NHS
Herts Valleys
Clinical Commissioning Group

ANNUAL REPORT AND ACCOUNTS

Q1 2022/23

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NHS Herts Valleys
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Accountable Officer

Date signed: 5th October 2022

PERFORMANCE REPORT: OVERVIEW OF PERFORMANCE

This section contains a summary of our performance as an organisation during 2022/23 plus a flavour of the work we do. You can read more about our work at: www. hertsvalleysccg.nhs.uk

ABOUT US

We are the local NHS organisation which plans and pays for the health services used by almost 627,000 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 £1bn should be spent.

We aim to:

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

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

WHAT IS COMMISSIONING?

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

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

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

Our role is to:

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

Our strategic objectives, which guide our work, are available on **our website**. Performance of the organisation is regularly reported to and discussed at the CCG's Board, which met virtually in public in June. This includes Board meetings in common with West Essex Clinical Commissioning Group, East and North Hertfordshire Clinical Commissioning Group and as the organisations move towards integration into the Hertfordshire and West Essex Integrated Care Board in July 2022/23.

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

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

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

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

PROVIDING CARE

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

The main hospitals our patients use are **West Hertfordshire Teaching Hospitals 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. Mental health and learning disability services are also provided by **Hertfordshire Partnership 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 **Hemel Hempstead** and **St Albans** (temporarily closed for infection prevention and control (IPC) purposes)**.**

The CCG also commissions community providers to deliver services including termination of pregnancy, vasectomy, In vitro fertilisation **(**IVF), end of life care, non-emergency patient transport and optometry.

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

Provider	
Buckinghamshire Healthcare NHS Trust	Acute
Central London Community Healthcare NHS Trust	Community
East & North Hertfordshire NHS Trust	Acute
East of England Ambulance Service NHS Trust	Ambulance
Hertfordshire Community NHS Trust	Community
Hertfordshire Partnership University NHS Foundation Trust	Mental Health
Imperial College Healthcare NHS Trust	Acute
Bedfordshire Hospitals NHS Foundation Trust	Acute
Royal Free London NHS Foundation Trust	Acute
Royal National Orthopaedic Hospital NHS Trust	Acute
University College London Hospitals NHS Foundation Trust	Acute
West Hertfordshire Teaching Hospitals NHS Trust	Acute

Hertfordshire County Council	Community
London North West Healthcare NHS Trust	Acute
Guys and St Thomas' NHS Foundation Trust	Acute

9.2% of the CCG's budget (a total of around £94.3m) is spent on primary care services. More information about our expenditure in 2022/23 can be found from page 62.

HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE SYSTEM (ICS)

What are integrated care systems?

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

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

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

Providers working together

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

These provider collaboratives have been developing, and NHS E/I and NHS Improvement will provide further guidance this year.

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

CHIEF EXECUTIVE'S SUMMARY AND ANALYSIS OF KEY PERFORMANCE

At the time this report is published, in the summer of 2022, 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. 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 42.

Transition to an Integrated Care Board (ICB)

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

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

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

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

Caring for our staff

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

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

Delivering services differently

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

A new ‘Shared Care Record’ has also started rolling out in Hertfordshire and west Essex to increase the information available to support joined-up direct care. The aim of the Shared Care Record is to allow health and care professionals access to a real-time summary of information from within a patient record. This information is used safely and securely to support patients as they move between different parts of the NHS and social care. GP practices are in the first phase of roll-out along with East and North Hertfordshire and The Princess Alexandra Hospital 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 clinicians actively accessing records. 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 Teaching Hospitals NHS Trust (WHTH) 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 are 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 being 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 access rapidly 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[1]) 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

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

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 great 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 present; providing translated materials, and communicating through trusted community and business leaders, there has 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-19 infection and isolation continue to impact across the board. This winter our system, like others across the country, has experienced increased activity in emergency departments, through our NHS 111 service and in primary care. Our mitigations, which I will go on to describe in more detail shortly, have enabled us to weather much of the storm, however for the first time our system has been planning a number of 'in extremis' measures for our urgent and emergency care services that we would hope never to need to implement.

As is usually the case during winter, our hospitals have been planning how they might rapidly increase their critical care capacity if required to do so. This surge planning is supported by the CCGs who also ensure that hospitals are able to work together to manage

ambulances arriving at emergency departments when a particular acute trust is under immense pressure. We work closely with the region's ambulance service to drive up performance. You can read more about this in the detailed performance information on page 44.

This year, at the request of NHS E/I and Improvement, 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. Primary care and hospital services have seen an increase in severe respiratory illness in children and babies this year.

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

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, The Princess Alexandra Hospital NHS Trust and West Hertfordshire Teaching 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 are kept to a minimum and are managed. Additional capital funding has been made available to our system to develop surgical hubs to increase bed capacity and to further separate planned from emergency activity to minimise disruption to routine surgery lists.

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

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

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 magnetic resonance imaging (MRI), computed tomography (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 and Improvement.

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

Key investments and developments include:

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

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

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

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

Improving access to primary care

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

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

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

In early 2022, the three CCGs and NHS E/I and Improvement funded 238,000 extra appointments until the end of March across the 135 GP practices in our area. These appointments were offered in usual practice operating hours, in extended hours services as well as in the respiratory hubs which are set up to safely care for patients with COVID. All GP practices have also received a supportive visit from the CCG to help resolve problems and share best practices. Work is also underway to improve GP practice phone access across the ICS, as out of date telephone systems are 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 been 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 2022/23

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

Improving access is one of the key work programmes as outlined across Hertfordshire and West Essex ICS (HWE) under the 'Restoration Framework' for Primary Care. The restoration framework is dependent on other areas including digital, primary care workforce, communication and engagement with patients and stakeholders.

The ICS ambition to continuously improve patient experience and outcomes through partnership working with primary care provider, patients and the LMC.

Key themes across the board include support with the following areas, with work ongoing throughout Q1 of 2022/23:

- Advanced telephony – support to enable practices to implement to improve patient access.

- Access to estates – through digitalisation of notes (EMIS practices underway for approximately 15 practices); off-site storage of note – project manager identified to progress this across HWE.

- Communications and engagement including patient education on ARRS roles; more support with social media, patient information system in the waiting rooms; support for websites. Specific support has included - Leaflet prepared to go out across key A&E usage postcodes across Hertfordshire and west Essex. This leaflet promotes GP practices and reminds people of how to access services as well as other methods of support such as pharmacies and NHS 111. This is being distributed across approx. 390,000 households; GP communications toolkit developed with materials on a range of topics including messaging around GP practice mask wearing for the public; Press release reminding the public of their role to play in wearing face masks when attending general practice and other health settings.

- Support in recruitment to primary care workforce – enhanced promotion of Primary Care Careers to show the benefits

- Support in supervision and support of all workforce – development of an approach to PCN learning organisation

- Plea to continue support with additional appointments as demand seems to continue

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. 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., 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. 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.

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[2], the total number of appointments attended across East & North Hertfordshire in June 2022 rose to 242,119 an increase of 19% when compared to June 2019, as a comparison of the pre-pandemic position.

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.

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

Primary Care Covid Response

Vaccination Programme

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

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

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

Seasonal Influenza Vaccination Programme

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

Primary Care Network Directed Enhanced Service (PCNDES)

NHSE PCN Plans for 2022/23

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

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

Key highlights for PCNs include:

- Confirmation of the increase in Additional Role Reinbursement Scheme (ARRS) funding for 22/23 and PCNs encouraged to maximise available funding.
- DES funding confirmed for Clinical Directors and Core Funding to support running, leadership and management of PCNs

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

Additional Role Reimbursement (ARR) Scheme

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

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

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

PCN Development Fund

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

Support development and maturity of PCNs including enhancing integration

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

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

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

Initial Accommodation Centres

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

For **South-West Herts area**, there are 4 Hotels and are supported by 5 GP Practices (1 Hotel is assigned to 2 GP Practices) by a Local Enhanced Service arrangement.

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

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

NHSE have confirmed there is no new funding guidance for 2022/23 – this is not likely to happen until a new Prime Minister is appointed. NHSE have stated the ICB should not make any further claims, however this is new information and ICB'S still have outreach GP sessions taking place at Bridging Hotels. Decision to be made if the ICB can continue funding this or a further decision is made to stand-down GP support (with notice). This would need to be managed sensitively with engagement with system partners and voluntary partners that provide on-site support.

Primary Care Premises

Common to all three CCGs is that the Premises Team continued to work with all practices and PCNs to further develop the PCN Workbooks which contained information on GP

practice premises as existing, plotted the planned housing growth and considered how the impact could be managed. This has enabled Practices and PCNs working in conjunction with the Premises Team to start to develop infrastructure plans. NHSEI launched their national programme of PCN Toolkits, working together with a blend of the data captured, clinical strategies and the infrastructure to support the ongoing demands in primary care will be developed. NHSEI have advised that this level of detail and planning will be necessary when considering future funding for both capital and revenue schemes.

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

To better inform the data of practice premises NHSEI have also funded 3 facet surveys on c70% of the primary care portfolio, this work is in progress and expected to complete during September 2022.

The primary care data gathering exercise, also commissioned by NHSEI completed during the reporting period.

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

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

The Premises Team has supported all other directorates at committees, panels, meetings as well as individual practices on premises issues relating to mergers, applications for branch closures, new leases, extended leases, extended access, vaccines etc.

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

During the reporting period, the only Estates Technology Transformation Fund (ETTF) project outstanding to complete was the extensively extended and improved premises at Parkwood in Hemel Hempstead which competed in late April 2022.

The Premises Team continue to support the following practices that have commissioners support and/or approval for new, extended or improved practice premises:

- Grovehill Surgery in Hemel Hempstead
- Vine House Surgery in Watford
- Holywell (branch of Attenborough) Surgery in Watford
- Garston Medical Centre
- Consulting Rooms at South Oxhey
- Manor View Surgery in Bushey for new branch premises
- Maltings Surgery in St Albans
- Midway Surgery in St Albans
- Schopwick Surgery in Elstree

Works at Watford Health Centre to fit out the additional acquired space started during the reporting period and will complete in October 2022.

SUMMARY OF PERFORMANCE QUARTER 1 OF 2022/23

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

The final Quarter 1 of 2022/23 positions are set out below:

A&E four hour operational standard

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

Performance at West Hertfordshire Hospitals NHS Trust remains challenged and failed to achieve the national standard:

A&E		Target	2021/22	Q1 22/23
A&E	Treated/Admitted/Transferred in under 4 hours	**95%**	**72.55%**	**60.25%**

ED attendances have remained consistently above historical average this has coincided with a period of deterioration in performance against the 4hr standard. The Trust has high demand and growth in attendances, a high number of ambulance conveyances and a continued increase in Mental Health presentation.

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)

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

EEAST Ambulance Response		Target	2021/22	Q1 22/23
EEAST Ambulance Response	C1 People with life threatening injuries and illness	**<7 minutes**	**08:31**	**09:18**
	C2 Emergency Calls	**<18 minutes**	**35:32**	**52:40**
	C3 Urgent Calls	**<120 minutes**	**262:48**	**363:49**
	C4 Less Urgent Calls	**<180 minutes**	**367:29**	**516:09**

Waiting times for cancer treatment

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

Two-week waits

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

28 day Faster Diagnosis Standards (FDS)

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

31 days

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

62 days

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

Table: Cancer waiting times for all Herts Valleys CCG patients

Performance remains challenged in Quarter 1 in the number of patients receiving their first appointment within 2 weeks, as well as those receiving a diagnosis within 28 days.

62day performance improved for the Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers, and targets met for 31 day waits.

Cancer Waiting Times at CCG Level		Target	2021/22	Q1 22/23
Two Week Waits	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	**93%**	**77.47%**	**67.78%**
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	**93%**	**62.46%**	**10.13%**
28 Day Faster Diagnosis (FDS)	Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request	**75%**	**71.16%**	**59.64%**
31 Day Waits	Maximum one month (31-day) wait FROM diagnosis to first definitive treatment for all cancers	**96%**	**95.83%**	**94.99%**
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	**94%**	**88.97%**	**84.62%**
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	**98%**	**99.82%**	**100.00%**

	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	**94%**	**98.18%**	**95.17%**
62 Day Waits	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	**85%**	**75.00%**	**63.02%**
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	**90%**	**72.83%**	**81.48%**
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	**85%**	**81.95%**	**74.74%**

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.

The table below [3] details the RTT performance for Herts Valleys CCG patients in Quarter 1 of 2022/23. Performance remains challenged and failed to achieve the national standard:

RTT Waiting Times		Target	2021/22	Q1 22/23
18 Weeks	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	**95%**	**70.21%**	**61.40%**

[3] Data shown is a 'snapshot' at end of June 2022

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 [4] The table details the Diagnostic performance for Herts Valleys CCG patients in Quarter 1 of 2022/23. Performance remains challenged and failed to achieve the national standard:

Diagnostic Waiting Times		Target	2021/22	Q1 22/23
6 Weeks	Percentage of patients whose diagnostic test is undertaken less than 6 weeks from request	**99%**	**81.54%**	**77.08%**

ENSURING QUALITY

The work of our nursing and quality team

Improving Quality

Quality continues to be a leading priority for HVCCG. One of our strategic objectives for 2020-2022 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. We have continually 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:

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

[4] Data shown is a 'snapshot' at end of June 2022

(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 Quality and Performance 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.

Infection Prevention and Control

Healthcare Associated Infection (HCAI) Data:

- ***Clostridioides difficile* infection (CDI)** – HVCCG have a rate below that of the East of England (EoE) region, and at the end of Q1, WHTHT are above the rate for acute trusts within the region. The Trust reported a period of increase in incidence on Sarratt Ward. All cases were subject to root cause analysis and antibiotic review and any themes in learning were reviewed. All positive samples undertook ribotyping and no links have been identified. A structured peer review was undertaken involving key internal and external stakeholders which did not identify and major concerns. A thorough action plan was also developed which included ensuring that any patient who is identified as an infection risk is isolated promptly and the appropriate stool specimens obtained. Increased IPC and cleaning audits were also implemented and adding an additional sluice to the ward was also investigated.
- **MRSA blood stream infection -** No cases were reported by WHTHT or in HVCCG during Q1.
- **MSSA blood stream infection (BSI) –**both WHTHT and HVCCG have a rate above region.

- ***E. coli* blood stream infection –** HVCCG were below their threshold and below the regional rate for Q1. WHTHT had exceeded their threshold but was below the regional rate.
- ***Klebsiella* spp blood stream infection –** At the end of Q1, HVCCG infection rate was above the regional rate and WHTHT had exceeded their threshold and had also significantly exceeded the regional rate.
- ***Pseudomonas aeruginosa* blood stream infection –** During Q1, HVCCG were below threshold, and below the regional rate and WHTHT were below their threshold and below the regional rate.

The ICB IPC team produce a monthly HCAI report and comparative data analysis that facilitates discussion with individual service providers. There is currently a process for RCA of HCAIs and identification of learning. However, a review and overhaul of this process is included within the draft integrated HWE IPC 5 Year Strategy. The proposed strategy also prioritises key areas that will positively impact on rates of the above HCAIs locally such as programmes to strengthen IV access practice, Aseptic Non-Touch Technique (ANTT), urinary catheter management etc. A more detailed integrated plan will be produced following the strategy workshop which was carried out in August. Assurance regarding the implementation of identified learning from case reviews is also reported and monitored via the trust IPC Committee. This includes reporting of Trust audit programmes and results. Learning and challenges are disseminated more widely and discussed at the monthly system IPC network group meetings.

Outbreaks and Incidents:

- ***COVID 19*** - Within the ICB, the number of reported outbreaks and clusters had been steadily increasing throughout Q1 – In total, there were 13 reported outbreaks in WHTHT and 2 in HPFT. There was also 1 outbreak reported within an independent hospital in HVCCG. In addition, there were 2 clusters relating to Covid – 1 in an independent hospital and 1 in HPFT. The ICB IPC team have attended the IMTs regularly and provided support to staff in the affected units. Outbreaks have also been discussed at the monthly network meetings were the risks associated with the hierarchy of controls were reassessed. Extraordinary meetings were also implemented to ensure appropriate development and implementation of risk assessments in terms of Living with Covid guidance and monitoring the impact on patient's and services.
- **Norovirus** - There were no reported outbreak of *Norovirus* in HVCCG.
- **Monkeypox** The incidence of monkeypox cases had been increasing steadily during Q1. Most cases were reported in London and in gay, bisexual men and other men who have sex with men. Extraordinary meetings with all provider settings were arranged to ensure that national guidance was implemented. Adult and children's care pathways have been developed which covered the responsibilities of the clinical risk assessment, safe swabbing procedures, treatment and follow up of possible/probable and positive cases. One of the major challenges was the development of a pathway for the under 18's where it is not appropriate for them to attend the sexual health clinics. A variation of contract through Commisceo was initially approved to cover West Essex and subsequently, a variation of contract that covered HWE ICS was investigated and at the time of writing this report (18th August), this contract is being finalised.

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

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

During Q1 in 2022/23 HVCCG were notified of 34 SIs in total; this compares with 42 SI notified to the CCG in Q4 2021/22. In some cases, an 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.

The Trust currently have a backlog of 31 serious investigations. This was caused in part by a surge in incident reporting through the first year of Covid that saw 122 serious incident investigations linked to the pandemic. This resulted in a comprehensive thematic review undertaken by the Trust.

We continue to meet with the Trust bi-monthly to support them with reducing the backlog and completing the investigations. We set and discuss trajectories with them and also identify improvements to the processes.

Never Events

In 2021/22, four Never Events were reported by organisations where Herts Valleys CCG is the host commissioner; these occurred at West Hertfordshire Teaching Hospitals Trust, Bishops Wood Hospital and East and North Hertfordshire NHS Trust. The details of the incidents are as follows:

Organisation	Type of Never Event	Detail	Level of harm sustained
West Hertfordshire Teaching Hospital NHS Trust	Retained Foreign Object (Theatres)	Patient had a retained swab following emergency surgery.	Low harm
Royal Free London NHS Foundation Trust	Misplaced naso- or orogastric tubes	Patient had NG tube incorrectly sited	Moderate Harm

Both Never Events have investigations that are ongoing. The CCG is assured that the immediate actions put in place by the providers are robust and will prevent a future incident of a similar nature as long as all the future actions that are identified are also embedded into practice. The Theatre incident also provided a focus of a Quality Assurance visit to the Theatres complex within the Trust. Significant learning had taken place and actions taken in response to the incident. Further assurance will be gained through further quality assurance visits planned for later this year.

Care Home and Quality Improvement Team

During the first quarter of 2022-23 the Quality Improvement and Assurance (QI/A) team have continued with COVID-19 support as cases increase in care homes. The team have returned to full face-to-face visits to all the adult care homes in West Hertfordshire to support with prevention of avoidable hospital admissions.

Each adult care home has their own dedicated Care Home Improvement Team (CHIT) nurse, who contacts them on a minimum monthly basis. Where the home requires more intensive support and training this is identified on a weekly basis to ensure we can be more proactive in assisting. The team offer planned and unplanned training, to ensure that care home staff teams receive appropriate training to keep them upskilled in being able to apply appropriate knowledge.

Key training delivered has been recognising deterioration, falls prevention, pressure area care and infection prevention and control practices. The training continues on a rolling basis and additional support is offered where avoidable hospital admissions have been noted, or where the care home requests.

The team collaborates and works closely with all system partners to support a joined-up approach around all care homes. The team have dedicated representatives at all Hertfordshire care home meetings and cells as part of the whole system's support and response to safety. This will move forward to include West Essex in the next quarter

The team works closely with the Hertfordshire Admission Avoidance Response Car (HAARC) (contracted) to support prevention of avoidable hospital admissions and additionally shares with homes all prevention of avoidable admission services available in West Hertfordshire.

The QI/A team has supported local authority partners to undertake monitoring visits and attend quality assurance meetings to ensure where any learning is identified the team are in a position to offer immediate support, signposting and training.

The QI team has continued to offer reactive support and training to Sheltered Living, Supported Living and homecare providers where requested. This includes signposting to other services which may assist and support them with education/training/prevention of avoidable admissions.

A new way of working is in development as the QI/A team will be cross working across the ICB and offering additional support to the quality assurance leads where critical improvement is required in the place-based areas of East and North and West Essex. Other resources are being reviewed as we are mindful that the QI agenda in S&W must not lessen our delivery of reduction of admissions and improvement of quality in care homes. Work on supporting home care and supported living providers will also escalate in the next two quarters across the ICB.

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.
- Undertaking scoping work for recruitment for Patient Safety Partners.
- Kept our Quality Committee, Primary Care Commissioning Committee and Governing Body updated with national timelines and local implementation throughout the year.

Complaints.

	Q1 2022/2023	2021/2022
Formal Complaints received by HVCCG (which includes 5 stage 1,2 or 3)	32	153
Provider Complaints – (which includes 1 stage 2)	12	55
Total	44	208

Further information

- 6 of the above complains came in via an MPs on behalf of their constituents.
- No complaints came from the PSHO:
  A complainant unhappy with the CCGs complaint responses; was questioning data relating to Melatonin and what HVCCG commission for the treatment of insomnia

Patient Feedback also handled 36 other cases of enquiries and concerns in this above period.

Key themes of complaints in Q1 were:

- Medications
- Care pathways
- Communication

In the last reporting year, the CCG focussed on improving the complaints processes and complaint's function. We ensured we became more proactive with supporting

complainants by follow up calls to establish clear facts and support the individuals in the process. Throughout Quarter one we have worked alongside our colleagues in both East and North Herts and West Essex CCG's to develop agreed processes as we become one team with the introduction of the ICB in July.

Healthwatch Hertfordshire

The Nursing and Quality Team has worked alongside Healthwatch Hertfordshire alongside other colleagues from within the CCG to provide assurances around key areas of focus such as veterans support and currently regarding services for Black and Minority Ethnic people in order to improve services.

Maternity Services

West Hertfordshire Teaching Hospitals NHS Trust (WHTH) -

The following key areas of work relating to Maternity Services for The Nursing and Quality team have been:

- 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.

Joining regular meetings with West Hertfordshire Teaching Hospitals Trust to seek assurance regarding the safety of maternity services during times of extreme pressure, and also in response to implementation of needed actions as identified in the unannounced Care Quality Commission (CQC) inspection in October 2021
Key areas of focus are:

- Recruitment and retention plan in place.
- Funds allocated through a bidding process to support capacity between establishment and birth rate +, all trusts successful in securing funding.
- Birth-rate review completed
- Regional lead to build capacity across the East of England
- International recruitment
- Support from ICB workforce leads

Primary Care

The following have been key areas of work for The Nursing and Quality team relating to Primary care:

- The following have been key areas of work for The Nursing and Quality team relating to 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.

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

- Attending monthly Risk register meeting to ensure all risks are mitigated and all practices feel supported and guided.

- QAS themes/concerns discussed at Risk register meetings to inform Practices planned interventions that will be taken forward.

- Attending Practice Forum meetings and providing additional support/advice.

- CQC Primary Care webinars to commence September 2022 to support practices on focused themes.

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

- Mental Capacity (Amendment) Act (2019): Coordinating the CCG response to the consultation on the draft Code of Practice and Regulations and contributing to the Hertfordshire multi-agency response. Working to ensure a strong foundation in the knowledge and use of the MCA within the CCGs and our providers.
- CCG staff are supported to complete their safeguarding learning through a blended approach of e-learning and participatory sessions. We continue to provide safeguarding supervision for all CCG staff who have patient contact to support them in their roles and promote best practice.
- Worked with partnership agencies to support care homes and care providers to monitor quality and management of risk with the CCG, chairing the HSAB Strategic Quality Improvement Group to drive forward quality assurance processes, shared learning and response to areas of concern.
- As part of the HSAB we chair the Safeguarding Adult Review (SAR) subgroup to promote effective learning and improvement.
- Represented the CCG in the recommissioning of the Independent Domestic Violence Advocate Service. We also chair the Quality and Innovation sub-group of the Domestic Abuse Partnership Board. One of the objectives of this sub-group is to identify learning, ensuring that it is shared and implemented by partners.
- The team supported CCG staff in managing complex cases through individual case discussions and group supervision. Support and guidance were also given for colleagues in providers and primary care managing complex cases through individual case discussions and interventions
- The team communicated regularly with CCG colleagues and primary care and kept the CCG Boards briefed on key actions.

Safeguarding children

- The Hertfordshire and West Essex (HWE) teams continue to work towards an integrated structure to reflect changes introduced by the Health and Care Act 2022 and transition to the HWE ICB.

- The NHSE/I safeguarding program funding in 2021/2022 has supported key areas of learning in relation to safeguarding priorities, in particular upskilling the workforces understanding of Mental Capacity Assessment in preparation for the impending Liberty Protection Safeguards, and supporting acute organisations manage complex trauma cases in clinical settings.

- The National Safeguarding Practice Review Panel (2022) and local Hertfordshire Serious Safeguarding Reviews have identified practice gaps in relation to:

- Information sharing and risk assessments for fathers and co-habiting partners.

- Safety planning where risk is known

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

The National Panel also published the findings following the deaths of A L-H and SH.

Key recommendations include a review of multi-agency arrangements and the integration of skilled professionals into Multi-Agency Child Protection Units.

The Designated team have joined Statutory Partners to review the arrangements of the existing Multi-Agency Safeguarding Hub which includes the recommendation for an increase in health partner capacity in the MASH. These temporary posts are out for recruitment.

The Designated team plan to host senior and front-line practitioner events in Quarter 2 2022-2023

- **Ukraine refugees and unaccompanied children**. Work is in progress to support the safe placement of unaccompanied children from the Ukraine into Private Fostering by the Local Authority. Oversight of arrangements is via the Essex Tactical Coordination Group and the Hertfordshire Ukraine Support Group. A Health needs group provides oversight of mental health support, processes for sponsors and appropriate escalations.
- **Child Death Overview Panel (CDOP)**: HCC and ICB risk registers have been updated due to recommended timescales not being met. A revised model of CDOP delivery is

currently out to tender to increase capacity and reduce the inequality in service provision between expected and unexpected death.

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

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

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

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

- **Child Looked After statutory Health Assessments (includes out of county)**

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

IHA/RHA Compliance

Compliance is over the locally agreed KPI of 85%

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

Improving the health of people with a learning disability

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

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

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

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

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

REDUCING HEALTH INEQUALITIES

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

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

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

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

- [5]Life expectancy is 10 years lower for men and 6.2 years lower for women in the most deprived areas of Dacorum than in the least deprived areas.
- Higher rates of respiratory disease mortality in Dacorum compared to other districts.
- Higher rates of childhood obesity compared to other districts.

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
- Living and working well
- Ageing well

The strategy has been reviewed and refreshed during Summer 2022 following disruption this year from the COVID-19 pandemic. Engagement with a wide range of stakeholders will

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

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, Healthwatch Hertfordshire 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** in the country. This brings NHS and social care money into a single shared fund to help prevent older and vulnerable people going into hospital when they don't need to and provide them with support in their community.

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

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

A renewed health and wellbeing strategy is in development and is expected to be approved by the Health and Wellbeing Board during 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, and 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 children looked after, 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 board to evaluate all proposals ensuring they produce the best outcomes for patients, offer good value for money and don't negatively impact on particular groups of people.

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

Improving our equality impact analysis

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

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

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

- Two full-time-equivalent BAME COVID-19 Recovery workers who started work in April (2-year project). The workers are linked to the COVID-19 Information workers and volunteers (Public Health England[1] funded) and are reaching into communities to provide a mixture of BAME social prescribing (SP) and advocacy and to provide input into the SP system (88 workers) to support cultural competence. They have worked with the BAME community on VCFSE capacity, but also particularly in partnership to assist in addressing vaccine hesitancy. The project runs to March 2023

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

- The Carers in Herts BAME breaks project commenced August 2021 and is identifying issues around identification and willingness to take up services as well as working in partnership with the HVCCG 'urgent short breaks on prescription project' which is also learning about how to reach 'hidden' carers in need in partnership with social prescribing link workers across the system
- As at June 2022, the Digital Inclusion project (Staying Connected) has received 177 donated IT devices, engaging 11 private companies, supplied 57 users with free equipment, and 58 with connectivity; 239 users have been supported to use kit by a volunteer Digital Champion and 57 Champions have been trained in 277 sessions. 90 Afghan refugees have benefited, including children helped with using IT for homework.
- A winter small grants process distributed £75k of NHSCT funding to projects on the basis of £1500 per PCN in consultation with CDs or link workers as well as an additional £30k to projects suggested by Districts or the VCFSE. Projects addressed digital exclusion, social isolation during Omicron, and local health inequalities. Additional funding was levered from Mental Health commissioners
- 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. The role in ENH has now accessed continuation funding and the role with Watford FC Trust has been extended with NHSCT monies
- Health inequalities is one of the ten strands within the new Health Creation Strategy being co-designed with the new VCFSE Alliance with the ICS and we have been involved in the successful bid for Core20Plus5 monies to address the specific health challenges in Cowley Hill, Hertsmere, the most deprived ward in the ICS
- The Hospital and Community Navigator service continues to develop, including among its 80 staff, 25 PCN link workers, a new Veterans worker and a Sensory Impairment worker. 26% of clients come from the most deprived 2% of the ICS population, which shows the important work being done to reach those facing the greatest health inequalities

A range of inclusive approaches and methods of communications and engagement are used to meet the needs of the community (including those protected by a characteristic under the Equalities Act 2010 and those affected by health and social inequalities) and we use diverse community channels for information, campaigns and engagement. We are increasingly working with local district and borough councils to tap into their extensive community networks for getting information to as many different people as possible.

Identification

The CCG have developed and published a document which outlines a breakdown on the Herts Valleys area from an equality perspective. See 'knowing our population' on this page.

https://hertsvalleysccg.nhs.uk/about-us/who-we-are . We access and use wider public health information used to commission services.

Engagement and inclusivity

• Health Ambassadors help us connect with different groups including young people and other equality groups including: Trans; people with dementia; young families; and disability groups (including LD). The community ambassadors come from a range of environments including voluntary organisations, care providers, community groups and housing providers. The community ambassadors scheme helps us link with their networks – and particularly those groups which face health inequalities **https://hertsvalleysccg.nhs.uk/get-involved/community-health-ambassadors** We are working directly with some of our ambassadors to arrange meaningful and targeted engagement on the development of the South and West Hertfordshire Health and Care Partnership.

• Work has continued to involve people with learning disabilities in patient participation groups (PPGs) in recognition of health inequalities for people with LD and absence of the LD voice. This has included working with specialist LD nurses, practice staff and their patient group members to produce guidance and support GP patient groups to include the LD voice. Involving people with LD is described on this webpage **https://hertsvalleysccg.nhs.uk/get-involved/patient-groups-and-networks**.

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

• The CCG has also undertaken community engagement by reaching out to where people are – so arranging attendance at community gatherings, giving out information outside supermarkets and attending events such as Herts Pride.

Accessibility of information to support engagement

HVCCG continues to share Non-English-language content for campaigns aimed at spcific groups as well as producing easy-read versions of all important information and publications such as ‘about us’, ‘how to get involved’, ‘find a health service’ and the ‘contact us’ form. **https://hertsvalleysccg.nhs.uk/legal/accessibility**

• The Herts Valleys CCG website is accessible for people whose first language is not English by adding a ‘Google translate’ button.

• The HVCCG reader and website panel check information to ensure it is clear, easy to understand and in plain English including service leaflets, consultation documents and website material. **https://hertsvalleysccg.nhs.uk/get-involved/listening-to-you**

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

Effectively engaging with our patients and local communities is a priority for the CCG. We always want to get better at engaging with GP practices, patients, carers, local people, health and care partners and our staff so that they can contribute effectively to our plans and influence our work. We also have a legal duty to engage and involve the public and others in any proposals for change that will impact on how health services are provided to local people.

Through our communications channels including our website, weekly Herts Valleys Update email bulletins and social media we provide regular updates on developments and planned changes. We encourage people to work with us in a number of different ways.

How we engage

Patient and Public Involvement (PPI) Committee

Our PPI committee provides assurance to our board that there is meaningful participation in the business of the CCG from patients, carers, families and local people across west Hertfordshire. The committee has two patient volunteers from each of our four localities together with a Healthwatch Herts representative and they are joined by our lead GP for patient and public involvement. They have the opportunity to formally and regularly discuss and comment on all aspects of CCG business – bringing a patient perspective to things like strategies and proposals**.** The committee is chaired by our lay board member with responsibility for patient and public involvement. A committee patient member also sits, as a patient representative, on our board. Two patients currently share this role.

We have updated them on plans for the Herts and West Essex Integrated Care Board and the South and West Herts Health and Care Partnership (HCP). Members were involved in discussions around how to best establish new public involvement structures and embed co-production in the work of the new HCP.

Patient volunteers on other CCG committees, projects and activities

We have a network of around 250 patient volunteers. Our volunteers are local patients, carers or members of the public with a personal interest or involvement in local health services. We involve them through patient network meetings, through our reader panel

and by inviting them to join working groups. We also have patient representatives on the CCG's commissioning executive committee, primary care commissioning committee and medicines optimisation clinical leads group. They bring a patient and community perspective and help to ensure that the public and patient voice is integral to all discussions, proposals and plans.

Working with East and North Herts CCG, who established the Cancel out Cancer volunteer-run programme a number of years ago, we have recruited some local volunteers to deliver these sessions in west Herts.

As a result of a patient network session on diabetes a group was formed, led by patient volunteers, to provide support and education across Hertfordshire to patients with diabetes.

GP practice participation group (PPG) network

We have an established PPG network which has patient and practice staff membership and involves around 275 direct members. This network, which meets regularly, helps to broaden our engagement and establish communication channels with the ever-increasing number of local people who are involved with their GP surgery patient group.

Information sent through the network, such as virtual engagement event invitations, is shared more widely as practices routinely share this information with their patient group members.

Practice Participation Groups (PPG) incentive scheme

To support our practice patient groups we launched an incentive scheme in 2020. This was designed in partnership with patients, practice managers and Healthwatch Herts, to encourage the development of effective groups. Out of 54 practices, 28 achieved gold level, nine achieved silver and 14 remained on bronze. Gold and silver levels could access additional funding towards the facilitation of their groups. There are now plans to adopt this scheme across the ICB.

Patient engagement networks

To maintain contact with our patient networks and other stakeholders we hold regular engagement meetings which are well attended by PPG members and other volunteers. Meetings have been held virtually and enable patients to become better informed about the NHS and its services and to become stronger influencers and connectors within their own networks by increasing their knowledge and confidence.

At these sessions, we provide context to proposals and developments from both a national and local level, for example highlighting how the CCG is responding to COVID-19, plans for recovery, NHS 111 First, mental health services and the review of Mount Vernon Cancer Centre.

These sessions also allow colleagues to hear, first-hand, people's experience of using services so that they can factor the patient perspective into their planning and respond to patients' concerns.

Reader panel

Our reader panel, is made up of around 50 volunteer patients, carers, community members and others who help us to get information right for the public. Panel members review leaflets and other material and feedback on whether information is easy to understand, accessible and free from jargon.

Having updated guidelines in line with panel members' feedback we now include longer response times for comments, more context on the information to be reviewed and we share the final version with the reader panel.

Recently we have asked the panel to comment on: patient information from our pharmacy and medicines optimisation team about changes to medication; a guide to local health services; and a public update on GP access. We review and amend information in response to the panel's feedback

GP access

We have supported work across the three CCG areas to listen to what patients say about access to their local GP, 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 and information to local people 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 rationale behind this approach.

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.

We also continue to work 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 improvements to patients' access to GP services, communications and engagement teams are working with primary care teams to support general practice to improve channels of communication with patients. As well as good telephony systems this includes improving practice websites and increasing their use of social media.

South and West Herts Health and Care Partnership (SWHHCP)

Herts Valleys CCG have been leading on the development of the approach to engagement at the new local partnership, or HCP, working alongside the partnership programme director. The HCP is working in 'shadow' form until July 2022. SWHHCP have an engagement framework in place co-production at its heart, committing to a strong patient and service user voice in all of its work.

The partnership has commissioned Healthwatch Hertfordshire to run a project to establish the new framework and co-production board. We expect this to be a major focus of our work in the coming months.

Involving all our community

In order to ensure our whole population is considered and consulted with in our decision-making; engaging with partners, stakeholders, community groups and local people is key to this.

We link in with many local groups including:

- Hertfordshire LGBTQ+ partnership
- Local authority health and wellbeing boards
- COVID-19 response Local Resilience Forum and its associated 'cells'
- West Herts Hospitals NHS Trust Co-production Board
- West Herts sensory group
- West Herts Stakeholder Reference Group
- St Albans and Dacorum Patient Groups

If there is no existing stakeholder group to reference or work with, we look to engage with specialist groups such as local voluntary, community, faith and social enterprise (VCFSE) organisations.

We aim to ensure public involvement meetings and access to engagement meet the needs of those taking part. We must ensure that if people cannot engage online, they that can do so by telephone or post. As the COVID-19 restrictions ease, we plan to re-introduce face-to-face engagement as an option, alongside virtual opportunities to make involvement as accessible as possible.

We work with an external company to produce different formats of documents and materials, including 'easy read' format.

Looking ahead

An updated communications and engagement strategy was agreed by the joint CCGs Board in common 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 from July 2022.

Our team have worked differently given 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.

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 external stakeholders, such as partner organisations and bodies, VFCSE 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-19 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 conditions
- continuing to support the engagement model for the South and West Hertfordshire Health and Care Partnership (HCP).

We want to say a huge thank you to patient member volunteers and stakeholders for supporting our engagement work. Your support helps us make important decisions, improve services and ensure quality is at the heart of what we do. To get involved with any of the activities you have read about, or simply have your say on local health services in Herts Valleys, visit **https://hertsvalleysccg.nhs.uk/get-involved**, or email **communications.hvccg@nhs.net**

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 2022/23 we remained fully compliant with all nine areas of **NHS E/I's Core Standards for Emergency Preparedness, Resilience and Response (EPRR).**

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

During this period, the CCG is an active member of the LHRP and in June 2022 co-chairing arrangements for the LHRP transferred from NHSE/I and Director of Public Health to our Accountable Emergency Officer and Director of Public Health in readiness for the transition from a CCG to an ICB.

Incident Response

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

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

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

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

SUSTAINABLE DEVELOPMENT

Introduction

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

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

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

- improve health and patient care and reduce health inequalities

- build a more resilient healthcare system that understands and responds to the threats of climate change.

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

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

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

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

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heatwaves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Board 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 Dacorum Borough Council who also provide facilities management on behalf of the organisation. The energy rating of the building is 'B', which indicates the energy efficiency of the building fabric and the heating, ventilation, cooling and lighting systems.

Total Energy Cost (All Energy Supplies)[6]

	2020-21	2021-22
Total	£6662	£10099

At the time of writing, energy consumption data wasn't available from the property landlord.

Travel

Herts Valleys CCG spent £1828 on business travel costs in Q1 2022/23, in comparison to £1,211 throughout 2021-22. 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.

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'.

The organisation continues to employ a number of sustainable initiatives, 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.

• 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.

[6] Please note that Herts Valleys CCG shares a building with Dacorum Borough Council 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.

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

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

REVIEW OF FINANCIAL PERFORMANCE

Financial Overview

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

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

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

Further details are provided in of the accounts from page 138 of this Annual Report.

Duty	What this means	Herts Valleys CCG's Achievement
Expenditure does not exceed sums allotted to the CCG plus other income received	To keep the amount spent on commissioning and delivering	✓ £1.556m in year underspend

	services to or below the amount allocated	
Capital resource use does not exceed the amount specified in Directions	To not spend more on buying property, plant and equipment then allocated	Not Applicable
Revenue Resource use does not exceed the amount specified in Directions	To not spend more on commissioning and delivering services than allocated	✓ £1.556m in year underspend
Revenue administration resource use does not exceed the amount specified in Directions	To ensure that CCG efficiently discharges its responsibilities and keeps the spend to or below the amount allocated	✓ Achieved Running costs achieved breakeven in Q1 2022/23
Cash Limits are not exceeded in any one year	To keep the cash in the bank within acceptable limits	✓ Achieved

Funding Allocated to the CCG

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

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

NHS England did allocate £2.3billion, on a fair share basis, to support elective recovery and HWEICB has initially received £45m to support additional elective activity. Where systems deliver additional activity above the annual target, they will earn additional funding at 75% of tariff. Where activity is below the annual target, funding will be reduced at 75% of tariff capped at the total received.

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

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

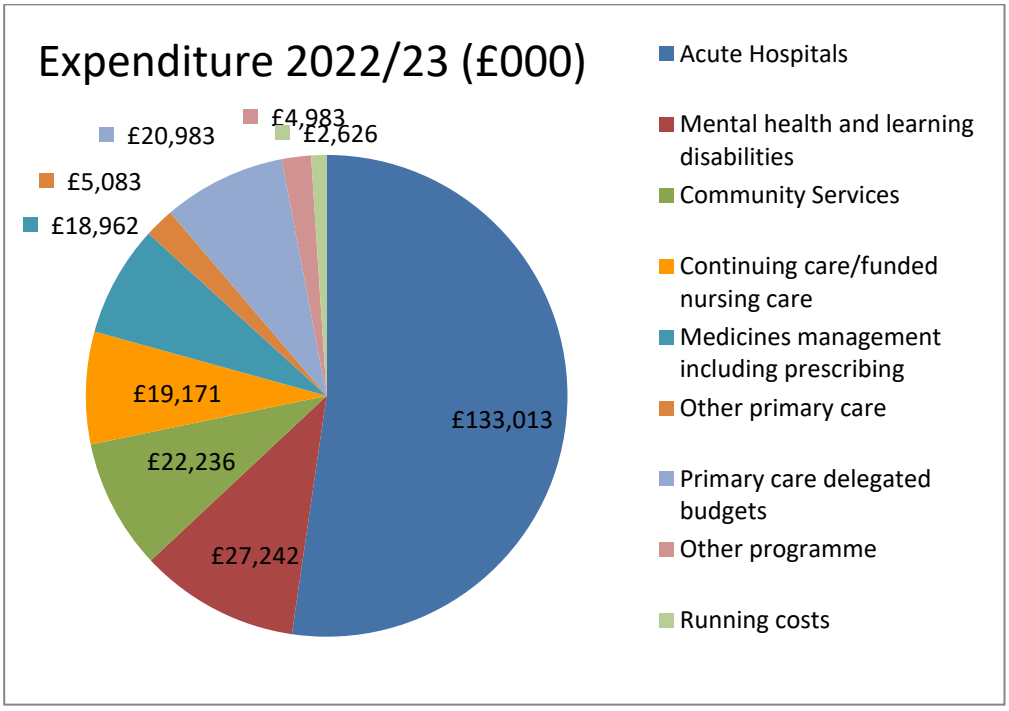
Herts Valleys CCG is reporting £1.556m in year underspend which will be carried forward into the ICB. NHS England will then make decisions on how much of this carry forward will be transferred to HWEICB.

The total allocation received by the CCG during Quarter 1 2022/23 was £255.9m.

Allocation Received	Total £'000
Programme	228,833
Devolved Commissioning	23,924
Running Costs	3,098
TOTAL	**255,855**

The CCG met the statutory requirement to keep spend within the resources allocated

Details of how the CCG spent its allocation during April to June 2022 is shown in the chart below and the categorisation of spend is consistent with the categories utilised for reporting to the Finance Committee.



Expenditure 2022/23 (£000)	Spend
Acute Hospitals	£133,013
Mental health and learning disabilities	£27,242
Community Services	£22,236
Continuing care/funded nursing care	£19,171
Medicines management including prescribing	£18,962
Other primary care	£5,083
Primary care delegated budgets	£20,983
Other programme	£4,983
Running costs	£2,626
	£254,299

NHS England holds the vast majority of the capital assets on behalf of CCGs and Herts Valleys CCG did not need to bid for capital resources. Although the CCG did purchase IT and other equipment, this expenditure did not need to be capitalised. The costs are shown as part of the revenue spend of the CCG, within the most appropriate expenditure category.

The CCG is provided with a cash limit based on our planned expenditure. This cash is used to pay for services commissioned from NHS and non-NHS Providers, for Primary Care contracts and other payments, for prescribing and other healthcare costs, and for the costs of running the CCG. The CCG draws down a proportion of the limit each month and the CCG drew down less cash than the limit and therefore met its statutory duty.

As well as staying within the cash limit, as a public sector organisation, we are expected to pay our obligations promptly. This is known as the Better Payment Practice Code and requires the CCG to pay 95% of valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Performance against this code is measured by value and volume of invoices paid and is shown in Note 4 of the Financial Statements.

The CCG has therefore met all of their financial duties for 2022/23.

Audit Arrangements

External audit services are provided by BDO LLP

The total fee for Q1 2022/23 was £61,800 excluding VAT (£58,800 for Financial Year 2021/22)

Internal Audit services are provided by West Midlands Ambulance Service. (RSM UK in Financial Year 2021/22).

The total fee for Q1 2022/23 was £17,500 excluding VAT (£44,000 for Financial Year 2021/22).

Please note:

The figures above are for periods of different duration, namely Quarter 1 2022/23 and the Financial Year 2021/22, but may cover similar levels of work, so they cannot be extrapolated or directly compared.

REVIEW OF STATUTORY DUTIES

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

Dr Jane Halpin
Accountable Officer

Date signed: 5th October 2022

ACCOUNTABILITY REPORT

PART ONE: CORPORATE GOVERNANCE REPORT

MEMBERS' REPORT

The 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 Nicolas Small was the Chair of the CCG and Jane Halpin was the Accountable Officer. There are 16 members of the CCG Board.

Information about our Board members and their responsibilities can be found on our website: **www.hertsvalleysccg.nhs.uk/about-us/who-we-are/leadership#our-governing-body-board**

MEMBER PRACTICES

During the year 2022/23, the membership body of the CCG was formed of 54 member practices, grouped below under their respective locality. Information about our member practices can be found on our website: **https://hertsvalleysccg.nhs.uk/about-us/who-we-are/leadership**

Dacorum practices (15)
Archway Surgery
Bennetts End Surgery
Coleridge House Medical Centre
Everest House Surgery
Fernville Surgery
Gossoms End Surgery
Grovehill Medical Centre
Haverfield Surgery
Highfield Surgery
Kings Langley Surgery (The Nap)
Lincoln House Surgery
Manor Street Surgery
Parkwood Surgery
Rothschild House Surgery
Woodhall Farm Medical Centre

St Albans and Harpenden practices (12)
Colney Medical Centre
Davenport House Surgery
Elms Medical Practice
Grange Street Surgery
Harvey Group Practice
Hatfield Road Surgery
Lattimore and Village Surgery
Maltings Surgery
Midway Surgery
Parkbury House Surgery
The Lodge Group
The Village Surgery

Hertsmere practices (9)
Annandale Surgery
Fairbrook Medical Centre
Highview Medical Centre
Little Bushey Surgery
Parkfield Medical Centre
Schopwick Surgery
The Grove Medical Centre
Theobald Medical Centre
The Red House Group of Practices

Watford and Three Rivers practice (18)
Abbotswood Medical Centre
Attenborough Surgery
Baldwins Lane Surgery
Bridgewater Surgeries
Chorleywood Health Centre
Gade Surgery
Garston Medical Centre
Manor View Practice
New Road Surgery
Pathfinder Practice
Sheepcot Medical Centre
South Oxley Surgery
Suthergrey House Medical Centre
The Colne Practice
The Consulting Rooms
The Elms Surgery
Vine House Health Centre
Watford Health Centre

Composition of Board

The Chair of the CCG is Dr Nicolas Small. The Chief Executive is Dr Jane Halpin.

From April 2022 to 30 June 2022, the Board was composed of the following members:

There are sixteen members of the CCG board:

Two general practitioners from each of the four locality areas, one of whom is the Chair of the CCG and one of whom is the deputy clinical chair.

Four lay members, one of whom is the appointed deputy chair of the CCG. Among these members, one has responsibility for governance matters, one for patient and public involvement, and one for primary care (medical services) commissioning.

A secondary care specialist doctor*

Four Executive members: the Chief Executive Officer (Accountable Officer), the Chief Finance Officer, the Director of Nursing and the HVCCG Managing Director

*Note: the secondary care specialist doctor post was vacant in HVCCG. In anticipation of the CCG transitioning towards the ICB, this vacancy was not advertised during this period, however, the HVCCG board has been meeting in common with ENHCCG and WECCG throughout 2022/23, meaning that there was a specialist secondary care input to their discussions.

Information about the composition of our Board including key responsibilities and membership can be found on our website. **https://hertsvalleysccg.nhs.uk/about-us/who-we-are/leadership**

Attendance records of the Board and its Committee members at their respective meetings, namely:

- Board Meetings in Public
- Board Meetings in Private
- Audit Committee
- Quality and Performance Committee
- Remuneration Committee

can be found **here**

The CCG membership is accountable for exercising the statutory functions of the CCG, which can be found in our constitution.

https://hertsvalleysccg.nhs.uk/application/files/5316/0751/9666/200924__Herts_Valleys_CCG_Constitution_Approved_by_HVCCG.pdf

Role	Name
Chair	Dr Nicolas Small
Deputy Clinical Chair	Dr Trevor Fernandes
Chief Executive (Accountable Officer)	Dr Jane Halpin
Managing Director	David Evans
Chief Finance Officer	Alan Pond
Director of Nursing and Quality	Jane Kinniburgh
Lay Member, Deputy Chair	Stuart Bloom
Lay Member	Alison Gardner
Lay Member	Paul Smith
Lay Member	Thelma Stober
Board GP and Locality Chair, Dacorum	Corina Ciobanu
Board GP and Locality Chair, Hertsmere	Kate Page
Board GP, St Albans and Harpenden	Richard Pile
Board GP and Locality Chair, St Albans and Harpenden	Daniel Carlton-Conway
Board GP and Locality Chair, Watford and Three Rivers	Rami Eliad
Board GP, Watford and Three Rivers	Asif Faizy

Committee(s), including Audit Committee

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

- Paul Smith – Lay Member (Governance), Audit Chair
- Stuart Bloom – Lay Member (Quality and Performance) and Deputy Chair, CCG Board
- Alison Gardner – Lay Member (Patient and Public Involvement)
- Rami Eliad – GP Board Member, Watford and Three Rivers
- Kate Page – GP Board Member and Locality Chair, Hertsmere

The Remuneration Report starting on page 97 provides details of the membership of the Remuneration Committee.

Registers of Interests

The Board maintains up to date registers of interests, which formally record the declarations of interests made by its membership, board and committee members and regular attendees, and employees and these are published on the CCG's website and referenced in the Governance Statement. Any interest that arises during a meeting is declared immediately and recorded in the minutes of the meeting. This ensures that the Board acts in the best interests of the organisation and avoids situations where there may be a potential conflict of interest. To view the Register of Interests please visit our website: **https://hertsvalleysccg.nhs.uk/about-us/what-we-do/managing-conflicts-interest**

Personal data related incidents

The organisation has not reported any Information Governance Serious Untoward Incidents to the Information Commissioner's Office in Q1, 2022/23.

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; and
- the member has taken all the steps that they ought to have taken 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 Herts Valleys Clinical Commissioning Group fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS E/I). NHS E/I has appointed Dr Jane Halpin to be the Accountable Officer of Herts Valleys CCG

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

The propriety and regularity of the public finances for which the Accountable Officer is answerable;

For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);

For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);

The relevant responsibilities of accounting officers under Managing Public Money;

Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended));

Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS E/I has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

Observe the Accounts Direction issued by NHS E/I, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

Make judgements and estimates on a reasonable basis;

State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,

Prepare the accounts on a going concern basis; and

Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

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: 5th October 2022

GOVERNANCE STATEMENT

Introduction and context

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

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

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

Scope of responsibility

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

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

Governance arrangements and effectiveness

The main function of the Board is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as

are relevant to it.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, the CCG follows the principles in the code that are most relevant to it given its size and nature, but does not comply with the code as a whole. The following section discusses the most relevant parts of the code where the CCG has complied. Evidence that the code's principles were applied, is provided through the **integrated governance protocol**

Governance Structure

The Board has created the statutorily required Audit Committee and Remuneration Committee. Additionally, the Board has established a Primary Care Commissioning Committee, a Quality and Performance Committee, a Finance Committee, a Commissioning Executive Committee and a Patient and Public Involvement Committee.[7]

Member practices

The CCG membership now consists of 54 GP practices.

The member practices are arranged into the four localities of Dacorum, Hertsmere, St Albans and Harpenden, and Watford and Three Rivers. Each of these localities has a Locality Clinical Chair who leads the Locality Committee, which is made up of representatives from member practices. The Locality Clinical Chair is also a member of the CCG Board and they each have a portfolio which they are responsible for.

Information about our member practices can be found on our **website**

Herts Valleys CCG Board

The Board met regularly last year in both public and private sessions. During the year the Board worked to support successful transition to an Integrated Care Board (ICB) and the development of Health and Care Partnerships (HCPs) for Hertfordshire and West Essex.

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

[7] The Board, Renumeration Committee and Primary Care Commissioning Committee met in Common with East and North Hertfordshire CCG and West Essex CCG in 2022/23

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

Audit Committee

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

During its work, activities, and areas of review throughout the year, the committee ensured that any areas of particular concern were brought to the Board 's attention through its regular committee Chair's reports and has summarised this information in its committee annual report to board and this 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 (GMS) and Alternative Provider Medical Services (APMS) contracts. This is with the exception of those functions relating to individual GP performance management, which have been reserved to NHSE.

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.

Remuneration Committee

The Remuneration Committee is a committee of the Board. It makes recommendations to the Board on determinations about pay and remuneration for all 'Very Senior Managers', and Board members, including GPs and Lay Members of the Clinical Commissioning

Group. A Very Senior Manager typically has Executive Director level responsibility and reports to the Chief Executive. No individual is involved in determining their own remuneration.

Information relating to non-statutory committees is contained within the **integrated governance protocol**.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, 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 has robust arrangements in place to ensure effective risk management.

During this period the CCG has sustained its continuous improvement approach to governance and risk management. The integrated governance protocol clarifies the systems and processes and behaviours by which HVCCG leads, directs and controls its functions in order to achieve its strategic objectives. Mandatory training on governance arrangements is included as part of the CCG's induction programme for new employees and members of the board. The Head of Corporate Governance continues to provide staff with further risk management training as required.

The CCG's system of internal control, incorporating both corporate and clinical governance, puts in place measures to both prevent and detect potential threats and deter any lack of compliance with effective governance. The board assurance framework (BAF) is being used to make sure that we focus on the key risks to delivering the CCG's strategic objectives within a framework of robust governance. Risk is intrinsic to the provision of healthcare and from the CCG's perspective the consequences of the risks inherent in commissioning decisions must be understood before decisions are made.

The internal operational risk management function is performed by the senior leadership team (SLT). The SLT provides a forum for peer challenge and discussion of risk and for a

collective approach to the management of organisation wide and system risk. Strategic and operational risks are considered in detail by SLT members, with any concerns escalated to the HVCCG Senior Management Team or the ICS Executive as appropriate. These discussions ensure that organisational wide impacts and interdependencies can be understood. SLT members also raise awareness within teams that understanding and managing risk is an everyday part of the CCG's commissioning responsibilities, by discussing their directorate teams at team meetings. As part of plans to transition from CCGs to ICB in 2022/23, HVCCG has been working with ENHCCG and WECCG to align their risks, which will support the development of an ICB BAF and risk register. A Risk Review Group for all three CCGs has been established and Integrated Governance reports to the 3 CCG boards meeting in common have included regular updates on progress with this work.

Public involvement in the management of the healthcare system's strategic and significant risks is an ongoing commitment for HVCCG. Widespread consultation has taken place with local bodies, the public, politicians and other key stakeholders in order to secure their involvement in plans to transform the delivery of care in south and west Hertfordshire and by so doing, manage the principle risks to the achievement of the CCG's strategic objectives.

Risks are formally identified through two routes:

1) **The board assurance framework (BAF) process**, which assesses and manages the principle risks to delivery of the CCG's strategic objectives. Monthly reviews of BAF risks take place with individual SLT and Senior Management Team members before being discussed collectively at SMT meetings. The SMT agrees a BAF proposal for discussion at committees and presentation to the board for approval. Each committee of the board receives, quarterly, a more detailed BAF report relating to the strategic risks in its sphere of responsibility, so that the committee can question and challenge the controls and actions in place to manage risk and provide assurance to the board. Committees and the board are also asked to report any new risks identified during a meeting. Any such feedback received from committees of the board is incorporated into both the committee Chairs' reports and the BAF report to board.

2) **The risk register process**, which is bottom-up and includes risks identified and reported by all levels of staff across the CCG and within its partnerships and collaborations. All significant risks are included on the corporate risk register, which is reported to the board. Less significant risks are managed as part of 'business as usual' activity within directorate, programme and project risk registers, but escalated to the corporate risk register as necessary.

The CCG engages with its internal auditors and local counter fraud specialists to ensure that it has an awareness of risks identified elsewhere and can take steps to prevent and deter adverse incidents that might impact on it. Internal audit advice and support has also been sought in relation to specific aspects of CCG work, including procurement processes and joint arrangements

with ICS partners. Equally, the CCG has a strong track record working with health and social care system partners in west Hertfordshire and across the ICS. Risks and information about the management of them is shared where this is appropriate, including taking account of the outcome of providers' clinical audits.

HVCCG recognises that risk management is not about risk elimination; it is about encouraging appropriate risk-taking while ensuring that sufficient and appropriate information about risks encountered is available and properly analysed. Redesigning pathways of care to secure the best possible services for our community requires a high degree of innovation, transformation and risk-taking. To succeed in this, we recognise the need to determine our risk appetite across all areas of our organisation and to apply this to all decisions about risk and opportunities in the pursuit of the HVCCG's objectives. HVCCG's risk appetite may be described as *'Seek'*, using the Good Governance Institute '*Risk Appetite for NHS Organisations*' matrix https://www.good-governance.org.uk/services/risk-appetite-for-nhs-organisations-a-matrix-to-support-better-risk-sensitivity-in-decision-taking/. That is, HVCCG is *"Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)"*, reflecting the large amount of transformation underway and gathering pace in the Hertfordshire and West Essex health and care system.

Committee effectiveness

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

The Audit Committee supports the Board and the Accountable Officer by reviewing the internal controls and levels of assurance to gain confidence about the reliability and quality of these assurances. The scope of the committee's work is defined in the terms of reference, encompassing all the assurance needs of the Board and Accountable Officer. Within this, the Committee has a particular alignment with the work of Internal Audit and External Audit and Financial Reporting. In May 2022, the Audit Committee undertook a self-assessment of their effectiveness with a positive outcome.

Capacity to Handle Risk

The CCG's Executives are assigned overall responsibility for delivery on the CCG's strategic objectives. The Executives are also responsible for endorsing the CCG's system of internal control and ensuring that there is effective management of risk.

Members of the Board have attended specific training in risk management during the previous 12 months. Risk management training is also mandatory for all managers and staff. As of 30 June 2022, the risk management training compliance for the CCG was 91.06%.

Control mechanisms

There are different levels of risk governance in the CCG:

- Board
- Audit Committee
- Quality and Performance Committee
- Finance Committee
- Primary Care Commissioning Committee
- Patient and Public Involvement Committee
- Commissioning Executive Committee
- ICS Executive
- HVCCG Senior Management Team
- West Herts Delivery Board
- Locality boards
- Programme and project groups

The board is accountable for ensuring that the CCG has an effective programme for managing all types of risk and reviews risks to the strategic objectives of the CCG. It receives details of any new high-level risk exposures at each formal meeting in public and reviews the board assurance framework and corporate risk register at least quarterly.

The ICS Executive Directors own all risks on the board assurance framework and the corporate risk register with the lead on management being undertaken by the CCG Senior Leadership Team (SLT) to ensure that timely and accurate information is shared assessing risks to compliance with the CCG's statutory obligations.

In order to verify that risks are being managed appropriately and that the CCG can deliver its objectives, the board receives and considers written reports from the audit committee and the executive. Every report to Herts Valleys committees includes a front sheet that requires the

author to set out any strategic or significant risks that are relevant to the subject matter and identify the appropriate level of assurance that the board can take in relation to each risk.

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. The integrated governance protocol sets out the ways in which reports to the board and committees routinely focus on the management of risk. Induction training includes high level information about integrated governance: team workshops and individual training and support are also delivered according to need.

Risk assessment

The HVCCG board receives reports every two months on the assessment, management and monitoring of its strategic risks, with these being published on the HVCCG website with board papers: https://hertsvalleysccg.nhs.uk/about-us/documents/board-papers . These have been included in a wider Integrated Governance Report presented to the three CCG Boards meeting in common. The integrated report also updates the board on work to align risks across the three CCGs in Hertfordshire and West Essex in preparation for transition of CCG powers and duties to the Integrated Care Board as the statutory body on 1 July 2022. Since the CCG boards have been meeting in common, the Audit Committee has also monitored detailed quarterly reports on the HVCCG Board Assurance Framework and Corporate Risk Register. The audit committee has also received updates on the ICS Transition Risk Register relating to objectives of the work streams beneath the Transition Board.

The table below summarises the strategic risks to the CCG's organisational objectives and the operational 'red' risks that were identified and managed during this period. Further detail on the information summarised below is available in the performance summary and analysis sections of this report and in the reports to board during quarter 1, 2022/23, published on the CCG website. Proposals for aligned risks in the ICB will include similar risks to be taken forward into the new ICB arrangements

HVCCG's Strategic Objectives 2020-22		
We will work with partners and local people to bring about real, sustainable change, in order to achieve: • Reduction in health inequalities; • Better health: preventing ill-health and supporting people to stay well; and • Joined-up, good quality, and safe services.		
Profile of risks to achieving our strategic objectives at June 2022 (the Board Assurance Framework)		
Red (High)	**Amber (Significant)**	**Yellow or Green (Low)**
3	**5**	**4**
10 of the 12 strategic risks met their forecast risk scores in 2021-22. The reasons why two risks did not are explained below.		

Board Assurance Framework: Strategic risks in 2021-22	
Risk description and score	**Assurance summary**
Risk that we do not engage effectively with a range of our patients, population and stakeholders. *Forecast score of 4 achieved*	Engagement is a priority for the CCG and we have been continuing to work with local people through a pandemic which has made it necessary for us to make changes to the frequency and way we engage. As well as the pandemic response, the CCG has supported patient and public engagement and understanding about a range of key programmes, including: the plans to redevelop WHTH; COVID vaccinations; access to general practice; the closure of some local services and planning for new ones; and the best ways to access the right services. The South and West Herts Health and Care partnership (SWHHCP) which covers the Herts Valleys geography has agreed an engagement framework with co-production at its heart, committing to a strong patient and service-user voice in its work, which has been a major focus of our work in recent months. A similar strategic risk is proposed to be taken forward into the new ICB arrangements as there will always be more work to be done, particularly where new structures and processes are not well known or understood.
Risk that member practices, local providers, local authorities and other partners do not respond constructively to engagement. *Forecast score of 8 achieved*	As detailed above, the pandemic has introduced even more focused and frequent engagement with member practices, local providers and local authorities that will support the development of planned new ways of working in the ICB. A primary care restoration framework has been implemented to support practices and PCNs identify and address their individual challenges and priorities. The local delivery board has been reinstated with good engagement from all partners. Unprecedented levels of cross-organisational collaboration to deliver solutions at pace have laid firm foundations which are now being built on for transition to the new arrangements. Continued development of the south and west Herts health and care partnership (SWHHCP), now running in shadow form, is key to maintaining 'organisational memory'.

	A risk relating specifically to sustaining primary care engagement under the ICB has been supported by the Primary Care Commissioning Committee.
Risk that we have an unengaged staff body and wider clinical workforce. *Forecast score of 4 achieved in Q4.*	Staff briefings from the MD and colleagues have been superseded in Q4 by fortnightly webinars and weekly written communications from the ICS CEO and Executive Team, to keep staff updated on work to support the transition from CCGs to the ICB and provide an opportunity to ask questions. There are also MD sessions, available to staff from all CCGs to attend. A transition internal communications and engagement plan has been agreed and a working group has been established to deliver it. Listening Events for all staff have been run by experts at OKA People and in response to feedback from the first set of events a series of information materials have been. Two groups of change champions 'Explorers' (supporting two-way comms with staff) and 'Pathfinders' (providing an interface with Executive) have also been established. Meetings are now scheduled for these two groups to meet. Joint meetings of staff forums across the ICB now support the development of staff involvement. Proposals for ICB strategic risks will include a similar risk to be taken forward.
Risk that we are unable to ensure access to good quality, safe and sustainable services for the population and patients of west Hertfordshire. *The forecast risk score of 12 has been maintained, with the introduction of additional mitigations each time a new threat is identified under unprecedented system pressures. The target of 8 is not achieved*	Performance and quality has been reviewed in synergy, with the sharing of information, intelligence and assurance from teams and clinical reviews. Quality reporting has been streamlined and a minimum data set for all providers has been agreed. System leads continue to work together to ensure minimum impact on service delivery while the system remains under pressure and the quality team are monitoring all areas for early warning signs. All the Nursing and Quality team are very focused on risk management, presenting detailed strategic and operational risk reports to each Quality and Performance Committee meeting and keeping the Committee closely advised of progress and the contingency arrangements in place should the risk be realised. The Nursing and Quality team are also embedded in multi-disciplinary and wider partnership conversations around recovery plans, and changing circumstances or demands are factored into the directorate risk management processes. Different ways of working have been actively considered, planned for by chief executives across the system, and approved by NHS E/I, to ensure continued access and good quality care. The established incident management process considers the impact of decisions taken and any mitigations required. If there were a threat to access and safe delivery of critical services, the NHS Incident Management and EPRR (Emergency Preparedness, Resilience and Response) processes would be stepped up and able to support requests from the wider Local Resilience Forum partnership.

Risk of lack of adequate system capability and interoperability in the management and security of information, data and technology. *The forecast improved score of 12 has not been achieved.*	Although there has been progress regarding implementation, both of shared care records across the ICS and the Electronic Patient Record at WHTH, further work and time is required to embed these new arrangements in a way that will allow the improvements anticipated to be realised and have a demonstrable impact on performance and resilience. For those reasons, the current risk score remains at 16 in the short term. Close working with partners and regulators is continuing to make progress at pace and this risk will be proposed as an ongoing, aligned risk for the ICB since improvements to system IM&T is a long-term process that can be impacted by external and internal pressures.
Risk that we do not comply with the General Data Protection Regulation (GDPR). *The forecast score of 4 has been achieved upon successful submission of the DSPT June 2022*	This risk is assessed against national requirements in the Data Security Protection Toolkit (DSPT) that the CCG submits every year. Training for all CCG staff on the practical aspects of GDPR compliance is mandatory and progress against the DSPT action plan has been monitored through the audit committee. The 2021-22 toolkit submission has been completed and all mandatory assertions met. The potential and evolving risk of data and cyber security breaches is something that will be recommended for inclusion in the ICB risk profile.
Risk of negative impact of the COVID pandemic on system resilience across west Hertfordshire. *The forecast of 9, set in anticipation of an improved COVID situation by year end, has not been achieved. Following re-assessment in Q4 the current risk score remains at 16.*	Recent increases in COVID numbers have led to a renewed call from the centre to prepare for a possible major incident due to extraordinary pressures on acute trusts, emergency departments, mental health and ambulance services, with 'super surge' plans once again being considered. While the severity of illness is less than seen in previous waves, system pressures are still high across most South and East of England areas. Contingency measures in place also continue to ensure the minimisation of harm and monitor patient wellbeing. Monitoring and support of the Urgent and Emergency Care (UEC) system across the ICS is managed through our escalation framework overseen by the System Escalation Control (SEC) group which comprises senior leads from HVCCG, ENHCCG and WECCG to address national, regional and place-based responses to system pressures. Advice will be sought from this group when drafting risks relating to UEC and system resilience for the ICB.
Risk that there will be insufficient capacity for GP practices, primary care networks and federations to deliver the transformation of care in	Throughout the third wave of the pandemic, we have seen extremely high pressures across the healthcare system, including on general practice, alongside patients requesting increased access to appointments. Primary care commissioners and communications teams are working at ICS level to support practices with messages and communications material that they can share with patients to manage expectations and provide reassurance around continued use of telephone consultations unless a face-to-face appointment is clinically advised. The CCG has made additional plans to support practice resilience in the light of increased demand, especially for same day urgent

west Hertfordshire. *The forecast score of 12 has been achieved.*	appointments. A new aligned risk, relating to this challenge for all three CCGs in Herts and West Essex, has been agreed by the Primary Care Commissioning Committees meeting in common. The forecast of 12 has been achieved but the target of 8 has not, reflecting the continuing uncertainty about pressures on primary care under COVID 19 and the further work necessary to continue to develop and operationalise PCNs. It has been agreed by the PCCCs that a risk relating to capacity in primary care should be included in the ICB strategic risk register.
Risk that workforce issues prevent us from transforming the delivery of care across the local health and social care system. *The forecast score of 12 has been achieved.*	It has been assessed that workforce is one of the biggest risks and challenges to the healthcare system for the delivery of transformation plans. An updated integrated People Plan has been developed and submitted to NHS E/I/. The people plan was refreshed with wide stakeholder engagement across the system, to take into account national and regional workforce agendas as well local our own local system priorities and needs. It is currently reflective of the present situation of the pandemic, the need for mutual aid, and system collaboration and further updated to take in account the evolving reality of the pandemic. Workforce recruitment and retention across the Hertfordshire and West Essex (HWE) system has been identified as a priority work stream during the pandemic so work continues in this area. Next steps will be to ensure that ICS priorities align with the ICS Development Framework; the HWE Workforce Plan; the System Workforce Improvement Recommendations; the Adult Social Care Plan and the National People Plan. This risk score has improved, but the target of 8 is not yet met. Discussions with the ICS Chief People Officer have confirmed that draft strategic risks for workforce in the ICB will be prepared for discussion at the People Board.
Risk that our plans do not focus on prevention of ill health and reduction of health inequalities. *The forecast score of 8 has been maintained with additional mitigations put in place in response to new health inequalities exposed by the pandemic.*	There is now better data availability on long waiters for referral to treatment and this is linked into the wider population health management work for assurance. The first cut of this data is being used to understand potential inequalities being felt in communities among long waiters and identify actions to take. Work on development of new place-based care models to deliver against the NHS Long Term Plan has been delayed due to COVID-19, but the closer partnership working that has been necessitated by the incident has laid firm foundations for development. The pandemic has brought into sharp relief some health inequalities and recovery work has been targeted to identify and support those patients most in need of care and treatment. The CCG continues to work on developing pathways to help earlier identification of conditions which can then support prevention. The CCG are also working closely with WHTH on a pathway to identify patients on waiting list for planned care services to be referred through the Community Navigator team to have support to prevent any further decline due to wellbeing or other issues such as mobility or loneliness. Some delays to transformation initiatives mean that the target score of 4 is not yet achieved. A new strategic risk will be drafted for the ICB and focus on any barriers to achievement of the key ICS objective to reduce health inequalities. The

	recent Healthwatch Hertfordshire audit is helpful in bringing fresh perspectives on how this work might best be progressed with more robust actions identified.
Risk that we do not deliver a financially sustainable integrated healthcare system in collaboration with our partners in the ICS. *The forecast score of 20 has been achieved, with the target of 5 being a longer-term aim.*	An Emergency Financial Framework has been in place for two financial years to 2021/22. The framework simplified the arrangements for payment and contracting with a greater focus on system partnership and the restoration of electives services. In line with the planning timetable for 2022/23 that was issued in January the ICS draft financial plan was submitted to the NHS E/I/I regional team on 14 March with the final submission due in late April. The CCG's 2021/22 plan delivers a breakeven position against its allocated share of the overall financial envelope, and the consolidated ICS Plan also delivers a breakeven position. There is a risk that actual growth and inflationary pressures exceed those detailed within the planning guidance, and this will not be able to be mitigated across the system. Due to the delays in receiving planning guidance, decisions on recurrent system transformation were made without that framework in place. A great deal of system work will need to be taken forward by the ICB to deliver the strategic objective of enhancing productivity and value for money across the ICS and manage the related risks. Aligned ICB strategic financial risks will be proposed.
Risk that we do not achieve financial balance in 2021/22. *The forecast score of 4 will be achieved once the year end position has been confirmed.*	At Month 12 the CCG reported a surplus of £0.5m against the 2021/22 plan. This position includes all Hospital Discharge Programme expenditure and Elective Recovery activity from the Independent Sector above allocation reimbursed by NHS E/I (NHS E/I). The main financial risks lay within the Continuing Healthcare (CHC) and Prescribing spend. Uplifts with planning guidance, particularly for H1 2021/22, were challenging and below the level of inflation and growth expected to be seen. The risks were mitigated through non-recurrent sources. The CCG has planned to deliver efficiencies of £1.25m in H1 2021/22 and £4m in H2 to mitigate against the known cost pressures. These efficiencies have been included within established budgets. The current risk score reduces as the breakeven position is confirmed for year end.
Profile of risks escalated to our Corporate Risk Register at June 2022.	

Red (High)	Amber (Significant)	Yellow or Green (Low)
6	**3**	**0**

- 4 risks on the Corporate Risk Register achieved their target scores in 2021-22, with another showing an improved current risk score.
- 5 corporate risks were de-escalated or closed, and two new corporate risks were added to the register
- 56 risks have remained "red-rated" at June 2022

Risk that patients are not assessed with a management plan and treated, admitted and/or discharged out of the Emergency Department within 4hrs. *Current risk score remains at 16 against a target of 8 with numerous actions taken to ensure patient safety and prevent harm.*	A&E/ED performance at WHTH has been extremely challenged throughout 2021/22 and deteriorated further since Q3 as reported above in performance analysis above. As a result of the continued increase in emergency demand and sustained pressure on the ambulance service WHTH have needed to declare Business Continuity Protocols on a number of occasions after opening all surge and escalation beds. This has been compounded by high numbers of mental health patients in ED and on the wards. Some elective activity was also stood down (small numbers) due to having to repurpose beds. Severe capacity pressures continued in March, with national requests to once more to prepare for management of a critical incident and exceptional 'super-surge' measures. Rising numbers of COVID- 19 admissions compounded the existing capacity, staffing and hospital flow challenges, with non-COVID demand also at unprecedented levels. Multi-agency discharge events (MADE) were run in January and are planned for April, to facilitate discharges and improve flow. The CCG has been negotiating with partners to establish a system MDT approach to replace the national Hospital Discharge Programme which ceased at the end of 2021/22. In the short term there are bridging arrangements agreed.
Risk that we do not deliver on the constitutional pledge to refer to treatment at WHTH. *The current risk score has remained at the high level of 16 during Q1 2022/23 due to unprecedented system pressures and operational challenges at the acute trust.*	The WHTH RTT position deteriorated during 2021/22. No organisations are currently meeting the national standard of 92% within our ICS, but Herts Valleys CCG overall has achieved the highest level of performance for RTT within our ICS. Oversight is maintained via the Overall Patient Tracking List (PTL), but volumes have increased since Q3, complicated by issues associated with the implementation of an Electronic Patient Record (EPR). 52 week and 104 week waits also rose in Q3. Ongoing challenges include capacity and workforce resources, increases in referrals, and continued challenges re patients deferring appointments due to COVID concerns. A detailed long waits improvement plan and clinical validation is in place at WHTH with no related serious incidents (SIs) being declared to date. Recovery of diagnostic waiting times towards the 99% national standard has been strong, but also deteriorated in Q3. Key issues are: prioritising the most clinically urgent patients which results in longer waits for more routine patients; and insufficient resources (including kit, capacity & workforce) to reduce backlog over a short timescale. Concerns about performance against 7 of the 8 cancer waiting time metrics since December has led to escalation of another specific risk to the corporate risk register. Urgent action is being taken with partners including NHS E/I/I and the CQC.

Risk that we do not deliver on priority ambulance key performance indicators (KPIs). *The current risk score has remained at the high level of 16 due to unprecedented system pressures.*	The system remains very pressured since COVID-19 lockdown was removed, with 999 conveyances remaining high. Achievement of the Category 2 target is extremely challenged. Infection prevention and control (IPC) measures remain in place for the ambulance service, and this has added extra pressure on an already stretched system. The CCG is working with the acute trust and East of England Ambulance Service Trust (EEAST) to support off-loading of patients at hospital. Use of HALOs (Hospital Ambulance Liaison Officers) aids and shortens ambulance stacking time and speeds up handover of patient to acute trust in ED. 111 is being promoted to divert avoidable call outs, including use of ECP (Emergency Care Practitioner) cars to support care home staff and residents to reduce unnecessary ambulance conveyance. Support is diverting conveyance to ambulatory services and/or Same Day Emergency Care (SDEC) services, such as frailty clinics, etc.
Risk that we are unable to maintain good quality, safe and sustainable services within the non-emergency patient transport service (NEPTS) *This risk has remained at the high level of 16*	HVCCG is working with WHTH, EEAST and wider system partners to improve resilience and find more efficient and cost-effective ways to handle same day / urgent requests in the NEPTS service. This challenge and the ongoing infection prevention and control (IPC) requirements, plus staff sickness, are the main causes for the reduction in capacity. A deep dive has been undertaken to compare the processes at PAH and ENHT and identify areas for improvement. The CCG is planning to pilot NEPTS same day discharge and urgent activity at WHTH to inform the future design / commissioning of this element of NEPTS. Fortnightly oversight meetings have been held between HVCCG and EEAST to address any performance / quality issues concerns / issues and plans to resolve this. Further challenges around year end mean that these discussions have now been escalated to Executive Director level.

Internal audit undertook a review of risk management and assurance in December 2021 and concluded that:

"Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective."

A further review is planned to take place within the first 12 months of the ICB.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. Because the system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk (see risk appetite above), it can only provide reasonable and not absolute assurance of effectiveness.

The audit committee has oversight of the internal control mechanisms on behalf of the board. Executives oversee the management and delivery of internal mechanisms. The audit committee bases its assessments, and therefore assurances, on the effectiveness of the CCG's controls:

- Assurances provided by the board and committees' work programmes;
- Reviews of CCG policies and procedures (e.g. annual review of detailed financial policies);
- Provision of assurance from independent sources (e.g. internal audit or third party reviews undertaken).

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 Strategy and workplan. West Midlands Ambulance Service provides the Internal Audit services for the organisation. The Head of Internal Audit reports independently to the Chair of the 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 registers and uses the template audit framework published by NHS E to support CCGs. An audit wasn't carried out during Q1 2022/23, however, the latest audit which was carried out in 2021/22 received reasonable assurance, with two management actions recommended, both of which have been completed.

Data Quality

Good information is essential for the commissioning of appropriate services. The CCG's Business Intelligence and Performance teams provide key metrics to all committees and to Executive directors and their staff to enable discharge of their respective functions. Collaboration agreements are in place between the CCG, East and North Hertfordshire CCG, Hertfordshire County Council, local NHS providers, Arden and GEM Commissioning Support Unit (CSU) and commercial partners to allow the necessary data flows. The board considers the quality of data it receives to be acceptable**.**

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees and in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. In 2022-23 the CCG met all the mandatory requirements.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious information governance incidents. We have developed data protection information risk assessment

(DPIA) and management procedures, and a programme has been established to embed an information risk awareness culture throughout the organisation.

The CCG completed and publish a Data Security and Protection Toolkit (DSPT) assessment in June 2022 and met all mandatory assertions.

Business Critical Models

The CCG can confirm that an appropriate framework and environment continued to be in place during Q1, 2022/23 to provide quality assurance of business-critical models. There are several aspects of the 2013 MacPherson review which are of relevance to the CCG to increase the robustness of the modelling work we undertake, as well as providing assurance to the relevant committee and board of the level of confidence which can be taken from the modelling estimates. The recommendations from the MacPherson report highlight several of these and they have been adapted for CCG use:

- All models have appropriate quality assurance of their inputs, methodology and outputs in the context of the risks their use represents.

- All models are managed within a framework that ensures that appropriately specialist staff are responsible for developing and using the models as well as quality assurance.

- There is a single Senior Responsible Owner (SRO) for each model through its lifecycle and clarity from the outset on how quality assurance (QA) is to be managed. Business cases using results from models summarise what QA processes have been undertaken, including the extent of expert scrutiny and challenge. They also confirm if the SRO is content that the QA process is compliant and appropriate with any model limitations, risks, and the major assumptions are understood and applied in generating in generating the model outputs. This includes end-users of any model prepared.

The CCG's data provider, Arden and GEM CSU, has all requirements necessary to ensure quality assurance of business-critical models included in their Service Level Agreement (SLA) with the CCG.

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). As a nationally recognised body, it is assumed that the ONS will have undertaken quality assurance processes about the construction of these models.

The CCG currently uses a risk stratification model which is made available through GEMIMA. HVCCG is included in the list of risk stratification approved organisations published here:

https://www.england.nhs.uk/publication/list-of-risk-stratification-approved-organisations/ This model is used to identify a discrete group of patients at risk of being admitted to the hospital as an emergency, who may be better looked after through local community or primary care services. The CCG has also 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.

System	QA activity	Date undertaken
GEMIMA NHS Arden and Gem Commissioning Support Unit	Reports and underlying business logic are Quality Assured by appropriate clinicians (CCIO is used where it is a more generic report) where this has been a requested report. For nationally mandated rules there are independent internal reviews to ensure the report meets the guidelines. Where feasible numbers are Quality Assured using nationally available data submitted by care providers directly.	Ongoing
Risk Stratification NHS Arden and Gem Commissioning Support Unit	This is independently Quality Assured by the ACG – John Hopkins.	Ongoing
PHM/SMITH NHS Arden and Gem Commissioning Support Unit	System still in development Quality reviews have taken place from; Analysts, GP's, Mental Health clinicians, Community based clinicians and ex Acute based clinicians.	Plan to release full documentation
SHREWD	QA process is as follows:	Upon set up and when there are any

Transforming Systems	• BI & IT teams are provided with a data definition and technical sign off that the data is flowing as expected is confirmed at both ends • Operations staff review the data and sign of that the data interpretation used fits operational activity • The data is ultimately signed off by the CCG UEC leads	changes to individual data points the process is repeated
Eclipse Prescribing Services Ltd	As an NHS Digital supplier and assured GPIT service provider our clinical safety and QA obligations are fully compliant with NHS Digital requirements. The designated Clinical Lead and Clinical safety Officer, Dr Julian Brown and his team complete a quarterly review of the clinical systems. The systems have clinical end user feedback built in to ensure all feedback or review requirements are escalated rapidly, and our NHS Digital central project management ensures continual QA review is applied	Ongoing quarterly

Third party assurances

Service Auditor Reports were not provided to cover the 1 April to 30 June 2022 reporting period, therefore service organisations were requested to provide a bridging letter to confirm there have been no changes in the CCG's control environment and, where relevant, to comment on the status of issues that gave rise to any 2021/22 accounts qualifications.

NHS Shared Business Services - Only two exceptions were identified from the twenty seven controls reviewed and this was not considered to represent a significant risk to the CCG.

NHS Digital - Three exceptions were highlighted against the twenty controls reviewed under the four main control objectives. In all other aspects the service auditor report was unqualified. In each instance where an exception was raised Management has identified the mitigating controls in place, such that these do not appear to represent a significant impact to the CCG's control environment.

Capita - Four out of the 17 control objectives were qualified by the service auditor. In each instance Management has set out improvements to controls to help prevent a recurrence and to mitigate the risk going forwards. Whilst noting the exceptions, we do not consider these sufficiently significant to impact on our overall Head of Internal Audit Opinion.

Control Issues

The CCG has had no significant control issues in Q1, 2022-23.

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

The effectiveness of the use of resources and financial performance of the CCG is monitored by the board as well as by its finance committee. The finance committee is chaired by a lay member of the board.

Significant elements of the finance committee's remit are to: review financial plans; monitor in-year performance against those plans; and monitor contract performance. Financial monitoring includes ensuring that the CCG does not exceed its running (management) costs allocation. The CCG regularly conducts benchmarking of its activity to identify areas for improvement and potential efficiencies. Corporate risks in respect of financial performance and the use of resources are captured in the board assurance framework and corporate risk register. The highest-level risks are reported to the audit committee and board. The audit committee is accountable to the board and its remit is to provide the board with an independent and objective view of the group's systems, information and compliance with laws, regulations and directions governing the group. It delivers this remit in the context of the group's priorities and the risks associated with achieving them. In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to a risk-based plan of work agreed with management and approved by the audit committee, on the overall adequacy and effectiveness of the CCG's risk management, control and governance processes. The opinion contributes to the annual governance statement.

The latest ratings for quality of leadership in the CCG Improvement and Assessment Framework in 2020-21 was good.

Delegation of functions

The functions of the CCG have not been delegated through any delegated authority agreement. The CCG has retained control of its functions.

Counter fraud arrangements

Counter fraud arrangements are in place for the CCG in line with the NHS Counter Fraud Authority Standards for NHS Commissioners 202/21: Fraud, Bribery and Corruption[8].

We have a responsibility to ensure that NHS resources are protected from fraud, bribery or corruption, which could impact on our ability to commission services and treatment, as NHS funds are wrongfully diverted from patient care. We adhere to the key standards that the NHS Counter Fraud Authority has set out for commissioners:

The fraud, bribery and corruption standards are set out in detail in the document under four key principles:

1: **Strategic Governance**. The aim is to ensure that counter fraud measures are embedded at all levels across the organisation, including a mechanism for continuous quality improvement in line with the NHSCFA's strategy.

2: **Inform and Involve**. Requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of fraud and bribery affecting the NHS.

3: **Prevent and Deter**. Requirements in relation to discouraging individuals who may be tempted to commit fraud against the NHS and ensuring that opportunities for fraud to occur are minimised.

4: **Hold to Account.** The substance of this principle corresponds to the Investigate, sanction and redress principle in the NHSCFA's strategy. This section sets out the requirements in relation to detecting and investigating economic crime, obtaining sanctions and seeking redress.

The following arrangements are in place:

- An accredited counter fraud specialist is contracted to undertake counter fraud work proportionate to identified risks. The CCG contracts West Midlands Ambulance Service to provide the counter fraud provision by way of a nominated lead local counter fraud specialist (LCFS). The LCFS is accredited by the NHS Counter Fraud Authority and qualified to undertake the duties of that role.
- The CCG Audit and Risk Committee receives a report against each of the Standards for Commissioners at least annually. There is executive support and direction for a proportionate proactive work plan to address identified risks.

[8] **NHS Counter Fraud Standards for Providers 2020-21 v1.3 (cfa.nhs.uk)**

- An executive member of the board is proactively and demonstrably responsible for tackling fraud, bribery, and corruption. This responsibility has been assigned to the Chief Finance Officer.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

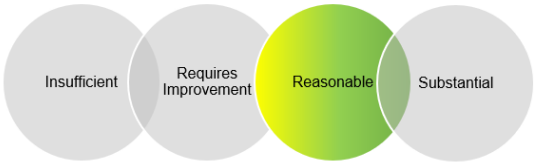
The audit committee provides lay member responsibility for the oversight of anti- fraud, corruption and bribery work. The committee receives the reports from the accredited counter fraud specialist on the work undertaken. Additionally, the committee receives an annual local counter fraud services report, which highlights key activities during the year and performance against agreed KPIs.

HEAD OF INTERNAL AUDIT OPINION

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

Final Head of Internal Audit Opinion 2022/23

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



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

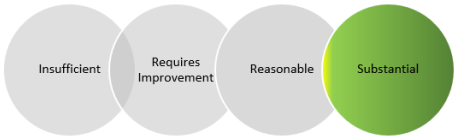
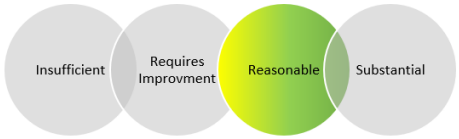
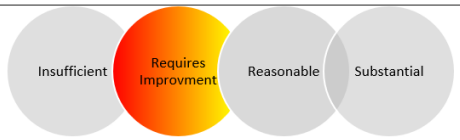
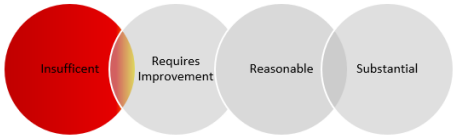
During the previous financial year 2021/22, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Personal Health Budgets	Reasonable Assurance
Continuing Healthcare	Partial Assurance
Conflicts of Interest	Reasonable Assurance
Secure Remote Working, Information Security and Operational Resilience	Reasonable Assurance *

CCG Change Management	Reasonable Assurance *
Integrated Care Partnerships	Reasonable Assurance
Recovery of Services	Reasonable Assurance
Risk Management and Board Assurance Framework	Reasonable Assurance
IR35 Compliance	Advisory

*Joint audits with East and North Herts CCG

Explanation of levels of assurance:

	Substantial assurance can be given that there is a sound system of internal control which is designed to meet the organisation's objectives and that controls are being consistently applied in all the areas reviewed.
	As a result of the work undertaken, our opinion is that reasonable assurance can be provided that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk
	As a result of the work undertaken, our opinion is that Requires Improvement assurance can be given as weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisation's objectives at risk in a number of the areas reviewed;
	As a result of the work undertaken, our opinion is that Insufficient Assurance can be given as weaknesses in control, and/or consistent non-compliance with controls, could result/ has resulted in failure to achieve the organisation's objectives in the areas reviewed.

There have not been any "no assurance" opinion reports in 2021-22 to date. One has received "partial assurance": Continuing Healthcare. Detailed actions have since been undertaken and followed up during Q1 2022/23 and reports planned to both the Audit and Risk Committee and the Finance and Investment Committee.

Actions related to compliance with the process for undertaking three-month reviews of patients assessed to be eligible for Continuing Healthcare (CHC) funding. In response, a demand and capacity exercise was completed which demonstrated an increase in demand for CHC over the previous 12 months. A workforce business case for interim staff resource was approved as a temporary measure to increase capacity within the team to support with completing the outstanding reviews.

In the audits shown as providing “reasonable assurance” some areas were identified where enhancements are required and in each of these cases management actions have been agreed, the implementation of which will improve the control environment.

Based on the work undertaken to date on the CCG’s system of internal control, West Midland Ambulance Service reported that they do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS).

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

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

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

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

- Board
- Audit Committee
- Quality and Performance Committee
- Internal Audit
- External Audit

Conclusion

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

Dr Jane Halpin
Accountable Officer
Date signed: 5th October 2022

PART TWO: REMUNERATION AND STAFF REPORT

REMUNERATION REPORT

The information on pages 97 to 99 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 during 2022/23 and all members were in attendance.

- Thelma Stober - Lay member (Primary Care Commissioning), Chair of the Remuneration Committee
- Paul Smith – Lay Member
- Asif Faizy – GP Board Member

REMUNERATION OF VERY SENIOR MANAGERS

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

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

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

SENIOR MANAGERS PERFORMANCE RELATED PAY (not subject to audit)

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

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

The CCG uses the NHS England published remuneration guidance for CCG Chief Officers and Chief Finance Officers in determining the remuneration for these roles. For other Very Senior Manager (VSM) roles, the previous NHS VSM framework is used as a guide. The CCG benchmarks with local CCGs to ensure that remuneration is in line with the local economy. Remuneration for all senior roles is agreed via the Remuneration and Terms of Service Committee. For all other staff, the Agenda for Change framework is applied.

The following are GP Board members

Dr Small
Dr Fernandes
Dr Carlton-Conway
Dr Ciobanu
Dr Eliad
Dr Faizy
Dr Page
Dr Pile

Lay members are also employed on fixed term contracts:

Stuart Bloom
Alison Gardner
Paul Smith
Thelma Stober

PAYMENTS TO PAST SENIOR MANAGERS (subject to audit)

There have been no payments to past senior managers.

SALARIES, ALLOWANCES AND PENSION BENEFITS

Employee benefits and staff numbers (subject to audit)

	2022-23 (3 months to 30 June)		
Employee benefits	**Total £'000**	**Permanent Employees £'000**	**Other £'000**
Salaries and wages	3,363	2,773	590
Social security costs	322	322	0
Employer Contributions to NHS Pension scheme	470	470	0
Apprenticeship Levy	11	11	0
Termination benefits	0	0	0
Total employee benefits expenditure	**4,166**	**3,576**	**590**

	2021-22		
Employee benefits	Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	13,066	11,265	1,801
Social security costs	1,184	1,184	0
Employer Contributions to NHS Pension scheme	1,915	1,915	0
Apprenticeship Levy	46	46	0
Termination benefits	0	0	0
Total employee benefits expenditure	**16,211**	**14,410**	**1,801**

Average number of people employed (subject to audit)

	2022-23 (3 months to 30 June)		
	Total Number	**Permanently employed Number**	**Other Number**
Total	**230.8**	**196.0**	**34.8**

	2021-22		
	Total Number	Permanently employed Number	Other Number
Total	230.3	201.7	28.6

OFF-PAYROLL ENGAGEMENTS

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

For all off-payroll engagements as of 30 June 2022, for more than **£245** per day and that last longer than six months.

Number of existing engagements as of 30 June 2022	**19**
Of which…	
Number that have existed for less than one year at time of reporting	8
Number that have existed for between one and two years at time of reporting	2
Number that have existed for between two and three years at time of reporting	2
Number that have existed for between three and four years at time of reporting	2
Number that have existed for four or more years at time of reporting	5

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2022 and 30 June 2022, for more than £245 per day 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 2022 and 30 June 2022	6
Of which…	
Number assessed as caught by IR35	6
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 3: Off-payroll board member/senior official engagements (not subject to audit)

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

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	8
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	19

HERTS VALLEYS CCG

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

Table 1:Single total figure

			2022-23					
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 - 30.56%	1,2	10-15	0	0	0	0	10-15
David Evans	Managing Director (to 30 April 2022)	3	10-15	500	0	0	2.5-5	15-20
Matthew Webb	Managing Director (from 1 May 2022)	4	20-25	0	0	0	7.5-10	25-30
Alan Pond	Chief Finance Officer - 30.56%	1	10-15	0	0	0	0	10-15
Jane Kinniburgh	Director of Nursing & Quality - 30.56%	1,2	5-10	0	0	0	0	5-10
Rachel Joyce	Director of Clinical & Professional Services - 30.56%	1	10-15	0	0	0	2.5-5	10-15
Avni Shah	Director of Primary Care Transformation - 30.56%	1	5-10	0	0	0	2.5-5	10-15
Frances Shattock	Director of Performance & Delivery - 30.56%	1	5-10	0	0	0	0-2.5	10-15
Elizabeth Disney	Director of Operations (from 6 June 2022)- 30.56%	1	0-5	0	0	0	0-2.5	0-5
Dr Nicolas Small	GP Director and CCG Chair	6	30-35	0	0	0	£NIL	30-35
Dr Trevor Fernandes	GP Director & Deputy Clinical Chair	6	20-25	0	0	0	£NIL	20-25
Dr Daniel Carlton-Conway	GP Director	5	15-20	0	0	0	£NIL	15-20
Dr Corinne Ciobanu	GP Director	5	25-30	0	0	0	£NIL	25-30
Dr Rami Eliad	GP Director	6	20-25	0	0	0	£NIL	20-25
Dr Asif Faizy	GP Director	5	25-30	0	0	0	£NIL	25-30
Dr Catherine Page	GP Director	6	20-25	0	0	0	£NIL	20-25
Dr Richard Pile	GP Director	6	15-20	0	0	0	£NIL	15-20
Stuart Bloom	Lay Member	7	0-5	0	0	0	0	0-5
Alison Gardner	Lay Member	7,8	0-5	0	0	0	0	0-5
Paul Smith	Lay Member	7	0-5	0	0	0	0	0-5
Thelma Stober	Lay Member	7	0-5	0	0	0	0	0-5

Notes

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

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

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

Note 1- Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the members remuneration has been apportioned across the three CCGs and ICS and only that relating to Herts Valleys CCG has been disclosed above based on 30.56% of their total remuneration. For transparency, members total remuneration across Hertfordshire and West Essex CCGs and ICS is disclosed in the table below.

Note 2 - Jane Halpin and Jane Kinniburgh chose not to be covered by the pension arrangements during the reporting period.

Note 3 - The taxable benefit for David Evans relates to their having a lease car with a taxable benefit as stated. The member has a salary sacrifice arrangement for their vehicle which has the effect of reducing the salary paid in the period April - June 22.

Note 4 - Prior to his appointment as Managing Director, 66% of Matthew Webb's salary was recharged to the CCG by West Essex CCG in respect of Hertfordshire and West Essex ICS.

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 - GP members who chose not to be covered by the Practitioner pension arrangements during the reporting period.

Note 7 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Note 8 - Alison Gardner was also a Lay Member of East & North Hertfordshire CCG Board for the period April - June 2022 for Patient and Public Involvement. The remuneration disclosed above relates only to Herts Valleys CCG.

The table below shows the total remuneration for the period April - June 2022 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	40-45	0	0	0	0	40-45
Alan Pond	Chief Finance Officer	30-35	0	0	0	0	30-35
Elizabeth Disney	Director of Operations (from 6 June)	5-10	0	0	0	2.5-5	10-15
Rachel Joyce	Director of Clinical & Professional Services	35-40	0	0	0	7.5-10	40-45
Jane Kinniburgh	Director of Nursing & Quality	30-35	0	0	0	0	30-35
Avni Shah	Director of Primary Care Transformation	30-35	0	0	0	12.5-15	40-45
Frances Shattock	Director of Performance & Delivery	30-35	0	0	0	7.5-10	35-40

Fair Pay disclosure (audited element of remuneration report)

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

The banded remuneration of the highest paid director/member in the CCG in the period April - June 2022, when annualised was £135,000-£140,000 (2021-22, £135,000-£140,000). 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	137,500:32,846	137,500:47,654	137,500:56,859
	4.19	2.89	2.42
2022-23	137,500:33,516	137,500:47,684	137,500:58,746
	4.10	2.88	2.34

In 2022-23 and 2021-22, no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from the highest paid director to £5,000-£10,000 (2021-22 highest paid director:£5,000-£10,000).

The remuneration for the lowest paid includes annual remuneration for a time commitment below the normal contractural hours and therefore the annualised FTE calculation reflects the different terms.

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 period April - June 2022, when annualised was £170,000-£175,000 (2021-22, £170,000-£175,000). The relationship to the remuneration of the CCG's workforce is disclosed in the table below.

YEAR	25th percentile total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio
2021-22	172,500:32,846	172,500:47,654	172,500:56,859
	5.25	3.62	3.03
2022-23	172,500:33,516	172,500:47,684	172,500:58,746
	5.15	3.62	2.94

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

Although there has been a small reduction in the number of staff in the current reporting period, this has been offset by additional senior management appointments resulting in a small increase (1.80%) from the previous financial year in the average employees salary and allowances (2022-23, £49,635:2021-22, £48,744).

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.

HERTS VALLEYS CCG

Table 2: Pension Benefits April – June 2022

Name	Role	Note	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£00
Jane Halpin	Accountable Officer - 30.56%	1,2	0	0	0	0	0	0	0	0
David Evans	Managing Director (to 30 April)	3	0-2.5	0	15-20	0	166	2	209	0
Matthew Webb	Managing Director (from 1 May)		0-2.5	0-2.5	45-50	90-95	745	9	838	0
Alan Pond	Chief Finance Officer - 30.56%	1	0	0	20-25	35-40	398	5	416	0
Elizabeth Disney	Director of Operations (from 6 June 2022) - 30.56%	1	0-2.5	0-2.5	0-5	0-5	27	0	40	0
Rachel Joyce	Director of Clinical & Professional Services - 30.56%	1	0-2.5	0-2.5	15-20	35-40	334	4	368	0
Jane Kinniburgh	Director of Nursing & Quality - 30.56%	1,2	0	0	0	0	0	0	0	0
Avni Shah	Director of Primary Care Transformation - 30.56%	1	0-2.5	0-2.5	10-15	20-25	182	3	205	0
Frances Shattock	Director of Performance & Delivery - 30.56%	1,3	0-2.5	0	0-5	0	9	1	18	0
Dr Nicolas Small	GP Director and CCG Chair	6	0	0	0	0	0	0	0	0
Dr Trevor Fernandes	GP Director & Deputy Clinical Chair	6	0	0	0	0	0	0	0	0
Dr Daniel Carlton-Conway	GP Director	4	0	0	0	0	0	0	0	0
Dr Corinne Ciobanu	GP Director	4	0	0	0	0	0	0	0	0
Dr Rami Eliad	GP Director	6	0	0	0	0	0	0	0	0
Dr Asif Faizy	GP Director	4	0	0	0	0	0	0	0	0
Dr Catherine Page	GP Director	6	0	0	0	0	0	0	0	0
Dr Richard Pile	GP Director	6	0	0	0	0	0	0	0	0
Stuart Bloom	Lay Member	5	0	0	0	0	0	0	0	0
Alison Gardner	Lay Member	5	0	0	0	0	0	0	0	0
Paul Smith	Lay Member	5	0	0	0	0	0	0	0	0
Thelma Stober	Lay Member	5	0	0	0	0	0	0	0	0

Notes

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

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

Note 1 - Where members have been appointed to the Hertfordshire and West Essex Joint Executive Team (JET), the disclosures above only relate to the CCG's proportion of pension benefits based on 30.56% and apportioned for the priod April-June 2022. For transparency the table below shows members total pension benefits across Hertfordshire and West Essex CCGs and ICS for the period.

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

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

Note 4 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practioner Pension Scheme". The CCG must make the post non-pensionsable on the payroll and for GPs who are members of the Practitioner scheme, submit an annual GP Solo form to the NHS Pension Authority to include the employer's pension contributionof 14.3% plus 0.08% administration levy.

Note 5 - As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions for Lay Members.

Note 6. The GP member has chose not to be covered by the pension arrangements during the reporting period.

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

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

Note 9 - Cash Equivalent Transfer Values

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

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

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

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

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

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

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

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

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

Total Pensions Benefits (April - June 2022)

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

HERTS VALLEYS CCG

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

Table 1:Single total figure (Subject to Audit)

			2021-22					
Name	**Role**	**Note**	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100**	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
			£000	**£**	**£000**	**£000**	**£000**	**£000**
Jane Halpin	Accountable Officer - 30.56%	1,2	**50-55**	**0**	**0**	**0**	**0**	**50-55**
Beverley Flowers	Acting Accountable Officer (from 1 November 2021-31 March 22) - 30.56%	1	**20-25**	**0**	**0**	**0**	**5-7.5**	**25-30**
David Evans	Managing Director	3	**125-130**	**6,900**	**0**	**0**	**30-32.5**	**160-165**
Alan Pond	Chief Finance Officer - 30.56%	1	**40-45**	**0**	**0**	**0**	**17.5-20**	**60-65**
Jane Kinniburgh	Director of Nursing & Quality - 30.56%	1,2	**35-40**	**0**	**0**	**0**	**0**	**35-40**
Rachel Joyce	Director of Clinical & Professional Services - 30.56%	1	**40-45**	**0**	**0**	**0**	**12.5-15**	**55-60**
Avni Shah	Director of Primary Care Transformation - 30.56%	1	**35-40**	**0**	**0**	**0**	**22.5-25**	**60-65**
Frances Shattock	Director of Performance & Delivery - 30.56%	1	**35-40**	**0**	**0**	**0**	**7.5-10**	**45-50**
Dr Nicolas Small	GP Director and CCG Chair	5	**135-140**	**0**	**0**	**0**	**£NIL**	**135-140**
Dr Trevor Fernandes	GP Director & Deputy Clinical Chair	5	**85-90**	**0**	**0**	**0**	**£NIL**	**85-90**
Dr Daniel Carlton-Conway	GP Director	4	**90-95**	**0**	**0**	**0**	**£NIL**	**90-95**
Dr Corinne Ciobanu	GP Director	4	**100-105**	**0**	**0**	**0**	**£NIL**	**100-105**
Dr Rami Eliad	GP Director	5	**85-90**	**0**	**0**	**0**	**£NIL**	**85-90**
Dr Asif Faizy	GP Director	4,7	**115-120**	**0**	**0**	**0**	**£NIL**	**115-120**
Dr Catherine Page	GP Director	5	**85-90**	**0**	**0**	**0**	**£NIL**	**85-90**
Dr Richard Pile	GP Director	5	**65-70**	**0**	**0**	**0**	**£NIL**	**65-70**
Stuart Bloom	Lay Member	6	**10-15**	**0**	**0**	**0**	**0**	**10-15**
Alison Gardner	Lay Member	6,8	**10-15**	**0**	**0**	**0**	**0**	**10-15**
Paul Smith	Lay Member	6	**10-15**	**0**	**0**	**0**	**0**	**10-15**
Thelma Stober	Lay Member	6	**10-15**	**0**	**0**	**0**	**0**	**10-15**

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

Notes

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

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

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

Note 1- Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the members remuneration has been apportioned across the three CCGs and ICS and only that relating to Herts Valleys CCG has been disclosed above based on 30.56% of their total remuneration. For transparency, members total remuneration across Hertfordshire and West Essex CCGs and ICS is disclosed in the table below.

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

Note 3 - The taxable benefit for David Evans relates to their having a lease car with a taxable benefit as stated. The member has a salary sacrifice arrangement for their vehicle which has the effect of reducing the salary paid during 2021-22.

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

Note 5 - GPs who are not members of the Practitioner pension scheme

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

Note 7 - The total remuneration for Dr Asif Faizy includes £10,000-£15,000 relating to a clinical lead role.

Note 8 - Alison Gardner was also a Lay Member of East & North Hertfordshire CCG Board in 2021-22 for Patient and Public Involvement. The remuneration disclosed above relates only to Herts Valleys CCG.

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	170-175	0	0	0	0	170-175
Alan Pond	Chief Finance Officer	135-140	0	0	0	60-62.5	195-200
Rachel Joyce	Director of Clinical & Professional Services	140-145	0	0	0	42.5-45	185-190
Jane Kinniburgh	Director of Nursing & Quality	125-130	0	0	0	0	125-130
Avni Shah	Director of Primary Care Transformation	125-130	0	0	0	75-77.5	200-205
Frances Shattock	Director of Performance & Delivery	125-130	0	0	0	27.5-30	150-155
Beverley Flowers	Acting Accountable Officer (from 1 November 2021) Director of Integration & Systems Transformation (April 21-March 22)	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 financial year 2021-22 was £135,000-£140,000 (2020-21, £135,000-£140,000). The relationship to the remuneration of the organisation'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	137,500:32,846	137,500:47,654	137,500:56,859
	4.19	2.89	2.42
2020-21	137,500:32,933	137,500:44,897	137,500:54,959
	4.18	3.06	2.50

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 £5,397 (2020-21 highest paid director-£15,360).

The remuneration for the lowest paid includes annual remuneration for a time commitment below the normal contractural hours and therefore the annualised FTE calculation reflects the different terms.

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	172,500:32,846	172,500:47,654	172,500:56,859
	5.25	3.62	3.03
2020-21	172,500:32,933	172,500:44,897	172,500:54,959
	5.24	3.84	3.14

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

There has been a marginal decrease (0.49%) from the previous financial year in respect of the average employees salary and allowances (2021-22, £48,744 :2020-21, £48,984) due to a 3% staff pay increase offset by a change in the grade profile of staff employed.

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

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

Relating to the period 1 April 2021 to 31st March 2022			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
Name	**Title**	**Note**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£00**
Jane Halpin	Accountable Officer - 30.56%	1,2	0	0	0	0	0	0	0	0
Beverley Flowers	Acting Accountable Officer (from 1 November 2021-31 March 22) - 30.56%	1	0-2.5	0-2.5	15-20	30-35	279	6	300	0
David Evans	Managing Director	3	2.5-5	0	10-15	0	134	14	166	0
Alan Pond	Chief Finance Officer - 30.56%	1	0-2.5	0-2.5	20-25	35-40	369	20	397	0
Jane Kinniburgh	Director of Nursing & Quality - 30.56%	1,2	0	0	0	0	0	0	0	0
Rachel Joyce	Director of Clinical & Professional Services - 30.56%	1	0-2.5	0-2.5	15-20	30-35	309	17	334	0
Avni Shah	Director of Primary Care Transformation - 30.56%		0-2.5	0-2.5	10-15	20-25	158	17	182	0
Frances Shattock	Director of Performance & Delivery - 30.56%	1	0-2.5	0	0-5	0	1	3	9	0
Dr Nicolas Small	GP Director and CCG Chair	6	0	0	0	0	0	0	0	0
Dr Trevor Fernandes	GP Director & Deputy Clinical Chair	6	0	0	0	0	0	0	0	0
Dr Daniel Carlton-Conway	GP Director	4	0	0	0	0	0	0	0	0
Dr Corinne Ciobanu	GP Director	4	0	0	0	0	0	0	0	0
Dr Rami Eliad	GP Director	6	0	0	0	0	0	0	0	0
Dr Asif Faizy	GP Director	4	0	0	0	0	0	0	0	0
Dr Catherine Page	GP Director	6	0	0	0	0	0	0	0	0
Dr Richard Pile	GP Director	6	0	0	0	0	0	0	0	0
Stuart Bloom	Lay Member	5	0	0	0	0	0	0	0	0
Alison Gardner	Lay Member	5	0	0	0	0	0	0	0	0
Paul Smith	Lay Member	5	0	0	0	0	0	0	0	0
Thelma Stober	Lay Member	5	0	0	0	0	0	0	0	0

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

Notes

Note 1 - Where members have been appointed to the Hertfordshire and West Essex Joint Executive Team (JET), the disclosures above only relate to the CCG's proportion of pension benefits based on 30.56% from the date of their appointment. For transparency the table below shows members total pension benefits across Hertfordshire and West Essex CCGs and ICS.

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

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

Note 4 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "Practioner Pension Scheme". The CCG must make the post non-pensionsable on the payroll and for GPs who are members of the Practitioner scheme, submit an annual GP Solo form to the NHS Pension Authority to include the employer's pension contributionof 14.3% plus 0.08% administration levy. Alternatively, if the GP has a pooling arrangement in place as agreed with HMRC, the employer's pension contribution is paid directly to the practice.

Note 5 - As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions for Lay Members.

Note 6 - GPs who are not members of the Practitioner pension scheme

Note 7 - Cash Equivalent Transfer Values

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

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

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

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme and may relate to a period more than their service in a senior capacity and to which the 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 8 - 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 scheme or arrangement).

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.

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 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 2022) Director of Integration & Systems Transformation	2.5-5	0-2.5	50-55	95-100	913	45	982	0
Alan Pond	Chief Finance Officer	2.5-5	0-2.5	75-80	115-120	1209	66	1301	0
Rachel Joyce	Director of Clinical & Professional Services	2.5-5	0-2.5	50-55	110-115	1013	54	1093	0
Jane Kinniburgh	Director of Nursing & Quality	0	0	0	0	0	0	0	0
Avni Shah	Director of Primary Care Transformation	2.5-5	5-7.5	35-40	70-75	519	55	595	0
Frances Shattock	Director of Performance & Delivery	0-2.5	0	0-5	0	2	3	29	0

Compensation on early retirement or for loss of office (subject to audit)

There were no payments made in 2021-22.

Payments to past members (subject to audit)

There were no payments made in 2021-22 to any individual who had previously been a director of the CCG.

..... Date ..... Chief Finance Officer

EXPENDITURE ON CONSULTANCY (NOT SUBJECT TO AUDIT)

The total spend on consultants in 2022/23 is shown within the accounts from page 138.

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

There are no exit packages for the three months of 2022-23 and none for 2021-22 financial year.

STAFF REPORT

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

Trade Union Facility Time

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

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

Activities can be, for example, taking part in:

- branch, area or regional meetings of the union where the business of the union is under discussion
- meetings of official policy making bodies such as the executive committee or annual conference
- meetings with full time officers to discuss issues relevant to the workplace.

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

Table 7: Relevant union officials

Number of employees who were relevant union officials during 2021/222	Number of employees who were relevant union officials during 2022/23	Full-time equivalent employee number
0	0	0

Table 8: Percentage of time spent on facility time

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

Table 9: Percentage of pay bill spent on facility time

Description	Figures
Total cost of facility time	£0
Total pay bill	£0
Percentage of the total pay bill spent on facility time	0%

Table 10: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	0%

About our CCG staff

As at 31 March 2022 (the latest data available) Herts Valley CCG employed a total of 276 staff (226.06 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	44	42.65
8b	29	28.06
8c	13	11.9
8d	11	10.70
9	2	2.00
VSM	6	5.62
Medical & Dental	-	-

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.

Herts Valleys CCG's engagement approach was fully cognisant of this duty and it will continue to promote equality of opportunity for the population of Herts Valleys 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 Workforce Race Equality Standard (WRES) and will be using *NHS Equality Delivery System* as tools to enable us to review our equality and diversity work and identify where improvements can be made.

NHS Workforce Race Equality Standards (WRES)

The CCG is required to implement WRES in respect of its own workforce. It is recognised that the small size of many CCGs means that the interpretation of the indicators should be approached with caution. Following the interpretation and publication of the WRES data, an action plan was produced and being implemented within the CCG.
The CCG's profile for staff-declared ethnicity appears in the table below (at 31 March 2022).

Ethnic Origin	Headcount	%
A White - British	150	55%
B White - Irish	7	3%
C White - Any other White background	11	4%
E Mixed - White & Black African	1	0%
F Mixed - White & Asian	1	0%
G Mixed - Any other mixed background	1	0%
H Asian or Asian British - Indian	31	11%
J Asian or Asian British - Pakistani	12	4%
K Asian or Asian British - Bangladeshi	2	1%
L Asian or Asian British - Any other Asian background	8	3%
M Black or Black British - Caribbean	6	2%
N Black or Black British - African	21	8%
PC Black Nigerian	1	0%
R Chinese	2	1%
S Any Other Ethnic Group	2	1%
Unspecified	1	0%

Z Not Stated	17	6%
Grand Total	**274**	**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 handover of EDS2, the NHS equality and delivery system for completion within the new ICB.

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

Disability

The CCG is working on the principles of **Disability Confident** which recognises our commitment to recruiting and developing disabled employees. Disability Confident award replaces the 'Positive About Disabled People' (PADP) award, this will be renewed for the ICB once established.

At 31 March 2022, 90.51% of staff have declared they have no disability, with 4.02% declaring a disability and the remaining 5.47% remaining undeclared.

Gender Profile

Gender Profile – overall workforce (at 31 March 2022)

Gender	%
Female	77
Male	23

% gender by pay band (at 31 March 2022)

Agenda for Change (AfC)	Male (%)	Female (%)
Band 2	25%	75%
Band 3	0%	100%
Band 4	18%	82%
Band 5	8%	92%
Band 6	3%	97%
Band 7	30%	70%
Band 8 - Range A	25%	75%
Band 8 - Range B	21%	79%
Band 8 - Range C	15%	85%
Band 8 - Range D	18%	82%
Band 9	0%	100%
vsm	50%	50%

Gender breakdown (as at 31 March 2022)

Governing Body members (covers VSM pay framework grades)			
Male		**Female**	
Headcount	%	Headcount	%
24	50%	24	50%
Bands 8a and above			
Male		**Female**	
Headcount	%	Headcount	%
21	21%	78	79%
All other bands (band 7 and below)			
Male		**Female**	
Headcount	%	Headcount	%
19	15%	108	85%

Gender pay gap reporting regulations

All public sector organisations in England employing 250 or more staff are required to publish gender pay gap information annually, both on their website and on the designated government website at **www.gov.uk/genderpaygap**. Herts Valleys is one of the few CCGs nationally which is required to publish this information, as most CCGs employ fewer than 250 members of staff. This information is reported and published annually.

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.

Herts Valleys CCG employs more women than men, with women making up approximately 77% of the workforce.

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

On 31 March 2022 (the latest available data) the mean gender pay gap was 38.66%

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 2022 (the latest available data) the median gender pay gap was 15.34%. This means that typically women are paid 15.34% less in the CCG than men.

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

Religion and beliefs

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

Religious Belief	Headcount	%
Atheism	39	14%
Christianity	101	37%
Hinduism	13	5%
Islam	14	5%
Jainism	2	1%
Judaism	5	2%
Not Disclosed	80	29%
Other	18	7%
Sikhism	1	0%
Unspecified	3	1%
Total	**276**	**100%**

Sexual Orientation

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

Sexual Orientation	Headcount	%
Bisexual	5	2%
Gay or Lesbian	4	1%
Heterosexual or Straight	202	73%
Not Disclosed	62	22%
Other sexual orientation not listed	-	-
Undecided	-	-
Unspecified	-	-
Grand Total	**276**	**100%**

Sickness Absence Data

Sickness absence data relating to the year 2021/22 extracted from ESR:

Total days lost:	916 days (equivalent calendar days)
Total absence (FTE)	916 days out of a total of 82,639 available FTE days
Average absence per employee:	4.11 days (average of total days lost by CCG employee headcount)
Of total days lost, long term absence episodes:	11
Long term days total:	396 days (included in total days lost)

The CCG's sickness absence rate for 2021/22 was 1.13%

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
13.66%

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

EMPLOYEE BENEFITS (SUBJECT TO AUDIT)

Employee benefits and staff numbers (subject to audit)

Employee benefits	2022-23 (3 months to 30 June) Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	3,363	2,773	590
Social security costs	322	322	0
Employer Contributions to NHS Pension scheme	470	470	0
Apprenticeship Levy	11	11	0
Termination benefits	0	0	0
Total employee benefits expenditure	**4,166**	**3,576**	**590**

Employee benefits	2021-22 Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	13,066	11,265	1,801
Social security costs	1,184	1,184	0
Employer Contributions to NHS Pension scheme	1,915	1,915	0
Apprenticeship Levy	46	46	0
Termination benefits	0	0	0
Total employee benefits expenditure	**16,211**	**14,410**	**1,801**

Average number of people employed (subject to audit)

	2022-23 (3 months to 30 June) Total Number	Permanently employed Number	Other Number
Total	**230.8**	**196.0**	**34.8**

	2021-22 Total Number	Permanently employed Number	Other Number
Total	230.3	201.7	28.6

Exit Packages (subject to audit)

There are no exit packages for the three months to 30 June 2022 and none for 2021-22.

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. 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- Paul Smith - to oversee the effectiveness of this process.

No action was considered necessary in relation to the effectiveness of the process.

During 2022/23, the CCG continued to support Freedom to Speak Up programme with Champions to help keep the CCG safe and supported. Including the Lay Member there are 9 trained champions based at the CCG, from different directorates, levels and backgrounds. To further support CCG staff the champions have also been trained as Mental Health First Aiders.

Training and values

The compliance rate for mandatory training as at 30 June 2022 was 86.70%. 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 enables managers to 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 2022/23 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 CCG values are:

1. Being caring and respectful

2. Having ambition, courage and high standards

3. Making sure we are open, transparent, honest and straightforward

4. Working - with partners and the public – as a team

5. Empowering and energising clinicians, staff and local people

6. Learning to be the best we can

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 Herts Valleys CCG has an annual Levy budget of approximately £50k. 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 2022/2023 the CCG obtained professional health and safety guidance through Dacorum Borough Council who also delivered health and safety training for CCG managers and staff.. Staff Mental Health First Aiders continue to refresh their skills and practice and a plan was in place for existing first aiders to refresh 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.

Employee consultation and communications

Joint Partnership Forum

The Joint Partnership Forum meets regularly 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. Other actions taken by the group to support the workforce included:

- Provide a forum to air staff views on key issues.
- Advise Herts Valleys 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 group has continued to be very active and has received a high number of queries and questions from staff. 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:

- **65**% reported that they felt involved in deciding changes that affect their work, compared to 54% in 2020 and 62% nationally.
- **80%** of CCG staff stated that they had adequate materials, supplies and equipment to do their work, compared to 71% in 2020 and 76% nationally.
- **66%** of staff reported that relationships at work were unstrained, compared to 58% in 2020 and 59% nationally.
- **76%** of staff reported that they have a choice in deciding how to do their work, compared to 67% in 2020 and 74% nationally.
- **90%** of staff reported that they had not experienced harassment, bullying or abuse from other colleagues, compared to 84% in 2020 and 90% nationally.

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 continued to provide access to an Employee Assistance Programme (EAP), provided by Vita Health group accessed through a free and confidential helpline.

The CCG now have a total of 19 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 network aims to empower staff from Black, Asian or minority ethnic backgrounds to engage with the organisation in a meaningful way and to discuss ways in which the experience and opportunities within the CCG can be improved and co-produce our Race equality action plan. Our organisation promotes diversity and inclusion training and has held a number of popular lunch and learn bitesize workshops which staff across Herts and West Essex CCGs have attended

PART THREE: PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

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

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

Opinion on financial statements

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

In our opinion the financial statements:

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

Basis for opinion on financial statements

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

Emphasis of matter - basis of preparation of financial statements

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

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

Conclusions relating to going concern

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

Other information

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

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

We have nothing to report in this regard.

Opinion on regularity

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

Basis for opinion on regularity

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

Opinion on information in the Remuneration and Staff Report

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

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

Matters on which we are required to report by exception

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

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

Other matters on which we report by exception

We are required to report to you if:

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

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether

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

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

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

Our procedures included the following:

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

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

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Governing Body;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and

- in addressing the risk of fraud in expenditure recognition, testing the accounting treatment of an increased sample of payments around the period end; testing an increased sample of accruals to supporting evidence to confirm a liability existed at period end; testing an increased sample of accruals to post period payments or other supporting evidence to verify their accuracy; testing the expenditure recognised with healthcare providers to agreed contracts and their performance against conditions.

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

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

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

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

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

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

Auditor's other responsibilities

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

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

Certificate

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

Use of our report

This report is made solely to the Members of the Board of NHS Hertfordshire and West Essex Integrated Care Board, as a body, in respect of NHS Herts Valleys CCG, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015.

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

Lisa Blake

Key Audit Partner

For and on behalf of BDO LLP, local auditor

Ipswich, UK

21 November 2023

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

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

	Note	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Revenue from contracts with customers		(155)	(617)
Other operating income		(9)	(41)
Total operating income		**(164)**	(658)
Staff costs	2	4,166	16,211
Purchase of goods and services	3	248,762	1,003,381
Depreciation		38	0
Provision expense	3	1,432	1,159
Other operating expenditure	3	64	595
Total operating expenditure		**254,462**	1,021,346
Net operating expenditure		**254,298**	1,020,688
Finance expense		1	0
Net expenditure for the year		**254,299**	1,020,688
Total Comprehensive Expenditure for the year ended 30 June 2022		**254,299**	1,020,688

The notes on pages 142 to 151 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000	31 March 2022 £'000
Non-current assets:			
Right-of-use Assets		251	0
Total non-current assets		**251**	0
Current assets:			
Trade and other receivables		2,742	3,700
Cash	5	149	581
Total current assets		**2,891**	4,281
Total Assets		**3,142**	4,281
Current liabilities			
Trade and other payables	6	(57,032)	(71,669)
Lease liabilities		(145)	0
Provisions	7	(5,225)	(4,173)
Total current liabilities		**(62,402)**	(75,842)
Total Assets less Current Liabilities		**(59,260)**	(71,561)
Non-current Liabilities			
Lease liabilities		(108)	0
Provisions	7	(67)	(67)
Total non-current liabilities		**(175)**	(67)
Assets less Liabilities		**(59,435)**	(71,628)
Financed by Taxpayers' Equity			
General fund		(59,435)	(71,628)
Total Taxpayers' Equity		**(59,435)**	(71,628)

The notes on pages 142 to 151 form part of this statement

The financial statements on pages 138 to 151 were approved by the Audit Committee (on behalf of the Board) on 17th November 2023 and signed on its behalf by:

Accountable Officer
Jane Halpin
17th November 2023

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

	General fund £'000
Changes in taxpayers' equity for 2022-23 (3 months to 30 June)	
Balance at 1 April 2022	**(71,628)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23 (3 months to 30 June)	
Total net expenditure for the financial year	(254,299)
Net Recognised NHS Clinical Commissioning Group Expenditure for the financial year including balance brought forward from previous year	**(325,927)**
Net funding	266,492
Balance at 30 June 2022	**(59,435)**

	General fund £'000
Changes in taxpayers' equity for 2021-22	
Balance at 1 April 2021	**(64,230)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22	
Net operating expenditure for the financial year	(1,020,688)
Net Recognised NHS Clinical Commissioning Group Expenditure for the financial year including balance brought forward from previous year	**(1,084,918)**
Net funding	1,013,290
Balance at 31 March 2022	**(71,628)**

The notes on pages 142 to 151 form part of this statement

Statement of Cash Flows for the year ended 30 June 2022

	Note	**2022-23 (3 months to 30 June) £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(254,299)	(1,020,688)
Depreciation		38	0
Decrease in trade and other receivables		957	2,120
(Decrease) / Increase in trade and other payables	6	(14,637)	5,754
Provisions utilised		(379)	(1,234)
Increase in provisions		1,432	1,160
Net Cash Outflow from Operating Activities		**(266,888)**	(1,012,888)
Net Cash Outflow before Financing		**(266,888)**	(1,012,888)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		266,492	1,013,290
Repayment of lease liabilities		(36)	0
Net Cash Inflow from Financing Activities		**266,456**	1,013,290
Net Increase in Cash	5	**(432)**	402
Cash at the beginning of the financial year		**581**	179
Cash at the end of the financial year		**149**	581

The notes on pages 142 to 151 form part of this statement

Notes to the financial statements

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

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

The CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 with Hertfordshire County Council (HCC), East and North Hertfordshire 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.

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

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

1.4 Employee Benefits

1.4.1 Short-term Employee Benefits

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

1.4.2 Retirement Benefit Costs

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

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

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

Notes to the financial statements

1.5 **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.

1.6 **Cash**

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

1.7 **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.

1.8 **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 accounting judgements and key sources of estimation uncertainty that will materially affect these financial statements.

1.9 **Funding**

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.

1.10 **Adoption of new standard**

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

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

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

Impact assessment

The CCG has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the taxpayers' equity with no restatement of comparative balances.

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

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

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

As of 1 April 2022, the CCG recognised £289k of right-of-use assets and lease liabilities of £289k under IFRS 16. The weighted average incremental borrowing rate applied at 1 April 2022 was 0.95% and on adoption of IFRS 16 there was no impact to tax payers' equity. As of 30 June 2022, the right-of-use asset value was £251k with a corresponding lease liability value of £253k.

2. Employee benefits

2.1 Employee benefits	2022-23 (3 months to 30 June) Total £'000	2021-22 Total £'000
Salaries and wages	3,363	13,066
Social security costs	322	1,184
Employer contributions to NHS Pension scheme	470	1,915
Apprenticeship Levy	11	46
Gross employee benefits expenditure	**4,166**	**16,211**

2.2 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

3. Operating expenses

	2022-23 (3 months to 30 June) Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	(49)	17
Services from foundation trusts	52,627	208,971
Services from other NHS trusts	112,295	428,246
Purchase of healthcare from non-NHS bodies	32,623	157,066
Purchase of social care	4,008	14,809
Prescribing costs	20,253	78,879
GPMS/APMS and PCTMS	26,201	108,104
Supplies and services – clinical	14	26
Supplies and services – general	(74)	2,497
Consultancy services	(6)	30
Establishment	572	3,080
Premises	206	807
Audit fees (Note 1)	74	71
Other non statutory audit expenditure		
· Other services	3	13
Other professional fees (Note 2)	36	449
Legal Fees	41	80
Education and training	(71)	196
Non cash apprenticeship training grants	9	41
Total purchase of goods and services	**248,762**	**1,003,381**
Depreciation		
Depreciation (Note 3)	**38**	**0**
Total Depreciation	**38**	**0**
Provision expense		
Provisions	1,432	1,159
Total provision expense	**1,432**	**1,159**
Other operating expenditure		
Chair and Non Executive Members	55	216
Expected credit loss on receivables	9	0
Other expenditure	0	379
Total other operating Expenditure	**64**	**595**
Total operating expenses	**250,296**	**1,005,135**

Note 1

Audit fee is shown inclusive of VAT and the net amount was £61.8k (2021-22 £58.9k).

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

Note 2

Other professional fees includes the sum of £21k for Internal Audit Fees (2021-21 £44k). Internal Audit fees is shown net of VAT.

Note 3

Relates to the depreciation of Right-Of-Use asset (2021-22 nil).

4. Better Payment Practice Code

Measure of compliance	2022-23 (3 months to 30 June) Number	2022-23 (3 months to 30 June) £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	6,679	79,431	23,148	279,629
Total Non-NHS Trade Invoices paid within target	6,512	78,080	22,646	276,369
Percentage of Non-NHS Trade invoices paid within target	**97.50%**	**98.30%**	97.83%	98.83%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	221	168,776	724	656,337
Total NHS Trade Invoices Paid within target	212	168,536	680	655,011
Percentage of NHS Trade Invoices paid within target	**95.93%**	**99.86%**	93.92%	99.80%

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.

5. Cash

	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Balance at 1 April	581	179
Net change in year	(432)	402
Balance at 31 March	149	581
Made up of:		
Cash with the Government Banking Service	149	580
Cash in hand	0	1
Balance at 31 March	**149**	**581**

6. Trade and other payables	**Current 30 June 2022 £'000**	Current 31 March 2022 £'000
NHS payables: revenue	327	1,776
NHS accruals	3,564	965
Non-NHS and Other WGA payables: Revenue	7,825	11,087
Non-NHS and Other WGA accruals	38,176	50,312
Non-NHS and Other WGA deferred income	1,206	938
Social security costs	196	195
Tax	287	262
Other payables and accruals	5,451	6,134
Total Trade and Other Payables	**57,032**	**71,669**

Other payables include £1,110k (£191k employees and £919k GP Practices) outstanding pension contributions at 30 June 2022 (£927k: £187k employees and £740k GP Practices - 31 March 2022).

7 Provisions

	Current 30 June 2022 £000	Non Current 30 June 2022 £000	Current 31 March 2022 £000	Non Current 31 March 2022 £000
Legal Claims	0	67	0	67
Continuing care	5,225	0	4,172	0
Total	**5,225**	**67**	**4,172**	**67**
Total current and non-current	**5,292**		**4,239**	

	Legal Claims £000s	Continuing Care £000s	Total £000s
Balance at 1 April 2022	**67**	**4,172**	**4,239**
Arising during the year	0	2,491	2,491
Utilised during the year	0	(378)	(378)
Reversed unused	0	(1,060)	(1,060)
Balance at 30 June 2022	**67**	**5,225**	**5,292**
Expected timing of cash flows:			
Within one year	0	5,225	5,225
Between one and five years	67	0	67
Balance at 30 June 2022	**67**	**5,225**	**5,292**

8. Financial instruments

8.1 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 standing financial instructions and policies agreed by the Governing Body.

8.1.1 Credit risk

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

8.1.2 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 draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

8.2 Financial liabilities

	Financial Liabilities measured at amortised cost	
	30 June 2022 £'000	2021-22 £'000
Trade and other payables with NHSE bodies	405	320
Trade and other payables with other DHSC group bodies	3,605	2,495
Trade and other payables with external bodies	51,585	67,460
Total at 31 March	**55,595**	**70,275**

9. Operating segments

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

	2022-23 (3 months to 30 June) £'000	2021-22 £'000
Commissioning of healthcare services	**254,299**	1,020,688

10. Pooled budgets

Under Section 75 of the NHS Act 2006, funds were pooled with Hertfordshire County Council, East and North Hertfordshire CCG and Cambridgeshire and Peterborough CCG for the joint commissioning of the following services:
- mental health, learning disabilities, including child and adolescent mental health
- integrated community equipment
- services commissioned through the Better Care Fund for social care services

The CCG's share of the income and expenditure handled by the pooled budget for 2022-23 (3 months to 30 June) and 2021-22 were:

2022-23 (3 months to 30 June)	**Equipment Service**		**Mental Health and Learning Disabilities** (Note 1)		**Better Care Fund**		**Hospital Discharge Programme Covid-19** (Note 2)		**All Pooled Funds**
	Total Pooled-Budget 2022-23 (3 months to 30 June) £000	**Herts Valleys CCG Contribution 2022-23 (3 months to 30 June) £000**	**Total Pooled-Budget 2022-23 (3 months to 30 June) £000**	**Herts Valleys CCG Contribution 2022-23 (3 months to 30 June) £000**	**Total Pooled-Budget 2022-23 (3 months to 30 June) £000**	**Herts Valleys CCG Contribution 2022-23 (3 months to 30 June) £000**	**Total Pooled-Budget 2022-23 (3 months to 30 June) £000**	**Herts Valleys CCG Contribution 2022-23 (3 months to 30 June) £000**	**Total Herts Valleys CCG Contribution 2022-23 (3 months to 30 June) £000**
Contribution	2,024	492	99,141	25,322	6,590	3,517	0	0	29,331
Expenditure	1,883	492	99,162	25,256	5,486	3,517	0	0	29,265
Total Variance:	141	0	(21)	66	1,104	0	0	0	66

Note 1

The contribution of the CCG also included £22,969k (2020-21 £86,700k) 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.

Note 2

Funding for the Hospital Discharge Programme came to an end on 31 March 2022. Previously this included £7,106k in 2021-22 on behalf of patients of East and North Hertfordshire CCG as this CCG commissioned Hospital Discharge Programme activity with Hertfordshire County Council on behalf of all Hertfordshire patients.

2021-22	**Equipment Service**		**Mental Health and Learning Disabilities**		**Better Care Fund**		**Hospital Discharge Programme Covid-19** (Note 2)		**All Pooled Funds**
	Total Pooled-Budget 2021-22 £000	Herts Valleys CCG Contribution 2021-22 £000	Total Pooled-Budget 2021-22 £000	Herts Valleys CCG Contribution 2021-22 £000	Total Pooled-Budget 2021-22 £000	Herts Valleys CCG Contribution 2021-22 £000	Total Pooled-Budget 2021-22 £000	Herts Valleys CCG Contribution 2021-22 £000	Total Herts Valleys CCG Contribution 2021-22 £000
Contribution	5,956	1,555	387,834	98,635	13,739	13,533	20,826	19,447	133,170
Expenditure	6,587	1,602	388,688	93,836	12,582	14,775	20,826	20,107	130,320
Total Variance:	(631)	(47)	(854)	4,799	1,157	(1,242)	0	(660)	2,850

11. Related party transactions

During the period, other than that declared below, none of the Department of Health and Social Care Ministers, CCG Board 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 East & North Hertfordshire 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 Board. Details of payments made by the CCG to their practices and related parties disclosed by the GPs and other Board members were as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Dacorum Healthcare Providers Ltd - (GP Federation) - Dr C Ciobanu	437	0	0	0
Direct Local Health Ltd - (GP Federation) Dr R Eliad & Dr A Faizy	431	0	0	0
Fairbrook Medical Centre - Dr C Page	479	0	0	0
Garston Medical Centre - Dr R Eliad	382	0	0	0
Haverfield Surgery - Dr C Ciobanu	117	0	0	0
Herts Health Ltd - (GP Federation) - Dr N Small	218	0	0	0
Maltings Surgery - Dr D Carlton-Conway	632	0	0	0
Parkbury House Surgery - Dr R Pile	652	0	0	0
Schopwick Surgery - Dr N Small	461	0	0	0
Stahfed - (GP Federation) Dr D Carlton-Conway and Dr R Pile	279	0	0	0
Vine House Health Centre - Dr A Faizy	417	0	0	0

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

Bedfordshire Hospitals NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust
Central London Community Healthcare NHS Trust
East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Guy's & St Thomas' NHS Foundation Trust
Hertfordshire Community NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Imperial College Healthcare NHS Trust
London North West Healthcare NHS Trust
Moorfields Eye Hospital NHS Foundation Trust
Royal Free London NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
University College London Hospitals NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
Hertfordshire County Council

2021-22 comparators are shown on the following page.

11a. Related Party Transactions 2021-22

During the year, other than that declared below, none of the Department of Health and Social Care Ministers, CCG Board 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 East & North Hertfordshire and West Essex CCGs:

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

During the year a number of local GPs were members of the CCG's Board. Details of payments made by the CCG to their practices and related parties disclosed by the GPs and other Board members were as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Dacorum Healthcare Providers Ltd - (GP Federation) - Dr C Ciobanu	1,730	0	194	0
Direct Local Health Ltd - (GP Federation) Dr R Eliad & Dr A Faizy	2,161	0	0	0
Fairbrook Medical Centre - Dr C Page	1,751	0	2	0
Garston Medical Centre - Dr R Eliad	1,334	0	45	0
Haverfield Surgery - Dr C Ciobanu	436	0	1	0
Herts Health Ltd - (GP Federation) - Dr N Small	947	0	115	0
Maltings Surgery - Dr D Carlton-Conway	2,387	0	52	0
Parkbury House Surgery - Dr R Pile	2,270	0	5	0
Schopwick Surgery - Dr N Small	1,756	0	0	0
Stahfed - (GP Federation) Dr D Carlton-Conway and Dr R Pile	992	0	137	0
Vine House Health Centre - Dr A Faizy	1,450	0	3	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 Department. The CCG adopted a disclosure level of £5m and the most significant material related parties are listed below. In addition, the CCG had a number of material transactions with local government bodies. Where appropriate, these entities have also been reflected in the list below.

Bedfordshire Hospitals NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust
Central London Community Healthcare NHS Trust
East & North Hertfordshire NHS Trust
East of England Ambulance Service NHS Trust
Hertfordshire Community NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Imperial College Healthcare NHS Trust
Moorfields Eye Hospital NHS Foundation Trust
Royal Free London NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
University College London Hospitals NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
Hertfordshire County Council

12. Events after the end of the reporting period

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

13. Financial performance targets

The CCG has a number of financial duties under Section 14Z2 of the NHS Act 2006 (as amended 2012).
The CCG performance against those duties was as follows:

	2022-23 (3 months to 30 June) Target £000	**2022-23 (3 months to 30 June) Performance £000**	2021-22 Target £000	2021-22 Performance £000
Expenditure not to exceed income	256,019	254,463	1,021,846	1,021,346
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	255,855	254,299	1,021,188	1,020,688
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	2,626	2,626	12,349	11,111

Accessibility Report

Filename: 06N_HVCCG_ANNUAL_REPORT_AND_ACCOUNTS_22_23___signatures_removed_for_website.pdf

Report created by: [Enter personal and organization information through the Preferences > Identity dialog.]
Organization:

Summary

The checker found problems which may prevent the document from being fully accessible.

- Needs manual check: 1
- Passed manually: 1
- Failed manually: 0
- Skipped: 1
- Passed: 23
- Failed: 6

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	Passed	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	Passed	All annotations are tagged
Tab order	Passed	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	Failed	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	Failed	Appropriate nesting

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