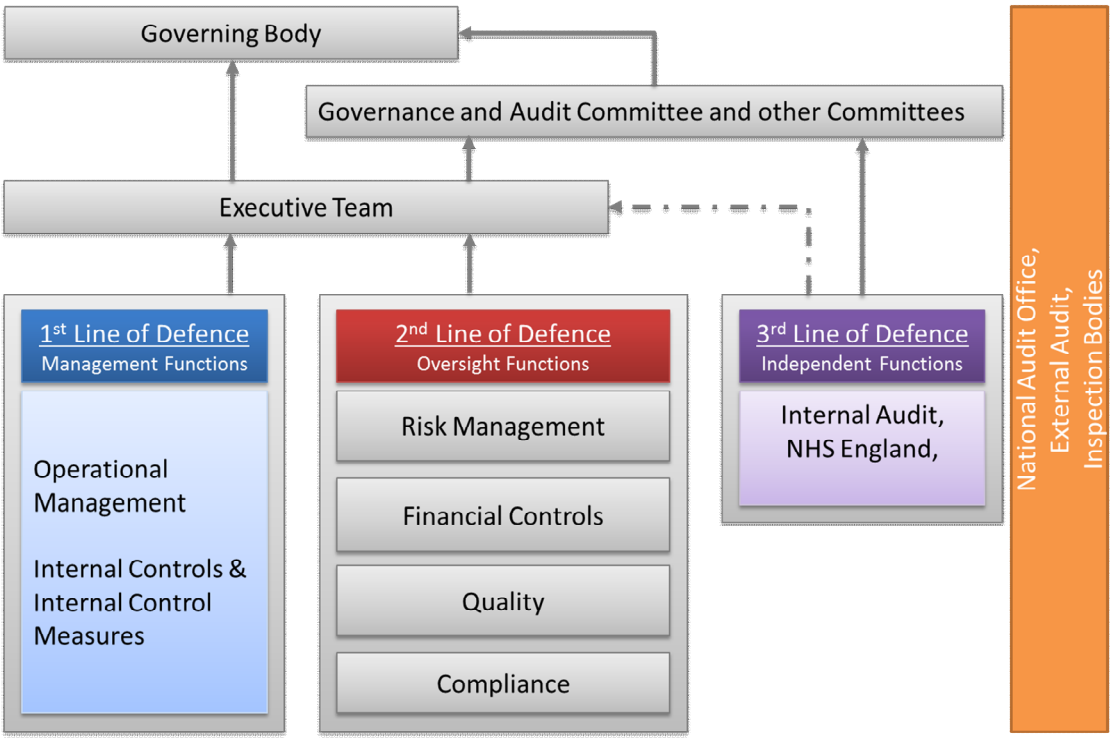
The following are the CCG’s risk escalation levels:

- 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.

## Specific Arrangement for COVID-19 Risks

In response to COVID-19, the CCG ensures governance and oversight from the CCG Governing Body and Executive team. As a Category 2 responder, the following Command and Control were established during this COVID-19 as follows:

- Strategic: CCG Executive Team
- Tactical: Incident Control Centre (ICC)
- Operational: Cells/key work programmes.

The ICC was established with a two-tier Director on Call, onsite support from ICC Managers, an ICC Officer, a Loggist and administrative support; to manage the command and control and oversee NHSE requirements, system leadership and distribution/ allocation of new tasks/ guidance to relevant cells. A Battle Rhythm was established to support the ICC's day-to-day functioning, outlining the key meetings that need to be attended. The ICC policy, action cards and battle rhythm gave clear structure to this, and the oversight functions were maintained at the Executive Level. A Single Points of Access (SPOCs) was established to operate the ICC 24/7. A weekly ICC briefing to update Directors on Call and Associate/Assistant Directors on the key actions taken in the ICC, any new actions or guidance issued from NHSE and receive any risks or escalations from across the organisation or key workstreams (cells). The CCG is part of the core members of the Hertfordshire Strategic and Tactical Coordinating Groups, which inform the broader strategy for the management of the incident at a local Hertfordshire level and feed into the ICC's battle rhythm.

The CCG's Organisation Performance Delivery (OPD) group manages the oversight functions and decision making about service transformation and changes in response to COVID-19, implementation of new guidance and the impact on the current provision of core services. The OPD group membership consists of the CCG Executive Team and is facilitated by the CCG's Performance Management Office (PMO), with AD's attending as required. The OPD group acts as an advisory group to the CCG's Governing Body and is managed by developing key workstreams/cells reporting into OPD with escalation into the Governing Body membership.

The Cells are grouped into eight workstreams, with dedicated senior leads cross directorates to deliver the required outcomes. Each cell is given a list of activities, which will be documented centrally, and risks to those activities are managed through the Datix risk management system.

The 'Cells' established are:

- Communications

- Primary care and localities
- Planned Care
- Unplanned care
- Contracts and Performance
- HR and Governance
- Pharmacy
- Recovery

As part of the 'Recovery' initiatives, the CCG has continued to hold a 'COVID-19 Secure Group' and invites colleagues across the Hertfordshire and West Essex Integrated Care System (ICS) to address issues and risks in the subsequent phases of staff returning to the site.

The CCG aligns its risk management arrangements by identifying a new Strategic Objective – 'SO9' and establishing a Cell Risk Register to capture COVID-19 related risks.

## 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 31 March 2022, the risk management training compliance for the CCG was 93.91%.

## 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<br>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<br>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<br>To deliver improved urgent and emergency care pathways across our commissioned services for unplanned care. |
| SO4 | Delivering health and care more efficiently and effectively<br>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<br>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<br>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. |

| Codes | Strategic Objectives (SO) |
|---|---|
| SO7 | Participation and Engagement<br>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<br>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. |
| SO9 | COVID-19 Pandemic<br>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 24th April 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 |
| 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) currently operate Monday to Friday 0900 - 1700. This is resulting in a lack of service in the evenings and over the weekends preventing timely discharge from the acute and increasing the footfall through the children's emergency department. This is also having a great impact across the ICS in terms of equitable service, particularly on discharges from PAH. Both West Essex and WHHT CCN teams operate a 7-day service 0800-2000. ENHCCG CYP equate to around 40% of attendances/admission at PAH, therefore this is having an impact on the flow of discharges out of PAH due to capacity in the ENHT CCN team. | 15 | 15 | 6 |
| | CY2 | Currently within East and North Herts there is no commissioned Tier 2 continence assessment service for Children and Young People. This is where a specialist children's continence nurse would deliver a comprehensive continence assessment and create a management plan for children and young people. Products are being provided and delivered through the adult Bladder and Bowel service delivered by HCT. This is resulting in a gap in quality and increases clinical risk. It could also be resulting in inappropriate levels of continence products being issued. This also goes against NHSE guidance June 2018. 'It is essential that all children and young people with a bladder or bowel problem have a comprehensive bladder and bowel assessment by appropriately trained staff with the correct treatment and management programme put in place.' | 15 | 15 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| | 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 |
| | NQ14 | If the national shortage of beds for Children and Young People who need an admission for a mental health crisis continues then this will have a knock-on impact on local areas as children wait longer than is ideal for a bed and then are often placed outside Hertfordshire resulting in families finding it difficult to maintain contact and poorer patient outcomes. | 16 | 20 | 9 |
| | 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 |

| | | | | | |
|---|---|---|---|---|---|
| | NQ22 | If the current quality and safety concerns relating to PAH, highlighted through the CQC's latest inspections and the ongoing quality oversight of the CCGs, are not adequately addressed (including ED section 31 notice, paediatrics, maternity services, core medical services and overall staffing rates and skill mix) there is a risk that our patients will not receive safe and effective care, as well as a risk to the wider system regarding operational pressures. This may result in patient harm. November 2021- PAH CQC report- rated Requires Improvement overall. Urgent & Emergency service rated Inadequate. | 20 | 16 | 8 |
| SO3 | OP1 | If there is increased demand and/or reduced capacity, for example workforce reduction, infrastructure incidents, pandemic, major incident, winter pressures, then there may be reduced patient flow throughout the system; this could potentially result in blockages in the pathway and an inability to sustain commissioned services, which may potentially have a detrimental impact on patient outcomes. | 16 | 20 | 12 |
| | OP3 | IF the CCG is not sufficiently prepared for an influenza Pandemic then there is a risk that, if an influenza pandemic occurs, delivery of essential services could be compromised resulting in poor outcomes for patients and staff welfare. | 20 | 12 | 9 |
| | OP6 | IF the CCG does not continue to respond to the current increased level of non-COVID-19 (Corona virus) activity, there is a risk that delivery of essential services could be compromised resulting in poor outcomes for patients and staff welfare. | 15 | 20 | 8 |
| 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 | 12 | 12 | 9 |
| | 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 22 | If HCT's children therapies service continues to experience an increase in referrals and waiting times for patients without an increase in capacity and achievable action plan, the service may become overwhelmed. This may result in patient harm due to the delays, and longer waits for ECHPs | 15 | 15 | 5 |
| | 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 | 20 | 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 |
| | 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, there is a risk that ENHT Maternity services may not be able to achieve National deliverables of the Ockendon recommendations, impacting workforce and patient experience and safety. Risks: - Increase in stillbirth rates - Increase in Neonatal death rates - Increase in pre-term births - A deterioration in workforce and team culture - Increase in unit closures and patient diversion | 15 | 15 | 9 |
| | MD7 | If ENHT's mechanism for reducing their diabetes patient backlog is not successful, then patients may not be seen resulting in harm to patients. | | | |

## 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*

In 2021, the monthly validation of all 'Secondary Uses Service' data was stood down for acute providers as a result of COVID-19 as they were being paid on a block arrangement. Data quality challenges continued for a few acute trusts where they have been able to review them. The Commissioning Information Groups were held monthly with our main providers (East and North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust) were also stood down in 2020/21 in line with national guidance and will be reviewed once the NHS E/I planning guidance is published for 2022/23.

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 has assessed its position against the DSPT and is on track to meet its assertions for 30 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 CCG receives some administrative services from nationally commissioned organisations and in 2021/22 also received Service Auditor Reports on these services, which it reviews.

Third party assurances for 2021/22:

- NHS Share Business Services Limited for finance, accounting and procurement services in 2021/22
- NHS Shared Business Services Limited for employment services in 2020/21
- Electronic staff record system in 2021/22
- NHS Business Services Authority for the prescriptions payments process in 2021/22
- NHS Business Services Authority for the dental payments process in 2021/22
- Capita for services by Primary Care Support England in 2021/22
- NHS Digital for GP payments on the NHAIS/open Exeter system from April 2021 to May 2022

There are some exceptions in these reports, with key control failures highlighted in the Capita report for services by Primary Care Support England. As a result our external auditor amended their audit strategy to increase the level of assurance required from substantive audit procedures in respect of primary care co-commissioning spend. Therefore no change to the overall Head of Internal Audit Opinion was required.

## 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 in order 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 CCG's in their own right, rather than just the services they commission

- regular reporting to the Governing Body on financial planning, in-year performance monitoring and central management costs

East and North Hertfordshire CCG Improvement and Assessment Framework rating will be published in July 2022

**Counter fraud arrangements**

The Clinical Commissioning Group contracts RSM 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.

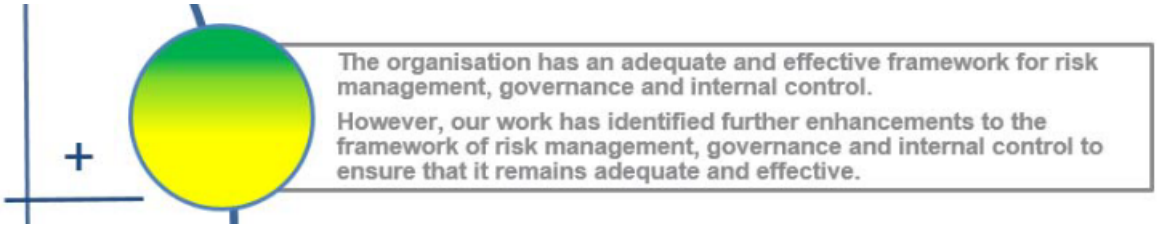
RSM provides the Clinical Commissioning Group with a LCFS Annual Report, which details all work undertaken in respect of counter fraud activities for the reporting year and measures each task as specified in the NHS Counter Fraud Authority Standards for NHS Commissioners: Fraud, Bribery and Corruption. 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.

Please see page 167 of this report for the CCG's 'whistleblowing' procedures.

# HEAD OF INTERNAL AUDIT OPINION

For the 12 months up to 31st March 2022, our head of internal audit opinion for East and North Hertfordshire CCG is as follows:




During the year, 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.

# PART TWO: REMUNERATION AND STAFF REPORT

# REMUNERATION REPORT

The information on pages 139 and 140 is not subject to audit, except for 'payments to past senior managers'.

## REMUNERATION COMMITTEE

The members of the Remuneration Committee for the year were as follows. The committee met twice in common with Herts Valleys CCG and West Essex CCG during 2021/22 and all members were in attendance.

- 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 31 March 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

# SALARIES AND ALLOWANCES (AUDITED SECTION)

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

### Table 1:Single total figure

| 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 |

**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 | 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)<br>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 & NORTH HERTFORDSHIRE CCG**

**Remuneration for members of the Board - Salaries and allowances in 2020-21**

**Table 1:Single total figure**

| | | | 2020-21 | | | | | |
|---|---|---|---|---|---|---|---|---|
| **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 (from 1 June 2020) -29.23% | 1,12 | 40-45 | 0 | 0 | 0 | 0 | 40-45 |
| Beverley Flowers | Accountable Officer (to 31 May 2020) | 2 | 10-15 | 0 | 0 | 0 | 2.5-5 | 15-20 |
| Alan Pond | E & N Herts CCG Chief Finance Officer (to 31 July 2020)/ Chief Finance Officer (from 1 August 2020) -29.23% | 1 | 70-75 | 0 | 0 | 0 | 35-37.5 | 105-110 |
| Sharn Elton | Director of Operations to 31 May 2020/ Managing Director from 1 June 2020 | | 125-130 | 0 | 0 | 0 | 105-107.5 | 230-235 |
| Denise Boardman | Director of Primary Care (to 30 June 2020) | 12 | 25-30 | 0 | 0 | 0 | 0 | 25-30 |
| Jo Burlingham | Interim Director of Operations (from 6 June 2020) | 3 | 85-90 | 0 | 0 | 0 | 82.5-85 | 170-175 |
| Rachel Joyce | Medical Director (to 30 September 2020)/ Director of Clinical & Professional Services (from 1 October 2020) -29.23 | 1,4 | 65-70 | 0 | 0 | 0 | 45-47.5 | 110-115 |
| Sheilagh Reavey | Director of Nursing & Quality (to 31 July 2020) | 5 | 260-265 | 0 | 0 | 0 | 0 | 260-265 |
| Jane Kinniburgh | Director of Nursing & Quality (from 1 August 2020) -29.23% | 1,12 | 20-25 | 0 | 0 | 0 | 0 | 20-25 |
| Avni Shah | Director of Primary Care Transformation (from 1 December 2020) -29.23 | 1 | 10-15 | 0 | 0 | 0 | 5-7.5 | 15-20 |
| Frances Shattock | Director of Performance & Delivery (from 1 March 2021) -29.23% | 1 | 0-5 | 0 | 0 | 0 | 0-2.5 | 0-5 |
| Phil Turnock | Chief Digital Officer | 6,12 | 105-110 | 5,600 | 0 | 0 | 0 | 110-115 |
| Prag Moodley | CCG Chair | 7 | 115-120 | 0 | 0 | 0 | £NIL | 115-120 |
| Ashish Shah | CCG Deputy Chair | 7,8 | 125-130 | 0 | 0 | 0 | £NIL | 125-130 |
| Tara Belcher | GP Board Member | 7 | 55-60 | 0 | 0 | 0 | £NIL | 55-60 |
| Sarah Dixon | GP Board Member | 7 | 55-60 | 0 | 0 | 0 | £NIL | 55-60 |
| Russell Hall | GP Board Member | | 50-55 | 0 | 0 | 0 | £NIL | 50-55 |
| Anindita Saha | GP Board Member | 7,9 | 100-105 | 0 | 0 | 0 | £NIL | 100-105 |
| Rupal Shah | GP Board Member | 7,10 | 60-65 | 0 | 0 | 0 | £NIL | 60-65 |
| Dianne Desmulie | Lay Member | | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| Linda Farrant | Lay Member | | 15-20 | 200 | 0 | 0 | 0 | 15-20 |
| Alison Gardner | Lay Member | 11 | 10-15 | 0 | 0 | 0 | 0 | 10-15 |
| Dermont O'Riordan | Secondary Care Specialist Doctor | | 10-15 | 0 | 0 | 0 | 0 | 10-15 |

**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.

The taxable benefits referred to in the table above relate to the re-imbursement of mileage incurred on official duties, unless included in the notes below. The benefit arises from the mileage allowance payments made to all staff, to reimburse them for expenses related to the use of their own vehicle for business travel. East and North Hertfordshire CCG pays the rate per mile set out in Agenda for Change, which exceeds the HMRC "approved mileage allowance payments" rate in 2020-21 of 45p a mile. The excess amount is taxable and is disclosed above.

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 - Beverley Flowers was Joint Hertfordshire & West Essex Sustainability & Transformation Partnership (STP) lead to 31 May 2021 at 40% WTE. The remuneration disclosed above relates only to the CCG role. Total remuneration is shown in the table below.

Note 3 - Jo Burlingham was appointed to the Board in an Interim role in June 2020, and prior to this held the position of Associate Director of Operations & Resilience. The remuneration disclosed relates to the period when appointed to the interim senior manager role.

Note 4 - Rachel Joyce was also Clinical and Professional Director for Hertfordshire & West Essex STP for the period April to Septemeber 2020 at 40% WTE. The remuneration disclosed above relates only to the CCG role. Total remuneration is shown in the table below.

Note 5 - On 1 August 2020 a joint appointment across the ICS and its 3 CCGs was made to the post of Director of Nursing & Quality. As a consequence the Director of Nursing & Quality roles in each CCG, including in E & N Hertfordshire CCG became redundant. A redundancy payment was made to Sheilagh Reavey in line with contractural entitlements.The remuneration disclosed includes £35,000-£40,000 basic pay for the period in office, £160,000 in respect of a compulsory redundancy payment, £55,00-£60,000 for payment in lieu of contractural notice and £5,000-£10,000 for payment of accrued and untaken leave.

Note 6 - 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 7 - 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 8 - The total remuneration for Dr Ashish Shah includes £5,000-£10,000 relating to a locality workforce lead role.

Note 9 - The total remuneration for Dr Anindita Saha includes £35,000-£40,000 relating to a clinical lead role.

Note 10 - The total remuneration for Dr Rupal Shah includes £0-£5,000 relating to a clinical lead role.

Note 11 - Alison Gardner was also a Lay Member of Herts Valleys CCG Board in 2020/21 for Patient and Public Involvement. The costs disclosed above are recharged by Herts Valleys CCG.

Note 12 - Jane Halpin, Jane Kinniburgh, Phil Turnock and Denise Boardman are not members of the NHS pension scheme.

The table below shows the total remuneration 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 | 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 (from 1 June 2020) | 140-145 | 0 | 0 | 0 | 0 | 140-145 |
| Alan Pond | E & N Herts CCG Chief Finance Officer (to 31 July 2020)/ Chief Finance Officer (from 1 August 2020) | 135-140 | 0 | 0 | 0 | 70-72.5 | 205-210 |
| Rachel Joyce | Medical Director & STP Clinical Director (to 30 September 2020)/ Director of Clinical & Professional Services (from 1 October 2020) | 145-150 | 0 | 0 | 0 | 102.5-105 | 250-255 |
| Jane Kinniburgh | Director of Nursing & Quality (from 1 August 2020) | 80-85 | 0 | 0 | 0 | 0 | 80-85 |
| Avni Shah | Director of Primary Care Transformation (from 1 December 2020) | 40-45 | 0 | 0 | 0 | 17.5-20 | 60-65 |
| Frances Shattock | Director of Performance & Delivery (from 1 March 2021) | 10-15 | 0 | 0 | 0 | 0-2.5 | 10-15 |
| Beverley Flowers | Accountable Officer & STP Lead (to 31 May 2020)/ Director of Integration & Systems Transformation (from 1 June 202 | 135-140 | 0 | 0 | 0 | 25-27.5 | 160-165 |

**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 the organisation and the median remuneration of the CCG's workforce, as at the reporting date (31 March 2021).

The banded remuneration of the highest paid director/member in East & North Hertfordshire CCG at the reporting date was £125,000-£130,000 (2019-20: £130,000-£135,000). This was 2.99 times (2019-20: 3.37) the median remuneration of the workforce, which was £42,685 (2019-20: £39,332).

In 2020-21 and 2019-20, at the reporting date, no employee received remuneration in excess of the highest paid director/member of the CCG's Governing body. In 2020-21 remuneration ranged from the highest paid director to £19,342 (2019-20: highest paid director to £17,465).

The main reason for the decrease in the ratio is due to the movement in the highest paid individual because of new management arrangements.

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 included in the Fair Pay disclosure were shared across the three CCGs and the ICS, for transparency, if the calculations had been based on the total salary for those directors, the following disclosure would apply.

The banded remuneration of the highest paid director/member in East & North Hertfordshire CCG at the reporting date was £170,000-£175,000 (2019-20: £130,000-£135,000). This was 4.04 times (2019-20: 3.37) the median remuneration of the workforce, which was £42,685 (2019-20: £39,332).

# PENSIONS BENEFITS 2021/22 (SUBJECT TO AUDIT)

| 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 | Acting Accountable Officer (from 1 November 2021-31 March 22) 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 | 25-30 | 312 | 17 | 336 | 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 |

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 | 65-70 | 95-100 | 1068 | 57 | 1151 | 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 |

EAST AND NORTH HERTFORDSHIRE CCG

Table 2: Pensions Benefits

Table 2: Pension Benefits 2020-2021

| 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 2021 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2020 | Real increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2021 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Relating to the period 1 April 2020 to 31st March 2021 | | | | | | | | | | |
| Jane Halpin | Accountable Officer (from 1 June 2020)-29.23% | 1,2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Beverley Flowers | Accountable Officer (to 31 May 2020) | 4 | 0-2.5 | 0 | 0-5 | 5-10 | 85 | 3 | 92 | 0 |
| Sharn Elton | Director of Operations (to 31 May 2020)/ Managing Director (from 1 June 2020) | | 5-7.5 | 7.5-10 | 55-60 | 125-130 | 918 | 100 | 1,052 | 0 |
| Alan Pond | Chief Finance Officer (to 31 July 2020)/ ICS Chief Finance Officer (from 1 August 2020)-29.23% | 1 | 0-2.5 | 0-2.5 | 30-35 | 45-50 | 507 | 39 | 565 | 0 |
| Denise Boardman | Director of Primary Care Development (to 30 June 2020) | 2,3 | 0 | 0 | 45-50 | 145-150 | 1,165 | 0 | 0 | 0 |
| Jo Burlingham | Interim Director of Operations (from 6 June 2020) | | 2.5-5 | 7.5-10 | 30-35 | 60-65 | 420 | 66 | 521 | 0 |
| Rachel Joyce | Medical Director (to 30 September 2020)/ Director of Clinical & Professional Services (from 1 October 202 | 1,5 | 2.5-5 | 0-2.5 | 20-25 | 50-55 | 395 | 41 | 452 | 0 |
| Sheilagh Reavey | Director of Nursing & Quality (to 31 July 2020) | | 0 | 0 | 40-45 | 130-135 | 1,067 | 12 | 1,103 | 0 |
| Jane Kinniburgh | Director of Nursing & Quality (from 1 August 2020)-29.23% | 1,2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Avni Shah | Director of Primary Care Transformation (from 1 December 2020 | 1 | 0-2.5 | 0-2.5 | 0-5 | 5-10 | 44 | 4 | 50 | 0 |
| Frances Shattock | Director of Performance & Delivery (from 1 March 2021)-29.23% | 1 | 0-2.5 | 0 | 0-5 | 0 | 0 | 0 | 1 | 0 |
| Phil Turnock | Chief Digital Officer | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Prag Moodley | CCG Chair | 6 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Ashish Shah | Deputy Clinical Chair | 6 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Tara Belcher | GP Board Member | 6 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Sarah Dixon | GP Board Member | 6 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Russell Hall | GP Board Member | | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Anindita Saha | GP Board Member | 6 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Rupal Shah | GP Board Member | 6 | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL | £NIL |
| Linda Farrant | Lay Member | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dianne Desmulie | Lay Member | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Alison Gardner | Lay Member | 7,8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dermot O'Riordan | Lay Member | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**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% from the date of appointment. For transparency the table below shows members total pension benefits across Hertfordshire and West Essex CCGs and ICS.**

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

**Note 3 - Denise Boardman ceased to be a member of the NHS pension scheme on 31 March 2020, retired on 30 June 2020 and is now in receipt of her pension. Values disclosed for accrued pension and Lump Sum related to accrued pension are those being paid or already paid. No Cash Equivalent Transfer Value is disclosed at 31 March 2021 because the pension is already being drawn.**

**Note 4 - Beverley Flowers held the position of joint Lead Officer for Hertfordshire & West Essex Sustainability & Transformation Partnership (STP) for the period to 31 May 2020 at 40% WTE. The disclosure above has been adjusted to reflect the CCG role only to 31 May 2020. For transparency, figures for the STP role, which is hosted by W Essex CCG are disclosed in the table below.**

**Note 5 - Rachel Joyce held the position of Clinical and Professional Director for Hertfordshire & West Essex STP for the period April to September 2020 at 40% WTE. The disclosure has been adjusted to reflect the CCG role only for this period. For transparency, figures for the STP role, which is hosted by W Essex CCG are disclosed in the table below.**

**Note 6 - 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 7 - As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions.**

**Note 8 - Alison Gardner was also a Lay Member of Herts Valleys CCG Board in 2020/21 for Patient and Public Involvement.**

**Note 9 - NHS employees contribute towards their pension benefits. In 2020/21 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 10 - 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 11 - 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).**

**Note 12 - The method used to calculate CETVs changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If the individual was entitled to GMP, this will affect the calculation of the real increase in CETV. This is more likely to affect the 1995 Section and the 2008 Section.**

**The table below shows the member's total pension benefits for the full year 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 2021 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2020 | Real increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2021 | Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|---|
| Jane Halpin | Accountable Officer (from 1 June 2020) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Alan Pond | E & N Herts CCG Chief Finance Officer (to 31 July 2020)/ Chief Finance Officer (from 1 August 2020) | 2.5-5 | 2.5-5 | 65-70 | 90-95 | 959 | 73 | 1068 | 0 |
| Rachel Joyce | Medical Director & STP Clinical Director (to 30 September 2020)/ Director of Clinical & Professional Services (from 1 October 2020) | 5-7.5 | 0-2.5 | 45-50 | 110-115 | 884 | 92 | 1013 | 0 |
| Jane Kinniburgh | Director of Nursing & Quality (from 1 August 2020) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Avni Shah | Director of Primary Care Transformation (from 1 December 2020) | 0-2.5 | 0-2.5 | 30-35 | 65-70 | 453 | 13 | 519 | 0 |
| Frances Shattock | Director of Performance & Delivery (from 1 March 2021) | 0-2.5 | 0 | 0-5 | 0 | 0 | 1 | 2 | 0 |
| Beverley Flowers | Accountable Officer & STP Lead (to 31 May 2020)/ Director of Integration & Systems Transformation (from 1 June 2020) | 0-2.5 | 0 | 45-50 | 95-100 | 850 | 29 | 913 | 0 |

# OFF-PAYROLL ENGAGEMENTS

**Table 4: Off-payroll engagements longer than 6 months (not subject to audit)**

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

| **Number of existing engagements as of 31 March 2022** | **15** |
|---|---|
| Of which… | |
| Number that have existed for less than one year at time of reporting | 0 |
| Number that have existed for between one and two years at time of reporting | 5 |
| Number that have existed for between two and three years at time of reporting | 1 |
| Number that have existed for between three and four years at time of reporting | 4 |
| Number that have existed for four or more years at time of reporting | 5 |

**Table 5: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months (not subject to audit)**

| **Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022** | 8 |
|---|---|
| Of which… | |
| Number assessed as caught by IR35 | 8 |
| Number assessed as not caught by IR35 | 0 |
| | |

| | |
|---|---|
| Number engaged directly (via PSC contracted to department) and are on the departmental payroll | 0 |
| Number of engagements re-assessed for consistency / assurance purposes during the year | 0 |
| Number of engagements that saw a change to IR35 | 0 |

**Table 6: Off-payroll board member/senior official engagements (not subject to audit)**

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

| | |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year | 7 |
| Number of individuals that have been deemed 'board members, and/or senior officials with significant responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements | 21 |

## EXPENDITURE ON CONSULTANCY (NOT SUBJECT TO AUDIT)

The total spend on consultants in 2021/22 is shown on page 188 of the accounts.

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

There are no exit packages for 2021-22. In 2020-21, there was one exit package totalling £224,478.

# 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 | £7,134.43 |
| Total pay bill | £16,128,991.28 |
| Percentage of the total pay bill spent on facility time | 0.04% |

**Table 10: Paid trade union activities**

| | |
|---|---|
| Time spent on paid trade union activities as a percentage of total paid facility time hours | 14.52% |

# 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[30] | 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.

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.

[30] 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.

*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.

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 in order to ensure equity and fairness, which will have a positive impact on the gender pay gap.

*Religion and beliefs*

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

| Religious Belief | 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:

| | |
|---|---|
| **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%** |

# EMPLOYEE BENEFITS (SUBJECT TO AUDIT)

**NHS East and North Hertfordshire CCG - Annual Accounts 2021-22**

**FOR ANNUAL REPORT ONLY**

**Employee benefits and staff numbers (subject to audit)**

| 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** |

| Employee benefits | 2020-21 Total £'000 | Permanent Employees £'000 | Other £'000 |
|---|---|---|---|
| Salaries and wages | 13,655 | 12,947 | 708 |
| Social security costs | 1,459 | 1,446 | 13 |
| Employer Contributions to NHS Pension scheme | 2,585 | 2,566 | 19 |
| Other pension costs | 3 | 3 | 0 |
| Apprenticeship Levy | 56 | 56 | 0 |
| Termination benefits | 224 | 224 | 0 |
| **Total employee benefits expenditure** | **17,982** | **17,242** | **740** |

**Average number of people employed (subject to audit)**

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

| | 2020-21 Total Number | Permanently employed Number | Other Number |
|---|---|---|---|
| **Total for CCG** | 274.3 | 263.8 | 10.5 |

NHS East and North Hertfordshire CCG - Annual Accounts 2021-22

**FOR ANNUAL REPORT ONLY**

**Exit packages agreed in the financial year (subject to audit)**

There are no exit packages for 2021-22. In 2020-21, there was one exit package totalling £224,478.

# HR shared service model

In order to continue to respond to the developing needs of the CCG, the human resources provision continues to be delivered via a shared service, hosted by Herts Valleys CCG. The service provides support to East and North Hertfordshire and West Essex CCGs.

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

CCG managers have access to the HRXtra service – a telephone and online resource providing advice and guidance on people and employee relations issues. In 2020/21, the HRXtra service held monthly face-to-face clinics at the CCG to increase accessibility and build rapport with managers. HRXtra have also provided a suite of management awareness sessions on people management topics such as having wellbeing conversations and compassionate leadership.

**Staff Policies**

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

**Whistleblowing**

The CCG has in place a 'Raising Concerns at Work – Whistleblowing' policy which provides staff with information and reassurance regarding their rights and responsibilities in reporting concerns. It sets out clearly how staff can report in confidence, good faith and without fear of retribution. As part of this policy, the CCG has nominated a lay member- Dianne Desmulie - to oversee the effectiveness of this process.

During 2021/22, the CCG introduced Freedom to Speak Up Champions to help keep the CCG safe and supported. Including the Lay Member there are nine trained champions based at the CCG, from different directorates, levels and backgrounds. To further support CCG staff eight of the champions have also been trained as Mental Health First Aiders.

**Training and values**

The compliance rate for mandatory training as at 31 March 2022 is 93%. Non-compliance is addressed via system alerts to relevant staff and their managers, OLM workshops and regular mandatory training reporting to Directors. The OLM system is fully operational and managers can view a dashboard of their teams' compliance in real time on My ESR.

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

During 2021/22 a wide range of optional learning and development opportunities were offered to staff via the MindTools web portal and face-to-face through the HR ODL shared service. The CCGs have 587 users registered with MindTools.

The CCG values are:

- Compassionate and caring
- Patient centred
- Striving for excellence
- Collaborative working

The values were coproduced with staff across the organisation.

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

**Apprenticeship Levy**

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

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

Employers with annual pay bills in excess of £3 million are required to pay 0.5 % of their pay-bill into the scheme. This means that East and North Hertfordshire CCG has an annual Levy budget of approximately £50k. The scheme has started to gain momentum in 2021 with four staff now taking part in the Apprenticeship programme. To date ENHCCG has one project management L4 apprentice, two completing their MBA and one completing their MSc through Ashridge. The CCG will continue to encourage staff to take up further opportunities.

**Health and safety**

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

During 2021/2022 the CCG obtained professional health and safety guidance through Hertfordshire County Council who also delivered virtual fire warden training for CCG staff. The CCG also completed its Fire Risk Assessment in line with its Annual Plan. Staff Mental Health First Aiders were formally trained online and 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 enabled staff to reclaim the costs of any equipment bought to enable effective working from home following a DSE assessment

The CCG has reviewed and refreshed our stress management policy and the developed a violence and aggression policy in partnership with management, staff-side and staff representatives.

## Employee consultation and communications

**Joint Partnership Forum**

The Joint Partnership Forum meets regularly, virtually during 2021/22, and is a chance for staff and union representatives to discuss key issues affecting their working lives with executive members and make plans for improvements.

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

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

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

**Staff Survey**

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

- 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 the 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 will take place across 5 months (May to September) with 5 themes with one Executive lead sponsoring each month. Staff will collaborative through various fora including focus groups and engaging with staff partnerships and the joint partnership group.

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

# Staff health and wellbeing

The CCG is fully committed to the health and positive wellbeing of its employees. The emphasis in this area has been especially important during the challenges of the past year and the CCG understands that a healthy and happy workforce is crucial to delivering improvements in patient care.

The CCG introduced a new Employee Assistance Programme (EAP) in 2020, provided by Vita Health group accessed through a free and confidential helpline.

The CCG now have a total of 16 members of staff who are trained 'Mental Health First Aiders', who support staff with a listening ear and signpost them to appropriate local services. The CCG also has access to occupational health services, to support staff with health concerns.

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

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

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

- Here for You programme has been launched for NHS staff. This is a service that is managed by our local psychologists
- Team building activities to support job role and partnership working
- HR masterclasses being promoted and delivered to line managers to ensure absence and performance issues are addressed at an early stage
- Compassionate leadership approach through coaching conversations with staff
- Health and wellbeing conversation training for all managers to promote a positive culture for health and wellbeing
- Launched Health and Wellbeing internet site so staff have a central point to access health and wellbeing resources and information for key services
- Staff have access to the HR ODL intranet that has a wealth of information on health and wellbeing
- Menopause awareness webinars
- Financial wellbeing; individual pensions and financial awareness sessions
- Access to carer information and resources

## Equality of opportunity for staff

Our organisation's **commitment** to challenging inequalities in the workplace and improving opportunities for all of our staff. Staff are encouraged to discuss equality issues within team meetings and bring forward comments and suggestions. Our BAME staff which aims to empower staff from Black, Asian or minority ethnic backgrounds to engage with the organisation in a meaningful way and to discuss ways in which the experience and opportunities within the CCG can be improved and co-produce our Race equality action plan. Our organisation promotes diversity and inclusion training and has held a number of popular lunch and learn bitesize workships which 146 staff across Herts and West Essex CCGs have attended

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

# PART THREE: PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

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 2021/22.

# EXTERNAL AUDIT OPINION

## INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS EAST AND NORTH HERTFORDSHIRE CLINICAL COMMISSIONING GROUP

## INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY 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 year ended 31 March 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 2021-22 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2021-22.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS East and North Hertfordshire Clinical Commissioning Group as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2021-22; 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.

### 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 CCG's ability to continue as a going concern 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.

### 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 will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to Hertfordshire and West Essex ICB.

Given the expected continuation of the CCG's services by other entities after the demise of the CCG, the CCG's financial statements have been prepared on a going concern basis in accordance with the requirements of the Group Accounting Manual 2021-22. Our opinion is not modified in respect of this matter.

## 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 (Revised 2020) issued by the Public Audit Forum. Our responsibilities in this respect are further described in the Auditor's other responsibilities section of our report. We believe the evidence obtained from this work, in conjunction with the evidence we have obtained in our audit of the financial statements, is sufficient and appropriate to provide a basis for our opinion on regularity.

## Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is subject to audit. In our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with Department of Health and Social Care's Group Accounting Manual 2021-22.

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

### *Matter on which we are required to report by exception*

We are required to report to you if, in our opinion, we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

We reported the outcome of our work on the CCG's arrangements in our commentary on those arrangements within the Auditor's Annual Report.

### *Responsibilities of the Accountable Officer*

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

*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 December 2021.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following other matters which the Local Audit and Accountability Act 2014 requires us 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.

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.

As explained in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is also responsible for the propriety and regularity of the public finances for which the Accountable Officer is answerable and for ensuring the CCG exercises its functions effectively, efficiently and economically.

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.

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 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.

We are also required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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.

## 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 and involving relevant internal and or external specialists, including specialist expertise to support our testing of IT General Controls regarding 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, posting of unusual journals and use of management estimates and judgements;
- 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 year does not exceed the amount specified by NHS England; and
- performing procedures designed to gain assurance over the accuracy and completeness of exit packages and whether any such severance arrangements that included characteristics that could be defined as special severance payments, if identified, received the required HM Treasury approval.

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 Governance and Audit Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Governing Body; and
- 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.

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.

## Certificate

We certify that we have completed the audit of NHS East and North Hertfordshire Clinical Commissioning Group for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

## Use of our report

This report is made solely to the Members of the Governing Body of NHS East and North Hertfordshire Clinical Commissioning Group, as a body, 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 Governing Body those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the Members of the Governing Body of the CCG as a body, for our audit work, this report, or for the opinions we have formed.

Lisa Blake
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK

27 June 2022

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

# ACCOUNTS 2021/22

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

| | Note | 2021-22 £'000 | 2020-21 £'000 |
|---|---|---|---|
| Revenue from contracts with customers | 2 | (12,131) | (11,679) |
| Other operating income | 2 | (212) | (173) |
| **Total operating income** | | **(12,343)** | **(11,852)** |
| Staff costs | 3 | 17,396 | 17,982 |
| Purchase of goods and services | 4 | 926,242 | 882,162 |
| Depreciation | 4 | 972 | 911 |
| Provision expense | 4 | 868 | 156 |
| Other Operating Expenditure | 4 | 482 | 448 |
| **Total operating expenditure** | | **945,960** | **901,659** |
| **Net Operating Expenditure** | | **933,617** | **889,807** |
| **Total Comprehensive Expenditure for the year ended 31 March 2022** | | **933,617** | **889,807** |

The notes on pages 184 to 186 form part of this statement.

**Statement of Financial Position as at 31 March 2022**

| | Note | 31 March 2022 £'000 | 31 March 2021 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 6 | 1,663 | 2,416 |
| Trade and other receivables | 7 | 229 | 216 |
| **Total non-current assets** | | 1,892 | 2,632 |
| **Current assets:** | | | |
| Trade and other receivables | 7 | 6,531 | 9,746 |
| Cash | 8 | 640 | 508 |
| **Total current assets** | | **7,171** | 10,254 |
| **Total assets** | | **9,063** | **12,886** |
| **Current liabilities** | | | |
| Trade and other payables | 9 | (60,179) | (57,410) |
| Provisions | | (452) | (243) |
| **Total current liabilities** | | **(60,631)** | (57,653) |
| **Total Assets less Current Liabilities** | | **(51,568)** | (44,767) |
| **Non-current liabilities** | | | |
| Provisions | | (282) | 0 |
| **Total non-current liabilities** | | **(282)** | 0 |
| **Assets less Liabilities** | | **(51,850)** | (44,767) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (51,850) | (44,767) |
| **Total taxpayers' equity:** | | **(51,850)** | (44,767) |

The notes on pages 184 to 186 form part of this statement.

The financial statements on pages 180 to 196 were approved by the Governance and Audit Committee (on behalf of the Governing Body) on 16 June 2022 and signed on its behalf by:

Jane Halpin
Accountable Officer

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

| | 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)** |

| | General fund £'000 |
|---|---|
| **Changes in taxpayers' equity for 2020-21** | |
| **Balance at 1 April 2020** | (51,350) |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21** | |
| Net operating expenditure for the financial year | (889,807) |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year including balance brought forward from previous year** | (941,157) |
| Net funding | 896,390 |
| **Balance at 31 March 2021** | (44,767) |

The notes on pages 184 to 186 form part of this statement.

## Statement of Cash Flows for the year ended 31 March 2022

| | Note | 2021-22 £'000 | 2020-21 £'000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (933,617) | (889,807) |
| Depreciation | 4 | 972 | 911 |
| Decrease in trade & other receivables | 7 | 3,202 | 209 |
| Increase / (Decrease) in trade & other payables | 9 | 2,769 | (7,715) |
| Provisions utilised | | (377) | (28) |
| Increase in provisions | | 868 | 157 |
| **Net Cash Outflow used in Operating Activities** | | **(926,183)** | (896,273) |
| **Cash Flows from Investing Activities** | | | |
| Payments for property, plant and equipment | | (219) | 0 |
| **Net Cash Outflow used in Investing Activities** | | **(219)** | 0 |
| **Net Cash Outflow before Financing** | | **(926,402)** | (896,273) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 926,534 | 896,390 |
| **Net Cash Inflow from Financing Activities** | | **926,534** | 896,390 |
| **Net Increase in Cash** | 8 | **132** | 117 |
| **Cash at the Beginning of the Financial Year** | | **508** | 391 |
| **Cash at the End of the Financial Year** | | **640** | 508 |

The notes on pages 184 to 186 form part of this statement.

**Notes to the financial statements**

## 1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups (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 2021-22 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 Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to 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. Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022, 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 CCG 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.

As 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 rather than on a percentage completion based upon performance obligations.

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

1.6 **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.

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

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the scheme is taken as equal to the contributions payable to the 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.

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

The Department of Health and Social Care GAM does not require the following IFRS Standard and Interpretation to be applied in 2021-22:

● IFRS 16 Leases – This has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard.

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

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

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

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

Having undertaken a detailed impact assessment of IFRS 16 and applying the transition processes as indicated above, the CCG concluded that this standard does not have a material impact on the financial statements of the CCG in 2021-22, had the standard been implemented in that year.

**2 Other Operating Revenue**

| | **2021-22 Total £'000** | 2020-21 Total £'000 |
|---|---|---|
| **Revenue from contracts with customers** | | |
| Non-patient care services to other bodies | 11,870 | 11,554 |
| Other revenue | 261 | 125 |
| **Total Income from sale of goods and services** | 12,131 | 11,679 |
| | | |
| **Other operating income** | | |
| Non cash apprenticeship training grants revenue | 20 | 4 |
| Other non contract revenue | 192 | 169 |
| **Total Other operating income** | 212 | 173 |
| | | |
| **Total Operating Income** | **12,343** | 11,852 |

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)**

| **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** |

| 2020-21 | **Non-patient care services to other bodies £'000** | **Other Contract Income £'000** | **Total £'000** |
|---|---|---|---|
| Source of Revenue | | | |
| NHS | 11,518 | 0 | 11,518 |
| Non NHS | 36 | 125 | 161 |
| **Total** | **11,554** | **125** | **11,679** |

**3. Employee benefits**

| **3.1 Employee benefits** | **2021-22 Total £'000** | 2020-21 Total £'000 |
|---|---|---|
| Salaries and wages | 13,505 | 13,655 |
| Social security costs | 1,361 | 1,459 |
| Employer Contributions to NHS Pension scheme | 2,466 | 2,585 |
| Other pension costs | 6 | 3 |
| Apprenticeship Levy | 58 | 56 |
| Termination benefits | 0 | 224 |
| **Gross employee benefits expenditure** | **17,396** | **17,982** |

**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 in 2021-22 (2020-21 £144k).

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

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

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

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

## 4. Operating expenses

| | 2021-22 Total £'000 | Restated (Notes 1, 2 and 3) 2020-21 Total £'000 |
|---|---|---|
| **Purchase of goods and services** | | |
| Services from other CCGs and NHS England | 651 | 668 |
| Services from foundation trusts | 163,531 | 159,664 |
| Services from other NHS trusts | 437,622 | 424,398 |
| Services from other WGA bodies | 1 | 0 |
| Purchase of healthcare from non-NHS bodies | 112,824 | 90,287 |
| Purchase of social care | 14,959 | 14,405 |
| Prescribing costs | 85,834 | 88,956 |
| GPMS/APMS and PCTMS | 96,822 | 87,780 |
| Supplies and services – clinical | 40 | 10 |
| Supplies and services – general | 1,605 | 1,819 |
| Consultancy services | 286 | 745 |
| Establishment | 9,423 | 9,754 |
| Transport | 345 | 699 |
| Premises | 1,626 | 2,131 |
| Audit fees (Note 1) | 71 | 64 |
| Other non statutory audit expenditure | | |
| · Other services (Note 2) | 13 | 12 |
| Other professional fees (Note 3) | 299 | 365 |
| Legal Fees | 114 | 58 |
| Education and training | 156 | 343 |
| Non cash apprenticeship training grants | 20 | 4 |
| **Total Purchase of goods and services** | **926,242** | 882,162 |
| **Depreciation** | | |
| Depreciation | 972 | 911 |
| **Total Depreciation** | **972** | 911 |
| **Provision expense** | | |
| Provisions | 868 | 156 |
| **Total Provision expense** | **868** | 156 |
| **Other Operating Expenditure** | | |
| Chair and Non Executive Members | 185 | 185 |
| Expected credit (gain)/loss on receivables | (2) | 2 |
| Other expenditure | 299 | 261 |
| **Total Other Operating Expenditure** | **482** | 448 |
| **Total operating expenses** | **928,564** | 883,677 |

Note 1

Audit fee is shown inclusive of VAT and the net amount was £58.9k. At the time of finalising the 2020-21 financial statements, the agreed audit fee was £53.5k (net). However a fee variation of £5.4k (net) was subsequently proposed and agreed bringing the total audit fee for 2020-21 to £58.9k (net). This additional fee variation for 2020-21 had earlier been disclosed under Other Professional fees.

Limitation on auditor's liability for external audit work carried out for the financial year 2021-22 is £1million.

Note 2

Fees for non audit assurance services include the review of the Mental Health Investment Standard. This is shown inclusive of VAT and the net amount is £10.5k (2020-21 £10k). In the previous year, this was shown under Audit Fees and the comparator has been restated accordingly.

Note 3

Other professional fees includes the sum of £42k for Internal Audit Fees (2020-21 £42k). Internal audit fees is shown net of VAT.

**5 Better Payment Practice Code**

| **Measure of compliance** | **2021-22 Number** | **2021-22 £'000** | 2020-21 Number | 2020-21 £'000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 23,522 | 259,654 | 21,777 | 232,598 |
| Total Non-NHS Trade Invoices paid within target | 23,294 | 257,750 | 21,661 | 231,208 |
| **Percentage of Non-NHS Trade invoices paid within target** | 99.03% | 99.27% | 99.47% | 99.40% |
| | | | | |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 655 | 603,069 | 1,402 | 607,725 |
| Total NHS Trade Invoices Paid within target | 647 | 602,906 | 1,370 | 603,171 |
| **Percentage of NHS Trade Invoices paid within target** | 98.78% | 99.97% | 97.72% | 99.25% |

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**

| **2021-22** | **Information technology £'000** | **Furniture & fittings £'000** | **Total £'000** |
|---|---|---|---|
| **Cost or valuation at 1 April 2021** | 5,100 | 597 | 5,697 |
| Additions purchased | 219 | 0 | 219 |
| Disposals other than by sale | (1,207) | 0 | (1,207) |
| **Cost/Valuation at 31 March 2022** | **4,112** | **597** | **4,709** |
| **Depreciation 1 April 2021** | 2,996 | 285 | 3,281 |
| Disposals other than by sale | (1,207) | 0 | (1,207) |
| Charged during the year | 847 | 125 | 972 |
| **Depreciation at 31 March 2022** | **2,636** | **410** | **3,046** |
| **Net Book Value at 31 March 2022** | **1,476** | **187** | **1,663** |
| Purchased | 1,476 | 187 | 1,663 |
| **Total at 31 March 2022** | **1,476** | **187** | **1,663** |
| **Asset financing:** | | | |
| Owned | 1,476 | 187 | 1,663 |
| **Total at 31 March 2022** | **1,476** | **187** | **1,663** |

The CCG did not hold any revaluation reserve balance for property, plant & equipment in 2021-22 and 2020-21.

| **7 Trade and other receivables** | **Current 31 March 2022 £'000** | **Non-current 31 March 2022 £'000** | Current 31 March 2021 £'000 | Non-current 31 March 2021 £'000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 2,832 | 0 | 5,695 | 0 |
| NHS prepayments | 0 | 0 | 71 | 0 |
| NHS accrued income | 0 | 0 | 994 | 0 |
| Non-NHS and Other WGA receivables: Revenue | 314 | 0 | 441 | 0 |
| Non-NHS and Other WGA prepayments | 3,274 | 229 | 2,296 | 216 |
| Non-NHS and Other WGA accrued income | 0 | 0 | 27 | 0 |
| VAT | 92 | 0 | 219 | 0 |
| Other receivables and accruals | 19 | 0 | 3 | 0 |
| **Total Trade and Other Receivables** | **6,531** | **229** | **9,746** | **216** |
| **Total current and non current** | **6,760** | | **9,962** | |

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

**8 Cash**

| | **2021-22 £'000** | 2020-21 £'000 |
|---|---|---|
| **Balance at 1 April** | 508 | 391 |
| Net change in year | 132 | 117 |
| **Balance at 31 March** | **640** | **508** |
| Made up of: | | |
| Cash with the Government Banking Service | 640 | 507 |
| Cash in hand | 0 | 1 |
| **Balance at 31 March** | **640** | **508** |

There were no patients' monies held by the clinical commissioning group in 2021-22 and 2020-21.

| **9 Trade and other payables** | **Current 31 March 2022 £'000** | Current 31 March 2021 £'000 |
|---|---|---|
| NHS payables: revenue | 481 | 1,315 |
| NHS accruals | 458 | 1,090 |
| NHS deferred income | 0 | 234 |
| Non-NHS and Other WGA payables: Revenue | 8,799 | 7,708 |
| Non-NHS and Other WGA accruals | 47,287 | 44,980 |
| Non-NHS and Other WGA deferred income | 18 | 81 |
| Social security costs | 239 | 225 |
| Tax | 218 | 198 |
| Other payables and accruals | 2,679 | 1,579 |
| **Total Trade and Other Payables** | **60,179** | **57,410** |
| Total current and non-current | **60,179** | **57,410** |

Other payables include £1,052k (£268k employees and £784k GP Practices) outstanding pension contributions at 31 March 2022 (£747k: £255k employees and £492 GP Practices - 31 March 2021).

## 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.

#### 10.1.1 Credit risk

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 31 March 2022 £'000** | Financial Liabilities measured at amortised cost 31 March 2021 £'000 |
|---|---|---|
| Trade and other payables with NHSE bodies | 265 | 949 |
| Trade and other payables with other DHSC group bodies | 1,061 | 18,554 |
| Trade and other payables with external bodies | 58,378 | 37,169 |
| **Total at 31 March** | **59,704** | **56,672** |

## 11 Operating segments

The CCG considers they have only one segment in 2022-21 and 2020-21: Commissioning of healthcare services.

| | **2021-22 £'000** | 2020-21 £'000 |
|---|---|---|
| Commissioning of healthcare services | **933,617** | **889,807** |

**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 for 2021-22 and 2020-21 were:

| **2021-22** | **Mental Health, Learning Disabilities & CAMHS** (Note) | | **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) |

Note

The contribution of the CCG also included £88,569k 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.

| **2020-21** | 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 |
| | 2020-21 £000 | 2020-21 £000 | 2020-21 £000 | 2020-21 £000 | 2020-21 £000 | 2020-21 £000 | 2020-21 £000 | 2020-21 £000 | 2020-21 £000 |
| Contribution | 373,552 | 91,632 | 5,956 | 1,428 | 5,794 | 1,960 | 23,413 | 14,771 | 109,791 |
| Expenditure | 373,727 | 91,723 | 6,079 | 1,457 | 6,092 | 2,312 | 18,854 | 14,771 | 110,263 |
| Total Variance | (175) | (91) | (123) | (29) | (298) | (352) | 4,559 | 0 | (472) |

**13 Related party transactions**

**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:

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 | 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

2020-21 comparators are shown on the following page.

**13a Related party transactions (2020-21)**

**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 clinical commissioning group.

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 | 1,922 | 0 | 5 | 0 |
| King George Surgery - Dr. A Saha | 2,442 | 0 | 18 | 0 |
| Portmill Surgery - Dr. T Belcher | 1,832 | 0 | 0 | 0 |
| South Street Surgery - Dr. S Dixon | 2,274 | 0 | 7 | 0 |
| Stanmore Medical Group - Dr. P Moodley | 5,083 | 0 | 61 | 0 |
| Wrafton House Surgery - Dr. A Shah | 1,169 | 0 | 4 | 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 | 40 | 0 | 0 | 0 |
| The following are payments made in the normal course of business to GP Federations of which GP practices are shareholders. | | | | |
| 12 Point Care | 2,891 | 0 | 93 | 0 |
| Ephedra Healthcare Limited | 782 | 0 | 0 | 0 |
| Stort Valley Health Care Limited | 1,175 | 0 | 8 | 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 clinical commissioning group 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
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**

The Health and Care Act received Royal Assent on 28 April 2022. Subject to the issue of an establishment order by NHS England, the CCG will be dissolved on 30 June 2022. On 1 July the assets, liabilities and operations will transfer to 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:

| | **2021-22 Target** | **2021-22 Performance** | 2020-21 Target | 2020-21 Performance |
|---|---|---|---|---|
| | **£'000** | **£'000** | £'000 | £'000 |
| Expenditure not to exceed income | 946,311 | 946,179 | 901,659 | 901,659 |
| Capital resource use does not exceed the amount specified in Directions | 219 | 219 | 0 | 0 |
| Revenue resource use does not exceed the amount specified in Directions | 933,749 | 933,617 | 889,807 | 889,807 |
| 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 | 12,005 | 11,194 | 12,013 | 11,693 |

# Accessibility Report

**Filename:** 06K_ENHCCG_ANNUAL_REPORT_AND_ACCOUNTS_FINAL___for_website_signatures_removed.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: 22
- Failed: 7

## 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 | Passed | 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 | Failed | All annotations are tagged |
| Tab order | Failed | Tab order is consistent with structure order |
| Character encoding | Passed | 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 | Passed | Figures require alternate text |
| Nested alternate text | Passed | Alternate text that will never be read |
| Associated with content | Passed | Alternate text must be associated with some content |
| Hides annotation | Passed | Alternate text should not hide annotation |
| Other elements alternate text | Failed | Other elements that require alternate text |

### Tables

| Rule Name | Status | Description |
|---|---|---|
| Rows | Passed | TR must be a child of Table, THead, TBody, or TFoot |
| TH and TD | Passed | 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 | Passed | LI must be a child of L |
| Lbl and LBody | Passed | Lbl and LBody must be children of LI |

### Headings

| Rule Name | Status | Description |
|---|---|---|
| Appropriate nesting | Passed | Appropriate nesting |

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