ANNUAL REPORT AND ACCOUNTS

2021/22

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Clinical Commissioning Group (CCG)

PERFORMANCE REPORT

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Accountable Officer

Date signed: 21 June 2022

PERFORMANCE REPORT: OVERVIEW OF PERFORMANCE

This section contains a summary of our performance as an organisation during 2021/22 plus a flavour of the work we do. You can read more about our work at: www. 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 9 times during 2021/22. 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 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**.

TYPES OF COMISSIONING

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.

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

- as ***lead commissioner***, where we procure services on behalf of other CCGs. For example, we are the lead commissioner for West Herts Hospital NHS Trust.

- as an ***associate commissioner***, where another commissioner has the biggest share of activity and holds the contract, examples of this include contracts with East of England Ambulance Service NHS Trust

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

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

We have strong governance arrangements in place to oversee the delivery of the priorities for patient care identified in the CCG's operational plan. We work together with other organisations in our local health and social care system to achieve these priorities, where appropriate. 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 2021/22 – 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 2021/22 can be found from page 98.

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 2021/22

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

PRIMARY CARE

What are Primary Care Networks?

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

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

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

Although primary care networks will be delivering services, they are also expected to think about the wider health of their population, taking a proactive approach to managing population health and assessing the needs of their local population alongside commissioners like the CCG to identify people who would benefit from targeted, proactive support.

Access to Primary Care and Restoration

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

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

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

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

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

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

The pandemic has catalysed digital transformation in primary care services. The requirement to deliver patient care differently limiting face-to-face contact due to the risk of COVID has seen a huge expansion in the use of telephone consultations and offering consultations via video has become commonplace. Loss of clinical workforce through self-isolation requirements has been a major challenge in terms of maintaining service delivery for patients. To support home working and remote patient consultations we have rolled out significant amounts of additional IT equipment and virtual desktop interfaces and also ensure the necessary licenses are in place for patient health questionnaires and video consultation technology. We worked closely with our GP practices to review and enact

(when faced with loss of workforce) their business continuity plans, including the ability to receive mutual aid from a 'buddy' practice to ensure patient care and safety was maintained.

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

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

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

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

In December 2021 NHS E/I/I launched a programme to improve access to GP services underpinned by additional funding. The Hertfordshire and West Essex ICS recognised that the pandemic has affected all practices and therefore established a programme of practice visits. The majority of these visits have now been completed and they have proved hugely valuable in understanding some of the practice specific challenges in terms of patients being able to make contact and obtain an appointment that meets their needs – such as

physical premises space and the telephony system. Critically we have, in many instances, been able to identify potential improvement action that can be taken to address such barriers and our Primary Care Teams are in the process of working with our practices on these initiatives.

The overall demand on primary care services has risen substantially as patients present with concerns that they haven't addressed during the pandemic, long-term conditions requiring monitoring and stabilization, 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 had 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. 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,** the total number of appointments attended across Hertfordshire and West Essex in November 2021 rose by 18% increase across the Herts and West Essex areas, with Herts Valleys increasing by 29, 329 appointments (11%).

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

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

Appointment data published by NHS Digital during the year indicates that nearly half of all appointments were provided on the day that they were requested and that 85% of appointments were offered within 14 days. Considering the high demand for appointments including those of a routine nature, these waiting times highlight how hard local primary care services have been working in order to provide care for our local population which is so important and valued.

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

Winter Access Fund Programme

On 14 October 2021 NHS E/I launched "*Our plan for improving access for patients and supporting general practice*" making available £250 million to support primary care and same day urgent care during the challenging winter period. The allocation available for the Hertfordshire and West Essex ICS was £6.16m for the five months November 2021 to March 2022, £2.94m of which was allocated to Herts Valleys CCG.

The two main uses of the fund are to:

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

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

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

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

- support on recruitment for all staff through Primary Care Careers
- short term estates support
- advanced telephony support
- maximising the use of online consultations and opportunities to integrate within the practice model
- access to training, especially telephone consultation for admin staff
- reinvigorating PPGs.

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

Community Pharmacist Consultation Service

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

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

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

The first Herts Valleys practice, Fairbrook Medical Centre, went live with this service in July 2020 and since then a further 21 practices have been trained are using the service. The remaining practices have either received training but are not live, or a training date is being identified.

Digital / IT

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

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

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

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

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

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

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

Workforce Development

Hertfordshire and West Essex (HWE) ICS receives funding, predominantly from NHS E/I and Health Education England (HEE), to support Primary Care Workforce recruitment and retention across the ICS. In 2021/22 this will amount to £3.7m. Some of this funding supports specific small initiatives; however, there are a number of major funding streams:

- NHS E/I/I Training Hub Infrastructure: £296k
- HEE Training Hub Infrastructure: £314k
- GP/GPN New to Practice Fellowship Scheme: £1,357k
- Primary Care Flexible Staff Pool: £120k
- Local GP Retention Fund: £300k
- Supporting Mentors Scheme: £200k
- International GP Recruitment £650k
- GPN/AHP CPD[2] £172k
- GPN/CARE Programme[3]: £158k

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

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

Workforce Numbers

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

2021/22						
Workforce Group	Baseline (Q4 20/21)	Q1 21/22 Target/ (Actual)	Q2 21/22 Target/ (Actual)	Q3 21/22 Target/ (Actual)	Q4 21/22 Target/ (Actual)	Year end change Target/ (Actual)
GPs (excluding Registrars)	693	698 (701)	702 (698)	706 (707 – M8)	710 (710)	17 (17)
Registered Nursing Staff	312	321 (306)	330 (303)	339 (310 – M8)	348 (312)	36 (0)

Other staff providing Direct Patient Care (ARRS)	273	341 (280)	374 (286)	407 (415)	440 (415*)	134 (142)
Other Practice Staff (Admin)	1642	1634 (1629)	1627 (1648)	1619 (1687 – M8)	1612 (1721*)	-23 (45)

*Please note the NHS Digital NWRS data[4] is dependent upon accurate and timely reporting by practices, there is work underway to improve reporting across the system

Health Education England Procurement – ICS Training Hub

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

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

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

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

Workplan Highlights

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

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

All training and development opportunities are published on the training hub website alongside a range of resources for the primary care workforce.[5]

COVID-19 Response and Wellbeing in Primary Care

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

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

Following on from this, we worked with colleagues across the ICS to deliver training opportunities for Mental Health First Aid and Compassionate Conversations. We have also made resilience training available locally, in addition to signposting national offers such as

[5] **https://www.hwetraininghub.org.uk/**

"Here for You Too". These opportunities have been made available to all practices via the GP newsletters and the training hub website.

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

Premises

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

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

- Major reconfiguration and improvements to a wing that had been vacant for several years at Gossoms End, Berkhamsted and now accommodates some of the activity by The Rothschild Group. The ETTF funded the capital cost and all professional fees.

- Rothschild Group completed another project at their Markyate site, this project involved an extension which doubled the size of the premises. The capital was part funded by ETTF and the practice with all professional fees met by the ETTF programme.

- A new build at London Colney known as Summerfield Health Centre, formerly known as Lattimore and Village Surgery. The capital cost of the project was privately funded with professional fees funded under ETTF.

- Works continue at Parkwood Surgery, Hemel Hempstead for a major extension and improvements, phase 2 is expected to complete in April 2022. The capital cost of the project was privately funded, with professional fees funded under ETTF,

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

- Full Business Case approval for Schopwick Surgery, to relocate the surgery to a new purpose build premises for which the GP partners will fund the capital and the CCG meet the professional fees and revenue.

- Full Business Case approval for Garston Surgery, to significantly extend and improve the surgery premises. The GP partners will fund the capital and the CCG meet the professional fees and revenue.

In January 2022, the Primary Care Commissioning Committee (PCCC) gave approval to PIDs that were submitted by Midway Surgery in St Albans, Grovehill Surgery in Hemel Hempstead and New Road Surgery in Croxley Green that will all work up their development plans that extend, improve or relocate the premises. The funding streams will be determined as the projects advance.

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

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

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

- Small fund and grant schemes have been supported via NHS E/I national funding under the Winter Access Fund as well as CCG funds.

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

Primary Care COVID Response

Vaccination Programme

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

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

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

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

A separate Health Inequalities workstream was set up during 2021/22; the main focus initially was to increase the uptake of covid vaccinations to our hard-to-reach groups.

Pop-up clinics were delivered in numerous locations to capture those groups in collaboration with local community leaders.

COVID Immunisation Programme 5-to-11 year olds

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

Seasonal Flu Vaccination

Despite some challenging vaccine supply issues and significant focus placed on the COVID vaccination programme, uptake for the adult cohorts has progressed well, with 82.6% of patients aged 65 and over and 51% of patients aged 50-64 years having received their

vaccination. Community Pharmacies are heavily supporting the programme and delivering more vaccines than ever this year.

Challenges remain with the children's cohorts, with 2-to-3-year-olds at 47.7%. Furthermore, the extended school-age programme has had a slower start, as a result of the COVID programme for 12-to-15-year-olds being in place. Across Hertfordshire and west Essex, HCT and EPUT have plans to accelerate the school aged flu vaccination programme and are looking to extend this to 5-to-11-year-olds. Improved uptake in particularly vulnerable groups such as those living in care homes has been particularly successful with 90% of this population having received the Flu vaccine. Pregnant women remain a key focus area with 44% of people who were currently pregnant at the time of vaccination during 2021/22 having been vaccinated.

A roving model with local community trusts is currently in place to support flu and COVID vaccination for care home staff and outstanding care home residents. All providers are committed to delivering the national trajectory[6] for their staff and where appropriate, those they care for.

Respiratory Hubs

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

The hub model in Herts Valleys was commissioned as a physical hub, separate from any GP surgery, in each of the four localities. As we went through the different waves of the pandemic and saw a reduction in the initial severity of COVID, the referrals to the hubs declined and a decision was taken to reduce the four hubs to two: this was then increased to three in the second wave of the pandemic. The physical hub in St Albans and Harpenden was not re-commissioned, however the hub in Dacorum operating from the Hemel Hospital site also saw patients referred from St Albans and Harpenden.

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

Oximetry at Home

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

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

A second tranche of NHS E/I General Practice COVID Capacity Expansion Funding of £120 million was awarded to general practice from April 2021 to Sept 2021: this was a reduced amount compared to the Nov 2020 to March 2021 of £150 million. One of the seven key priorities as part of this funding criteria was: Supporting the establishment of the simple COVID oximetry at home model.

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

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

3 different models were used across the ICS. The model used in Herts Valleys was a more developed service with three commissioned 'hot hubs'. The service was fully commissioned from March 2020 for the Home Oxygen Saturation Pathway. GPs were paid to run the service from hot hubs and linked with the local community provider. Monitoring is done through the locality hot hubs. The Red Cross deliver the devices to patients' homes.

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

Managed Quarantine Hotels

Throughout the pandemic, people arriving in England who had visited or passed through a country/territory where travel to the UK is banned ('red list' countries) were required to quarantine in a Managed Quarantine Scheme (MQF) hotel. This national guidance was withdrawn on 21 March 2022.

In addition, families from Afghanistan were placed in isolation hotels when entering the country.

During this time, Herts Valleys CCG worked with the Department of Health and Social Care (DHSC), Home Office, local authorities and voluntary sector partners to commission health provision for the MQF and isolation hotels.

Despite very short notice requests, mobilisation was successfully completed with the local GP surgeries, pharmacies and incumbent providers to minimise impact on general practice and the wider system. Following confirmation that countries were being removed from the red list, the primary care team liaised with the Department of Health and Social Care (DHSC) to finalise arrangements for the existing guests and decommission the health provision.

Blood Pressure at Home

Home blood pressure monitoring was identified as a priority for cardiovascular disease (CVD) management during the COVID-19 pandemic to ensure that patients who were

vulnerable to becoming seriously ill with COVID, were able to manage their hypertension well and remotely, without the need to attend GP appointments.

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

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

Since the scheme started the number of people who have submitted home blood pressure readings each month has increased steadily. The data from February 2022 showed that the number of people submitting home readings has increased by approximately 50% since April 2021.

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

Afghan Relocations and Assistance Policy (ARAP) / Asylum Seekers Resettlement Programmes

The Home Office has commissioned four hotels in Hertfordshire and West Essex area to accommodate guests evacuated from Afghanistan under the Afghan Relocations and Assistance Policy (ARAP) scheme, these are known as 'bridging hotels' where the evacuees are placed pending resettlement by the Home Office across the UK.

Three of these hotels are in the Herts Valleys CCG area. A GP practice expressed a willingness to be commissioned to register the evacuees and put in place the necessary healthcare required to support them. The practice has worked collaboratively with a wide range of system partners, the hotel management team, and the British Red Cross to ensure people are able to access the range of health and social care services they need. Public Health England have specifically worked to establish a Tuberculosis (TB) testing programme.

The evacuees in HVCCG have received their covid and flu vaccines administered to all age cohorts in line with JCVI guidance including children aged 12 years and over. Residents aged over 11 have also been offered blood borne virus screening. In line with the advice of the NHS E/I Public Health team, all children have commenced or been offered the full vaccination programme to ensure they have adequate cover starting with the measles vaccine.

Two GP partners from the HVCCG practice are from Afghanistan themselves and speak the three main languages used in Afghanistan: this has reduced a reliance on translators. The GPs have provided education sessions on understanding how to access health care in the UK.

Initial Accommodation Centres (IAC)

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

The IAC hotels in Herts Valleys are being supported by a Local Enhanced Service arrangement with a local practice, in line with guidance from NHS E/I.

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

Primary Care Network Directed Enhanced Service (PCN DES)

NHS E/I PCN Plans for 2021/22 and 2022/23

In August 2021, NHS E/I published the plans for the PCN DES for the remainder of 2021/22 and for 2022/23, to take effect from 1 October 2021. These plans emphasised that the COVID-19 pandemic has clearly demonstrated the value and effectiveness of the PCN model as a basis for local partnership working. The previously anticipated new PCN DES service requirements and majority of Investment and Impact Fund (IIF) incentives had been deferred until October 2021. The IIF is a financial incentive scheme, focusing on resourcing high quality care in areas where PCNs can contribute significantly towards Improving health and saving, improving the quality of care for people with multiple morbidities and helping to make the NHS more sustainable.

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

The new service requirements will be phased over 18 months, with the main implementation focus being 2022/23 rather than 2021/22, so that PCNs have the maximum

possible time to prepare. The two specifications introduced in 2021/22 were introduced in a reduced or preparatory form, as below:

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

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

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

Temporary changes from December 2021

In response to the emergence of the Omicron variant of COVID-19 and the need to accelerate the delivery of booster vaccinations, NHS E/I made a number of changes:

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

Extension to the deadlines associated with tackling neighbourhood health inequalities requirement; with the area of focus to be identified by 28th February 2022 and the ICS further agreeing an extension to agreeing a plan to 30th April 2022.

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

Additional Role Reimbursement (ARR) Scheme

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

PCNs were required to submit workforce plans for 2021/22 by 31 August 2021. These plans were reviewed, with a particular focus on those forecasting significant underspend versus budget, emphasising that PCNs planning underspend will not be able to carry this forward, so will lose this entitlement. PCNs that were planning to maximise utilisation of the ARR scheme budget for 2021/22 were invited to bid for Unclaimed Funding; this is ARR scheme funding that other PCNs are not planning to utilise.

A summary of ARR scheme roles for HWE ICS is provided below:

ARRS roles at end Q4	Planned roles end Q4
180	203

The most popular scheme roles include Clinical Pharmacists, Care Co-ordinators, Social Prescribing Link Workers, and First Contact Physiotherapists.

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

PCN Development Fund

NHS E/I provided the ICS with funding to specifically support PCN development in line with key objectives:

- Support development and maturity of PCNs including enhancing integration.
- Continue to improve patient access through use of a range of technology, including telephony if appropriate to the PCN, but more importantly engaging and co-designing with patients via patient participation groups.
- Improve working conditions for staff including continued support to recruitment, embedding and retention of staff in particular Additional Roles.

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

Upon agreement of the plans the funding was released to each PCN to allow them to proceed with implementing their plans. A further report was requested from PCNs at year end, focusing on key outcomes. It is expected that the CCG will be required to report to NHS E/I confirming utilisation of the funding

SUMMARY OF PERFORMANCE 2021/22

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

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

A&E four-hour operational standard

There is a national requirement that 95% of patients attending A&E are treated, admitted or transferred within 4 hours of arrival. New national requirements that track full patient journeys from attendance through to discharge or admission are being run in parallel with new Internal Professional Standards being monitored weekly[7].

Over 2021/22 the total number of A&E attendances increased from 2020/21 and rose above pre-Covid levels for the majority of months putting further pressure on A&E departments and flow through the system.

[7] **rig-making-internal-prof-standards-work.pdf (england.nhs.uk)**

Performance at West Hertfordshire Teaching Hospitals NHS Trust followed the national trend and failed to achieve the 4- hour standard:

Treated / Admitted / Transferred in under 4 Hours		Target	Q1	Q2	Q3	Q4	2021/22
WHTH	Percentage of patients admitted, discharged or transferred out within 4 hours of arrival in the dept.* - WHTH	**95%**	**82.55%**	**75.83%**	**69.36%**	**62.23%**	**72.55%**

Focused work streams were introduced in response to the pandemic with the aim to improve patient assessment, flow and discharge including:

- A&E services were reconfigured and split into COVID and non-COVID pathways to optimise flow and meet infection prevention and control (IPC) standards
- Work continued across the system to provide alternatives to admissions, including community-based streaming of COVID patients and expansion of community support for sub-acute COVID patients. This includes virtual ward and remote monitoring with the rapid response service providing 2-hour response access to prevent avoidable admissions
- The Hospital Ambulance Liaison Officer (HALO) service was extended over the 2021/22 winter period and a new cohorting8 team started to assist handover delays and allow crews to respond to community pressures
- Increased use of alternative urgent care pathways for same day emergency care, including ambulatory emergency care, frailty and surgical assessment
- Roll out of 'Think 111 First' to encourage the use of the NHS 111 service as a means of accessing A&E or alternative service where A&E was not the appropriate choice
- Implementation of professional standards (currently under review for 2022/23) and escalation protocols
- Surge and escalation planning across the ICS
- Development and implementation of COVID Oximetry at Home models and implementation of COVID virtual wards to maximise available capacity

- Continued development of the Princess Alexandra Hospital 'out of hospital care model', implementation of the REACT frailty service and new build assessment and ambulatory care wards/service

[8] **https://www.england.nhs.uk/wp-content/uploads/2020/08/Reducing_ambulance_handover_delays_-_key_lines_of_enquiry_v1.1.pdf**

- Ongoing work with the Ambulance service and community providers to develop more effective pathways into community provision as alternative to ambulance conveyance
- Multi-agency Discharge Events (MADE) held in November 2021 & January 2022 to maximise discharges and daily "not meeting criteria to reside" meetings (NMCTR)[9] to provide a system response to support discharges
- As part of winter monies investment for 2021/22, a joint voluntary service/ clinical team has been established at all three acute trusts to facilitate timely discharge for patients not requiring ongoing statutory service support.

Response times to ambulance calls

- Ambulance services are measured on the time it takes from receiving a 999 call to a vehicle arriving at the patient's location. There are four categories of call with associated required average response times:
- **C1** People with life threatening injuries and illness (mean response time of 7 minutes)
- **C2** Emergency calls (mean response time of 18 minutes)
- **C3** Urgent calls (90% of calls to be responded to within 120 minutes)
- **C4** Less urgent calls (90% of calls to be responded to within 180 minutes)

The East of England Ambulance Service NHS Trust (EEAST) has continued to have a challenging year with the impact of COVID-19 in 2021/22. C1 to C4 standards were not met for the majority of periods across the year, and performance overall in 2021/22 when compared to 2020/21 in all categories shows a deteriorated position.

Table: EEAST Ambulance response times

EEAST Ambulance Response	Target	Q1	Q2	Q3	Q4	2021/22
C1 People with life threatening injuries and illness	**<7 minutes**	**06:34**	**08:14**	**09:40**	**09:16**	**08:31**
C2 Emergency calls	**<18 minutes**	**21:25**	**33:46**	**42:11**	**46:13**	**35:32**
C3 Urgent calls	**<120 minutes**	**121:50**	**262:17**	**304:36**	**339:00**	**262:48**

[9] This means that people who no longer meet the clinical criteria to reside for inpatient care in acute hospitals should be discharged as soon as possible on the same day. Any assessment of short and long-term needs should happen in the community via the 'discharge to assess' model.

C4 Less urgent calls	**<180 minutes**	**176:43**	**421:02**	**517:42**	**496:06**	**367:29**

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

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

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

Waiting times for cancer treatment

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

Two-week waits

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

28-day Faster Diagnosis Standards (FDS)

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

31 days

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

62 days

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

West Hertfordshire Teaching Hospitals NHS Trust (WHTH)

Performance at Watford General Hospital fell below standard in the majority of areas during 2021/22 with the impact of COVID-19 affecting outpatient, diagnostic and elective capacity, compounded by workforce issues and patients cancelling their appointments due to concerns around infection or a need to isolate. Throughout the year two week wait referrals have been consistently higher than before the pandemic with November reporting showing referral rates at 111% compared to pre pandemic rates. More recently the introduction of the new Electronic Patient Record system has had further impact.

'2 Week Wait' urgent cancer GP referrals were non-compliant at (76%) and breast symptomatic referrals were also non-compliant (62%) . 31-day first definitive treatment performance have on the whole been compliant for all pathways; with the exception of surgery (96%), primarily due to elective capacity.

62 days urgent GP performance has also been challenged throughout the year and has been non-compliant at 75% and 62-day screening at 64% . The Trust has consistently achieved compliance with the 28-day FDS (Faster Diagnosis Standard) throughout the year which reflects the ongoing work in the Trust around improving their 28-day FDS pathways.

CCG have been working closely with the Trust to improve performance and cancer pathways, and detailed action plans are in place for each speciality in the Trust. The CCG Cancer Action Group and Cancer Development Meetings have clear oversight on performance against the national cancer waiting standards and supports the Trust with pathway development and transformation in line with national guidance.

Royal Free London NHS Foundation Trust (RFL)

Cancer performance has remained a challenge, with high referral rates and limited capacity leading to and increasing cancer waiting lists as well as an increase in the backlog of patients waiting over 62 days. Performance on the 2 week wait target has been below the standard (77%) for key specialities predominantly dermatology and breast, and diagnostic waits are further contributing to the delays.

The Royal Free fell below standard in the majority of areas in 2021/22 apart from 31 days surgery, drug, and radiotherapy where they met their standard target. The 62-days urgent GP referral standard is the lowest at 65% and 62-day screening is 79%.

The clinical and operational teams are focused on improving performance and tracking patients closely to reduce delays. Key actions are to increase staffing levels within the dermatology and breast services aimed at increasing capacity from early 2022 and increased diagnostic capacity.

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

Table: Cancer waiting times for all CCG patients [10]

Cancer Waiting Times at CCG level		Target	Q1	Q2	Q3	Q4	2021/22
Two Week Waits	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	**93%**	**87.27%**	**83.43%**	**74.16%**	**66.03%**	**77.47%**
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	**93%**	**54.39%**	**89.63%**	**74.60%**	**16.01%**	**62.46%**
31 Day Waits	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	**96%**	**97.14%**	**97.10%**	**95.38%**	**93.67%**	**95.83%**
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	**94%**	**92.17%**	**88.89%**	**86.00%**	**88.46%**	**88.97%**
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regime	**98%**	**99.32%**	**100.00%**	**100.00%**	**100.00%**	**99.82%**

[10] **Cancer-Waiting-Times-Apr-Mar-2022-Data-Extract-Provider.xlsx (live.com)**

	Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy	**94%**	**98.74%**	**100.00%**	**99.23%**	**94.78%**	**98.18%**
62 Day Waits	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	**85%**	**83.21%**	**75.79%**	**74.03%**	**66.14%**	**75.00%**
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	**90%**	**64.52%**	**85.37%**	**75.00%**	**67.21%**	**72.83%**
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	**85%**	**87.67%**	**82.56%**	**82.22%**	**77.00%**	**81.95%**
28 Day Faster Diagnosis Standard (FDS)	A maximum 28-day wait from urgent GP referral to be diagnosed with, or have cancer ruled out, all 2ww referrals	**75%**	**73.33%**	**76.06%**	**70.58%**	**59.37%**	**71.16%**
	A maximum 28-day wait from urgent GP referral to be diagnosed with, or have cancer ruled out, breast symptom 2ww referrals	**75%**	**97.71%**	**96.67%**	**93.82%**	**21.79%**	**86.93%**
	A maximum 28-day wait from screening referral to be diagnosed with, or have cancer ruled out	**75%**	**66.67%**	**70.00%**	**71.43%**	**61.11%**	**67.21%**

Referral to Treatment Times (RTT)

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

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

Herts Valleys CCG is working in partnership with WHTH to achieve the key strategic objectives of: improving access to care (national waiting time standards) by eliminating waits of over 104 weeks by March 2022, except where patients choose to wait longer; hold or where possible reduce the number of patients waiting over 52 weeks and stabilise RTT waiting lists around the level seen at the end of September 2021.

Table: RTT waiting times for all CCG patients

RTT Waiting Times		Target	Q1	Q2	Q3	Q4	2021/22
18 Weeks	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	**92%**	**73.52%**	**73.82%**	**69.57%**	**65.74%**	**70.21%**

The response to COVID-19 diverted resources from elective care resulting in an increase in backlogs and waiting times. This was in line with national and local directives to increase capacity for COVID-19 patients, pausing routine elective activity at peak times of the pandemic through 2021/22. As a result, the number of CCG patients on an incomplete list increased over the year together with the number of patients waiting over 18 and 52 weeks.

Clinicians continue to review all patients on their elective waiting lists and risk-stratify patients to enable prioritisation according to clinical need in line with the national Risk Stratification programme[11]. However, prioritising the most clinically urgent patients has resulted in longer waits for more routine patients. Patients are being booked and treated in order of clinical priority. Independent sector capacity has been utilised for elective pathways were possible throughout the year, with NHS capacity being increased at peak times of the pandemic. Work is also underway across the ICS to jointly review demand and capacity and offer mutual aid where possible.

WHTH has a long waits improvement plan in place which includes:

- Outsourcing to fully utilise independent sector capacity
- Additional clinic sessions are being offered at evenings and weekends
- Operational recovery group oversight of activity delivery
- Weekly review of long waits with Director of Performance

Moving forward, recovery plans and trajectories are focused on restoring activity back to pre-COVID levels. The CCG has worked with providers to manage demand on services by reviewing pathways and introducing Referral Assessment Service (RAS) pathways to ensure triage and streamlined management of referrals. Also, services have been maximising the use of advice and guidance, use of virtual consultations where clinically appropriate, and virtual hospital models and patient-initiated follow up (PIFU) pathways.

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

Diagnostics

Table: Diagnostic Waiting Times

Diagnostics Waiting Times		Target	Q1	Q2	Q3	Q4	2021/22
6 weeks	Percentage of patients waiting 6 weeks or less for a diagnostic test*	**99%**	**83.98%**	**81.01%**	**80.94%**	**80.82%**	**81.54%**

WHTH response to COVID has diverted resources from elective care resulting in increase in backlogs and waiting times for diagnostics. The average performance against the 6-week standard achieved is 74%[12], which is in line with the national average.

The most clinically urgent patients are prioritised, resulting in longer waits for more routine patients, and there have been insufficient resources, both capacity & workforce, to reduce backlogs over a short timescale. COVID related staff absences have also resulted in unplanned reduction in capacity (theatre & clinic lists).

A long waits improvement plan has been implemented which includes:

- Outsourcing to supplement in house capacity
- Additional sessions in place
- Mobile, staffed MRI scanner in service since end of November
- Operational recovery group oversight of activity delivery

Upcoming changes to Key Performance Standards

Access Standards

Following a national review, changes to standards in mental health services, cancer care, elective care and urgent and emergency care started to be field tested at a selection of

[12] *Only WHTH diagnostics data is reported due to the proportion of diagnostics for HVCCG patients being carried out by the Trust*

sites across England. Revised standards were originally expected to come in during Spring 2020, but the programme of work has been delayed due to COVID-19. NHS E/I and Improvement have sought views on the proposed recommendations[13] for urgent and emergency care standards which will inform final recommendations and guidance for 2022/23.

NHS Oversight Framework

NHS Organisations will be assessed in 2021/22 via the NHS System Oversight Framework. The Framework contains a broad range of oversight metrics which are utilised by NHS E/I and NHS Improvement to flag potential issues and prompt further investigation of support needs. There are more than 80 indicators which are grouped around 6 key themes:

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

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

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

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

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

terminology of ‘Outstanding’, ‘Good’, ‘Requires Improvement’ and ‘Inadequate’. Our last rating was ‘Good’ but at the time of writing in June, our rating for 2021/22 isn’t yet available.

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

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

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

The final narrative assessment will identify areas of good and/or outstanding performance, areas of improvement, as well as areas of particular challenge. This is not expected to be published until Summer 2022.
Further details of the assessment methodology can be found on the **NHS E/I** website.
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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. During 2021-22 we have looked at the inclusion of new ways of scrutinising quality with regard to our CCG processes and commissioned services and which utilised technology more creatively as part of our overall approach. The following analysis reflects our ratings available for the CCG at the following sources on the NHS website:

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

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

In addition to the above the team has:

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

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

- maintained a 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.

Maintaining quality during the COVID-19 pandemic

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

Patient Safety

Serious Incidents

'Serious incidents' in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The CCG's Serious Incident Panel meets weekly to review investigation reports to make sure they are robust and have considered all aspects of how an incident happened and what is being done to learn from it.

During 2021/22 HVCCG were notified of 225 SIs in total up until the end of January; this compares with 184 SI notified to the CCG in 2020/21. The increase in declared SI's is during the past two years is due to the reporting of Covid related SI's. In some cases, a SI will be downgraded following full investigation, as it has been identified that SI criteria was not actually met. These cases would still be included in the data provided.

Never Events

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 NHS Trust	Retained Foreign Object (Maternity)	Patient had a retained swab following delivery.	Low harm

West Hertfordshire NHS Trust	Wrong Site Surgery	wrong lesion removed	Not Stated
Bishops Wood Hospital	Wrong Implant Prosthesis	Patient had a wrong prosthesis element size inserted	Moderate harm
East and North Hertfordshire NHS Trust	Wrong site surgery	Patient had incision made into wrong finger, but surgical procedure was not completed.	Moderate harm

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

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

Care Home and Quality Improvement Team

During 2021-22 the Quality Improvement (QI) team have absorbed the COVID-19 response as business as usual and returned to face-to-face visits to all 137 adult care homes in West Hertfordshire to support with prevention of avoidable hospital admissions, as well as where COVID-19 outbreak and other infections required management advice, support, and training. Each adult care home has a dedicated Care Home Improvement Team (CHIT) nurse who contacts them on a minimum weekly basis, more if required, for example during an outbreak, where new staff require training, or where an increase in avoidable hospital admissions is noted.

The QI team have continued to collaborate and work closely with all system partners to support a joined-up approach and response both formally (through the Safety Improvement Process -SIP) or informally, where care homes require. The QI team continue to have representation at all care home related calls, meetings and cells as part of the whole system's support and response to safety. This has allowed a more reactive focused

support approach to be provided at the point of identification to care homes, as they require it.

The QI team continue to offer planned and unplanned training, onsite at care homes and via webinars to ensure that care home staff teams receive appropriate training to keep them upskilled in being able to apply appropriate knowledge to support the prevention of avoidable hospital admissions. Key training delivered has been recognising deterioration, falls prevention, pressure area care and infection prevention and control practices. This training continues on a rolling basis and additional support is offered where an avoidable hospital admission/infection outbreak has been identified, or where the care home requests, for example new staff or a resident with a particular condition. The team works closely with the Hertfordshire Admission Avoidance Response Car (HAARC) (contracted by the CCG) to support prevention of avoidable hospital admissions and additionally shares with homes all prevention of avoidable admission services available in West Hertfordshire.

The QI 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. A new weekly meeting introduced during the pandemic to identify where care homes require support has been agreed by all partners to continue as it allows all partners to discuss any queries/concerns and good practice within the care homes. This meeting then further feeds into the Safety Improvement Process as required.

The QI team has offered reactive support and training to Sheltered Living, Supported Living and homecare providers. This includes signposting to other services which may assist and support them.

National Patient Safety Strategy

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

- Implementation of the Patient Safety Specialist role within the CCG and across the local system
- Establishment of a Patient Safety Specialist Network for all Patient Safety Specialists across Hertfordshire and West Essex
- The roll out of the national patient safety training for all staff within the CCG
- Participated in national workshops looking at how the patient safety strategy can be implemented within primary care

- Ongoing work to support our local Medical Examiner Offices with the roll out of the Medical Examiner system for community deaths, following successful implementation for deaths occurring in our acute hospitals.
- Supported areas of COVID 19 recovery, including working with our acute providers to ensure there is a robust process across our local system for undertaking harm reviews for those patients that have waited significantly longer than usual on the waiting lists, with consistent reporting of harm review outcomes and learning.
- Kept our Quality Committee, Primary Care Commissioning Committee and Governing Body updated with national timelines and local implementation throughout the year.

Complaints.

	2021 / 2022	2020 / 2021
Formal Complaints received by HVCCG (which includes 5 stage 1,2 or 3)	**153**	124
Provider Complaints – (which includes 1 stage 2)	**55**	42
Total	**208**	166

Further information

- 68 of the above complains came in via an MPs on behalf of their constituents.

2 of 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

- A complainant was unhappy with the progression of an appeal

Patient Feedback also handled 131 cases of enquiries and concerns in this above period

Key themes of complaints 2021/2022 are:

- Lack of face-to-face appointment with GPs

- Lack of guidance for immunosuppressed patients
- CHC - Delays in processes, poor communication and challenges over decision making.

In the last reporting year, the CCG focussed on improving the complaints processes and complaints 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. We have increased resilience within the team by ensuring there is cross cover between the patient safety and patient experience teams. We have also worked closer with our CHC team to define a more coordinated approach to our more complex complainants. Going forward into the coming year, the focus will be on ensuring our functions, policies and processes are aligned with our fellow CCGs across Hertfordshire and West Essex as we move into the ICB as well as ensuring appropriate collection of demographic data from complainants and patients as part of the wider health inequalities workstream.

Healthwatch Hertfordshire

The Nursing and Quality Team has worked 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

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.

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.
- Helped practices identify learning and improvements following the publication of the annual GP Patient Survey (2021), including identifying good practice and sharing as part of the Winter Access Fund visits.
- Supported practices with IPC measures, developing guidance and checklists, and undertaking support visits to offer advice and support to help practices become 'COVID-secure'
- 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.

Caring for vulnerable residents

Safeguarding adults

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

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

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

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

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

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

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

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

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

- We worked with partnership agencies to support care homes and care providers to monitor quality and management of risk with the CCG chairing the HSAB Strategic Quality Improvement Group in Herts to drive forward a robust action plan which focuses on quality assurance processes, shared learning and responding to areas of concern.

- As part of the HSAB, the team chair the Safeguarding Adult Review subgroup and have led the development of a trauma and resilience framework to support panel

members.

- Represented the CCG in a number of domestic abuse work streams in response to the Domestic Abuse Bill, including the development of a Strategy for 2022 – 2025 which was published January 2022 and the future development of the Independent Domestic Violence Advocate Service. We also chair the Quality and Innovation sub-group of the Domestic Abuse Partnership Board. One of the objectives of this sub-group is to identify learning ensuring that it is shared and implemented by partners.

- We worked with private providers to ensure safeguarding processes were in place for migrants seeking asylum and for those coming from Afghanistan. We sought assurance that hotel staff within Quarantine Hotels had received appropriate safeguarding training to enable them to support this vulnerable cohort of people.

- The team supported CCG staff in managing complex cases through individual case discussions and group supervision. Support and guidance were also given for colleagues in providers and primary care managing complex cases through individual case discussions and interventions.

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

Safeguarding children

- The CCG is committed to safeguarding and promoting the welfare of children. The responsibilities for safeguarding are a statutory requirement supported in legislation. The Children Acts 1989 and 2004, and Children and Social Work Act 2017 places a duty on local authorities to promote and safeguard the welfare of children in need in their area. The Act makes the child's welfare paramount. Section 27 imposes a duty on health bodies to co-operate with a local authority to support children and families. The duties are further clarified within Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019[14], which sets out how all NHS organisations, including those they may contract, should fulfil their responsibilities.
- The Children and Social Work Act 2017 implementation was underpinned by the statutory guidance Working Together to Safeguard Children (2018), making CCGs equal partners with Local Authority and Police forces.

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

- The Hertfordshire and West Essex teams with support from the East of England regional team are in the initial stages of merging to work together around new structures for safeguarding to support transition to the HWE ICB. The teams have met regularly to discuss joint areas of work, alignment of policies and sharing best practice.
- The NHS E/I safeguarding programme funding in 2021 was used to support key pieces of safeguarding work within the local health economy, in particular upskilling the workforce's understanding of MCA in preparation for the impending LPS.

Safeguarding Support to Primary Care

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

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

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

- Learning from local reviews has resulted in changes and improvements to safeguarding practices within Primary Care to include enhanced information sharing processes. Following an audit reviewing the quality of returned information requests to Children's Services, an automated electronic form has been created to facilitate accurate, timely information sharing. This has recently been embedded within Primary Care electronic patient record systems enabling auto-population of much of the required information, vastly reducing the time taken to share this vital

information. A training webinar in January 2022 provided an overview and demonstration to Primary Care colleagues of this improved process. A 'gold standard' template has also been produced to support staff with the completion of these requests for information.

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

- An audit of the GP child protection case conference reports submitted to Children's Services has been completed. Identified learning will be addressed to achieve compliance with standards set. The report and action plan has been shared with GP practices for comment. Discussions are planned with Primary Care to consider options moving forward.

Safeguarding Support to Secondary Care

- The team continued business as usual throughout the pandemic and delivered increased levels of support to provider organisations, especially focussing on solutions for presenting issues/incidents, facilitating joined up working and ensuring that multi-agency partner organisations were continually sighted on any changes in health service provision. Assurance workstreams continued via quarterly dashboards and statutory annual Section 11[15] assurance visits to large providers, along with supporting public health commissioners with the same. Action plans continued to be monitored via provider organisation quarterly safeguarding meetings and close working with quality and contract teams where required.

  The Designated teams have continued to work with agencies to ensure that protecting children remains a priority despite the pandemic, and to highlight identified risks to ensure our most vulnerable children were seen, with a focus on mental health issues, invisibility of children, exploitation and domestic abuse. The team are active members of the Safeguarding partnership, supporting a number of

[15] Section 11 of The Childrens Act which outlines statutory obligations of health providers

workstreams, consistently attending subgroups to drive change and improve outcomes for children. The risk to children emerged in serious incidents both locally and nationally, identified through reviews. Learning events with the safeguarding partnership were held to support front line practitioners to ensure robust approaches to identify invisible children and ensure they are not overlooked.

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

Looked after children (LAC)

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

The Hertfordshire Initial Health Assessment (IHA) compliance initial reduction in Q1 -Q2 2021/22 due to impact of pandemic, has now increased to 85% compliance against a target of 100%.

- During the pandemic the Designated Children's Looked After team (CLA) has worked to develop closer working relationships between CLA Health and Social Care. Particularly in relation to identification and sharing of information around specific vulnerable children who are in crisis or requiring additional support. This has been helpful and, in some cases, has improved understanding of each other's roles in the care of CLA.
- The Designated CLA team contribute to the Partnership including a working group to establish an Exploitation hub. The partnership group - Vulnerable Adolescent Strategic Group (formerly SAAG) will be able to identify hot spots of activity and risk by sharing data from all services/providers. This will enable development of targeted strategies to reduce child sexual/criminal exploitation and associated risks that present to young people.
- The Designated CLA team have audited records of children who have declined a statutory Health Assessment over the last 18 months. Recommendations on how the refusal process may be improved by working with some children currently in care as well as some care leavers to develop an understanding of why young people

refuse as well as use their skills to develop some more user-friendly information around the process.

- The NICE Quality Standard on Foetal Alcohol Spectrum Disorder (FASD) has yet to be published. As it is known that FASD affects many CLA the designated team have been doing some preliminary work. The team were lucky to secure national experts for an afternoon session to raise awareness of FASD across the partnership. Following this, the Designated team are contributing to a round table exercise being run to share knowledge and expertise of others who have commissioned / work in FASD services with a view to contributing to a business case for a local service.
- Dental access for routine appointments for CLA has proved increasingly difficult over the last 2 years and current data suggests that the number of children in care with a dental check in the last year is 52%. The designated team are working with local dental commissioners to improve this over the next year. This is a national problem, and a regional workshop has taken place with a follow up meeting in February.
- During the last year the number of children coming into care has increased with the number from Hertfordshire currently 1015. This number has been impacted by an increase in separated migrant children[16] coming into Hertfordshire although numbers remain consistent at around 85 as the age of becoming CLA is usually around 16 -18yrs.
- There has been an increased requirement for Tier 4 beds[17] and where the demand has exceeded availability the Designated team have been sighted on concerns and attended meetings where appropriate.
- The Designated CLA team have been involved with creating a survey to establish the impact of trauma on professionals working with and those that have experienced trauma first-hand. The survey findings will contribute to the Trauma Informed Practice strategy work that is taking place by Hertfordshire County Council for implementation across the partnership.

Child Deaths

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

[16] Formerly known as unaccompanied asylum-seeking children or UASC.

[17] Tier 4 are specialised services that provide assessment and treatment for children and young people with emotional, behavioural or mental health difficulties.

- The CCG facilitated two development workshops for Child Death Overview Panel (CDOP) members exploring the impact of the changes introduced by Working Together 2018 Section 5 Child Death Reviews. The workshop was an opportunity for members of Hertfordshire Safeguarding Children Partnership (HSCP) Child Death Overview Panel (CDOP) to review the working of the panel; taking into consideration membership, roles and responsibilities and business as usual following the introduction of eCDOP, to ensure the statutory function of the panel was discharged and child deaths reviewed within statutory time frames. A further workshop is planned to ensure the equity of service for unexpected and expected deaths across the County, this will be supported by an integrated protocol.
- The CCG have worked closely with QES (electronic child death recording system provider) to facilitate a virtual seminar for Named GPs in the completion of child death reporting forms to enable support to be offered to the wider system. This has led to increased participation in the use of the virtual platform.
- To ensure continual awareness raising and support for the child death process the team have collaborated with Providers and Region to provide training on all aspects of child death and supporting process, including contributing to the updated Safe Sleep leaflet.

Section 11 and NHS E/I/ Improvement Safeguarding Assurance Tool (SAT)

The CCG submitted the safeguarding assurance tool to NHS E/I in November /December 2021.

Improving the health of people with a learning disability

A new national LeDeR (Learning from Lives and Deaths) policy was introduced in March 2021. Locally, the LeDeR Leadership group and Improving Health Outcomes Group (IHOG) continues to meet virtually to ensure requirements of the policy are met and that learning from reviews leads to cross system service improvement.

Delivery of Annual Health Checks for people with learning disabilities continues to be a priority. An Annual Healthcheck preparation tool has been further promoted by the Learning Disability Nursing Service to increase the quality of completed checks and embed a collaborative approach. The national target for Annual Health Check delivery is 75%. Data from regional NHS E/I&I team up until end February 2022 shows HVCCG have achieved 62.4% (national comparison 56.5% and East of England comparison 54.3%). Historically the majority of annual health checks are completed in Q3 & Q4.

The official year end national data is usually published in June for the preceding year. Monthly data from NHS Digital released for April – February 2022 shows cumulatively that HVCCG completed 1914 annual health checks[18].

The 'STOMP/STAMP' programme[19] to address over-medication of people with a learning disability or autism with psychotropic medications was restarted after a pause due to the pandemic. The STOMP nurse continues to support reductions of medications and work has begun on a national pilot to understand prescribing and medications for children and young people.

- Significant effort has been focused on the COVID-19 vaccination programme. A collaborative approach between health and social care has ensured maximum uptake of both the primary vaccinations and boosters for people with a learning disability.

- Care and Treatment Reviews have continued in a virtual adapted format for both community and inpatient settings. 6-to-8 week monitoring visits of specialist LD hospitals have returned to on-site formats. Host commissioner responsibilities continue, overseeing community and inpatient specialist LD hospital services in the Hertfordshire footprint.

- Safe and Wellbeing reviews[20] have taken place for inpatients in specialist learning disability/autism beds as of 31st October 2021. With ICS panel review of findings in February 2022, and learning feeding to the national team by the end of March 2022.

REDUCING HEALTH INEQUALITIES

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.

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

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

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

- [21]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.

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

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 will be reviewed and refreshed in Summer 2022 following disruption this year from the COVID-19 pandemic. Engagement with a wide range of stakeholders will take place to gain a better understanding of the diversity and variety of health and wellbeing activity that takes place across the county and the role that local areas, networks and communities can play in helping to achieve improvements.

The role of Hertfordshire's Health and Wellbeing Board

The Health & Wellbeing Board brings together the NHS, public health, adult social care and children's services, including elected representatives from the County and District Councils, 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 signed off by the Health and Wellbeing Board in Summer 2022.

The CCG's approach on inequality

Using insight

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

One of the challenges facing Hertfordshire is how we deliver the best care for our increasingly ageing population. We expect the number of over-75s to increase by 37% in the next 10 years. We are working to increase the support available, and we aim to identify people at risk of avoidable hospital admission sooner, 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 led the bid to NHS Charities Together (NHSCT) on behalf of HCT Trust as lead charity and the ICS, in partnership with HCC, 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[22] funded) and are reaching into communities to provide a mixture of BAME social prescribing (SP) and advocacy and to provide input into the SP system (88 workers) to support cultural competence. They will also address capacity issues in the BAME sector which has suffered Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) funding cuts disproportionately in the last 10 years.

- A BAME carers project with Carers in Herts is also funded out of NHSCT monies and will commence in June, addressing cultural competence in carers' breaks and building on the 'urgent short breaks on prescription project' funded in all 4 localities, designed to address a quick response to carers who have not had a break for over a year and may present to primary care in need.
- A digital inclusion project (Staying Connected) commenced 1 February, with a worker employing a CSR approach to the acquisition of kit (already received 50 dongles from Tescos, and donations of tablets from other companies, HCC and others) which is cleansed by volunteers and can be socially prescribed to people whose wellbeing will be significantly improved by access to the internet. Volunteers also provide with motivation and support to use.
- A winter small grants process (with Hertfordshire County C and the ten District Councils) to distribute £75k of NHSCT funding to 33 projects, which helped with digital exclusion, social isolation and ensuring maximising of volunteer capacity. Additional funding was levered from Districts (£9k), from Mental Health commissioners (£11k) and HCC (£14k food and fuel poverty monies). This will be repeated next winter.
- NHSCT monies also funded two pilot posts supporting adolescents in crisis (one at WHTH and one at ENHT) before admission/in hospital/after hospital attendance with social prescribing to link them into support on their return home. Both workers are now in post.
- The CCG worked with ENHT, Carers in Herts and Community Development Herts to develop the NHS E/I funded "Mind the Gap" Sickle Cell Zoom carers' support group for the 135 families affected across Herts, seeing it as an exemplar for outreach to marginalised groups.
- The Central Watford PCN Link Worker and the BAME workers are among key local partners designing an outreach approach to 80 black males identified as not looking after their diabetes and seeking to address the social issues blocking the best clinical outcomes.
- The CCG led on work with HCC to develop proposals for a new joint strategic commissioning board for Health Creation and the VCFSE Sector, designed to ensure the ICS treats the VCFSE as a key partner in 'health creation'. This has been supported by heightened collaboration within the sector, including a presentation

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

by key players to 70+ elected members in February of what had been achieved during COVID-19, which presented details of the 130,000 calls taken by HertsHelp in one year and the thousands of interventions by organisations across the county. The board will ensure this improved integration is maintained and built upon. Key themes will be the focus on "No Wrong Door" approach (to ensure access for those most in need through HertsHelp and the social prescribing system) as well as ensuring Family Carers and Volunteering are always considered in the commissioning of the VCFSE.

The CCG have worked with HCC commissioned Sensory Services to identify feedback from people with sensory needs and ensure they are able to access services appropriately. This has included ensuring all referral forms identify if patients have sensory needs so that they get the right support when referred.

Social media targeted ad campaign to focus on people from BAME backgrounds on the signs of cancer started in March for 3 months across HVCCG.

National Diabetes Prevention Programme (NDPP): online programmes now available in different languages including Urdu and Punjabi to ensure better access from people whose first language is not English, as well as a specific programme for people with learning disabilities.

Project working with learning disability nurses to increase uptake of cervical screening for people with learning disabilities is underway across HVCCG, a cervical screening decision process document which covers Mental Capacity Act (MCA), Best Interest looking at risk and benefits etc and resources, i.e. comic strip, videos and easy read to be used alongside a cervical demonstration model having been developed and training with GP practices.

Integration and better networking are an outcome in themselves helping local, cost effective (often free) solutions to problems citizens face

Working with people on the ground such as education leads for travellers, homeless leads, and community leaders is important to identify the groups and issues, for example, we identified 1,000 unregistered patients in the Portuguese community in Watford.

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

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

• 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

• The CCG have shared easy-read, Purple Superstars and non-English language social media for major campaigns such as the 'flu and COVID-19 vaccination programmes. HVCCG also shared Non-English-language content for these campaigns aimed at specific 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**

• Following a request from the HVCCG Inequality, Diversity and Inclusion Group, work has been undertaken to ensure the Herts Valleys CCG website is more 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.

This section details how we have undertaken our engagement this year, continuing to work with local people through the ongoing COVID-19 pandemic which has made it necessary for us to make changes to the frequency and way we engage.

“ I am the Lay Member for patient and public involvement on Herts Valleys CCG board and undertake the same role in East and North Herts CCG. I chair the Patient and Public Involvement Committee which, as a committee of the board, supports me in providing assurance that we are involving local people in a range of different ways in our work.

I love getting involved with this work to put patients and local communities across Hertfordshire at the heart of our thinking (‘involve me and I will understand!’) and of course this year has mainly meant virtual engagement on a range of matters. I’m invited to patient network meetings, webinars which support our wider learning about health and care topics, and any areas of work where my involvement supports my board oversight role of making sure we meet our statutory requirements to involve and engage different groups of people.

Patient involvement representatives have a strong desire and show real commitment to supporting our efforts, and it is clear to me that our communications and engagement teams have responded appropriately and harnessed the enthusiasm of these volunteer advocates to good effect.

As we transition to the formal establishment of integrated care systems and the integrated care board that will replace CCGs, I really feel that there are some fantastic ways of doing things in CCGs that we can take forward, as well as introducing new and inventive but also accessible ways to do involvement and engagement in 2022 and beyond. In particular I feel there are many lessons we can learn from how we engaged and communicated with the public during COVID-19 and we can use these lessons to refocus and strengthen our commitment to reducing health inequalities across the whole ICS.

Thank you to our PPI committee and everyone involved in patient and public involvement work during this year: our volunteer representatives continue to be valuable 'critical friends' and advocates alike in their roles: challenging and supporting. I am committed to understand more, explore best practice, and support engagement activities as we work towards recovery and an ever-more integrated system in Hertfordshire and west Essex. ”

Alison Gardner,
Lay member for Patient and Public Involvement

How we engage

Patient and Public Involvement (PPI) Committee

Our PPI committee continues to provide 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.

In line with the need to prioritise pandemic management, and following national guidance, we suspended formal meetings of the PPI committee at certain times during the COVID-19 pandemic. But in order to maintain the dialogue and information- sharing, we continued to hold regular sessions with members, updating them on the vaccination programme, COVID-19 responses, hospital development plans and other services. We have also 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 an increasing patient and practice staff membership. This year it has grown to 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.

We have held 10 network sessions since April 2021 and have had around 500 people register, hearing about topics such as the role of the voluntary sector, establishment of a health and care partnership, virtual patient consultations and hospitals and respiratory services. All sessions were recorded so that the information could be shared really widely through the many networks that participants are part of.

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 during the pandemic. Attendance averages between 25 and 50 people. These meetings 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, following a recent recruitment drive, is now 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

"In 2013, when the CCGs were first established, as well as finally retiring from active work, I had just been made chair of the patient participation group (PPG) of my surgery in St Albans. At that point, my knowledge of the world of commissioning, representing the patient voice, and improving patient experience was as close to zero as it was possible to be!

The two CCGs ran a course to brief us on all things related to the NHS and that was the start of my association with Herts Valleys CCG. That, and the PPG group that the CCG created, provided me with a rapid learning curve, and being engaged with the CCG from those early stages gave me an incredible grounding in the rewarding art of articulating the patient voice (even when it means advocating a position with which I don't fully concur!). Having a network with which to establish a common view, is a critical part of the job description, and developing that network has been one of my highly valued initiatives of my life in retirement.

From these humble beginnings I have maintained a close liaison with the HVCCG communications and engagement team and managed to get myself into all kinds of interesting roles. From the patient voice on procurement, to regular meetings and briefings, to engagement on committees, steering groups and programmes; the experience has been awesome and I have always found that my contribution has been both welcomed and appreciated.

Having diabetes Type2, and with a daughter who has Type1, I have especially focused on the whole area of diabetes. I am one of the patients on the Diabetes Clinical Forum, as well as on the steering group for the Herts Integrated Diabetes Service ("HIDS") which is a collaboration between the acute, community, and HPFT organisations to provide a "one-stop " facility for all diabetics in south and west Hertfordshire. And over the last few months, with support from HVCCG, we have been able to set up a diabetes support group, to provide monthly online webinars, support services, a newsletter and a co-design capability working with diabetes care across all areas (primary, community and acute) to ensure that patient engagement and experience is at the centre of service re-design.

The future, within the ICS, is looking bright, and I sincerely hope that patient engagement will be as central and as exhilarating as it has been over the last nine years.

Alan Bellinger

Patient representative

Review of our engagement work over the last year

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.

In October 2021, Hertfordshire CCGs took part in the county council's health scrutiny 'GP access topic group' to explain the challenges faced by general practice in meeting rising

patient demand and work to improve access. This resulted in recommendations by the topic group members that were taken back for a further discussion with CCGs in March 2022[23].

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

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

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

To provide lasting 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.

GP contract changes

During the year we have talked with patients about the future of two GP practices: The New Surgery, Tring and Pathfinder, South Oxhey. Both were approaching the end of their Alternative Provider Medical Services contract. In each case we wanted to hear about patients' views on future options for delivering GP services to patients. We followed a targeted approach for each engagement, writing to registered patients to outline the options. We offered a range of response channels including online survey, email, telephone and virtual engagement sessions.

[23] **Agenda for Health Scrutiny Committee on Monday, 14 March 2022, 10.00 am | Hertfordshire County Council**

We worked with surgery patient groups and Healthwatch Hertfordshire to promote the engagement. Staff working at each surgery were briefed and invited to complete the survey.

For Pathfinder we commissioned an independent company to make direct calls to some patients in order to ensure a larger, more representative response.

The responses were analysed independently and reported to the CCG's Primary Care Commissioning Committee for a decision to be made on the options, taking account of feedback from patients.

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.

In December 2021, the board of SWHHCP agreed an engagement framework with 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.

St Albans urgent care

During 2021 we engaged with patients as part of developing plans for urgent care services at St Albans City Hospital, once services are able to reopen during 2022. The hospital's minor injuries unit (MIU) has been temporarily closed as part of the COVID-19 response and remains so as part of infection control measures to protect planned surgery on the site.

Over the summer of 2021 we invited local people and stakeholders to share their views on options for the site through a public engagement programme. We wanted to test a full range of options from 'do nothing' (having no service at all), a 'do minimum' option of

reopening the MIU, an enhanced option of an integrated urgent care hub, and the most comprehensive option of an urgent treatment centre.

Over 3,200 people responded to the engagement which included a public open survey, virtual patient meetings and discussion groups for particular audiences such as young people and carers. The engagement showed clear support for continued urgent care facilities at St Albans City Hospital. Public support increased according to the level of service being offered. Accordingly, the most favoured option was the urgent treatment centre (UTC) which 91% of respondents supported but there was also substantial backing for the CCG's preferred option of an integrated urgent care hub which was supported by 83%. This will provide a minor illness and minor injury service, bookable via NHS111 or GPs, that is led by specialist and experienced nurses with support from GPs.

A number of people who replied to the engagement said that they wanted to be kept informed and we are continuing to update them at key points.

Besides the formal public engagement exercise, we are actively listening to the view of patients throughout the process to develop a future service. There are patient and Healthwatch Hertfordshire representatives on the project group, the reader panel has reviewed patient information and patient representatives will be involved in the procurement which is scheduled to take place from April 2022.

Further communications and engagement will take place over the coming months to ensure patient buy-in to the new service.

Hospital redevelopment

We have continued to liaise with colleagues in West Hertfordshire Teaching Hospitals Trust to promote opportunities to be involved in the public engagement on developing future hospital provision in west Hertfordshire. In early 2021 the trust ran a 'Your Care, Your Views' engagement, inviting views on a future vision for each of its sites and improvements to services. A further phase of engagement ran during May and June 2021, with the trust sharing feedback from phase one and inviting feedback.

Work on the redevelopment programme over the last six months has mainly focused on the development of the outline business case (OBC) and securing investment for the trust's plans. This has therefore been a 'quieter' period in terms of engagement. The CCG has supported the trust in keeping communities informed and maintaining interest in the

hospital plans by sharing updates, including the trust's 'Blueprint' newsletter, through our communications channels.

Mount Vernon Cancer Centre Review

We have continued to support the Mount Vernon Cancer Centre (MVCC) review which started in 2019 and is led by NHS E/I.

The independent clinical review of MVCC services concluded in 2019 that the centre should be co-located in an acute hospital to provide modern, specialist cancer services. In 2021, expressions of interest were made to the government's new hospital programme to redevelop Watford, Hemel Hempstead and St Albans hospitals, and to build a new cancer centre at a redeveloped Watford General Hospital. There are also options being explored to have a networked radiotherapy unit at either Lister Hospital in Stevenage or Luton and Dunstable Hospital.

We have helped promote several patient and public involvement opportunities run by NHS E/I colleagues, including via social media and our various channels. We worked with NHS E/I to set up a virtual session for the west Herts area. Around 30 people attended and were able to have discussions specifically from a local perspective. We also supported the MVCC review patient reference group to ensure there was representation from west Hertfordshire on the group. Involvement of patients, carers and local people is continuing as proposals are further developed, and this will include a consultation on options. We will continue to work with NHS E/I to ensure the involvement of local people.

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

COVID-19

Background

The NHS continues to respond to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China and which has now been detected in more than 100 locations internationally, including the United Kingdom. The virus has been named "SARS-CoV-2" and the disease it causes has been named "coronavirus disease 2019" (abbreviated "COVID-19"). On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the outbreak a "public health emergency of international concern" (PHEIC). On 11 March 2020, the World Health Organisation publicly characterized COVID-19 as a pandemic. A pandemic is a global outbreak of disease.

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

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

Clinical Commissioning Groups (CCGs) Role in the Response

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

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

ICC action cards and other supporting documentation have been developed for all key roles to manage the incident response. The Command-and-Control structure for the CCG is as follows:

- Strategic: Incident Management Team
- Tactical: Incident Coordination Centre
- Operational: Key work programmes.

ENHCCG has led the health response to COVID-19 on behalf of Hertfordshire, supported by HVCCG. ENHCCG chair the Health Economy Tactical Coordination Group (HETCG) and is the health representative at the Hertfordshire Strategic Coordination Group (SCG) and the Health Protection Board (HPB).

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

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

The CCGs internal governance structures developed have supported them to:

- Engage at the Hertfordshire Strategic Co-ordinating Group to represent their population from a strategic multi-agency health perspective
- Engage at the Hertfordshire Tactical Co-ordinating Group to ensure involvement at a local level with joint working from the county or area systems
- Continue to engage with the Hertfordshire Director of Public Health on the Health Protection Outbreak Board

- Provide updates about CCG and system progress to the board through the reporting routes established
- Continue to work with NHS E/I for situational awareness and reporting
- Attend Hertfordshire meetings with the other commissioners and providers on the health TCGs to provide a tactical health response
- The CCGs also work as part of the Hertfordshire and Essex communications cell to plan and deliver COVID-19 communications for the public, staff and stakeholders.

Mass vaccination and outbreak cells

A mass vaccination cell was established to support the roll out of the COVID-19 vaccination programme. However, when gaps in uptake were identified, a further cell was established to address the inequalities across different cohorts of the population and reduce the gaps. The CCGs have also supported the booster campaign with several staff being redeployed to support the effort.

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

Debriefing and Recovery

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

Workforce

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

The CCG continues to promote flexible working arrangements such as homeworking to encourage work-life balance for staff and to provide a COVID-19 secure environment for those that attend the offices. In making the offices COVID-19 secure, extensive improvements were made to the staff environment; measures include: wearing face masks in general office building areas; socially distanced desks and meetings room; and enhanced office cleaning schedules for both equipment and the offices themselves.

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

Concurrent Incidents

The CCG has responded to several concurrent incidents, listed below, throughout the COVID-19 pandemic. These incidents have all been managed within the existing command and control structure for the COVID-19 response.

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

The Immediate Future

The CCG continues their attendance at national leaders' webinars, together with representation at strategic and tactical meetings as required by multi-agency partners, NHS E/I/I and system operational rhythms.

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

SUSTAINABLE DEVELOPMENT

Introduction

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

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

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

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

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

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

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

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)[24]

	2020-21	2021-22
Total	£6662	£10099

This spend has increased compared to the previous year due an increase in CCG staff working within the office space.

Travel

Herts Valleys CCG spent £ 1,211 on business travel costs in 2021-22. This has substantially reduced compared to previous years due to the majority of CCG staff working from home. 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

[24] 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.

to work' scheme. This allows staff to purchase a bike and cycle safety equipment as a tax-free benefit.

Key Initiatives 2021/22

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

Locally and, in line with government legislation, the organisation successfully moved largely to remote working as a result of the Covid-19 pandemic. Our health and safety arrangements were reviewed and the risks assessed, which continue to be monitored. A number of Covid-19 protection arrangements have continued to a number of sustainable positives, which support lowering the organisation's carbon footprint including:

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

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

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

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

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

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

REVIEW OF FINANCIAL PERFORMANCE

Financial Overview

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

The CCG has a statutory duty to manage their finances within the resources available. key duties and the performance of the CCG are set out in the table below:

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 services to or below the amount allocated	✓ Achieved Breakeven with a cumulative underspend of £8.499m
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	✓ Achieved Breakeven with a cumulative underspend of £8.499m
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 underspent by £1.238m in 2021/22
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 normal financial planning process for the year 2021/22 was suspended at the end of March 2020, when NHS E/I removed the routine burdens on NHS bodies, freeing up resource to focus on the operational response to the COVID-19 pandemic. NHS E/I

instigated an emergency financial regime for all NHS organisations to ensure financial viability for the NHS and to remove unnecessary administrative burdens. Funding was made available to CCGs, NHS and non-NHS providers and Local Authorities to cover costs arising from managing COVID-19 patients.

These emergency financial arrangements effectively simplified financial management and allowed greater focus on health system partnership working to manage overall resources. The regime included providing funding to be distributed to individual organisations within the Hertfordshire & West Essex Integrated Care System (ICS) with funding envelopes, incorporating mandated block values to NHS Providers, prospective top-up, growth and COVID-19 allocations for 2021/22. A summary of the framework over the full period of the emergency financial regime is shown in the table below:

Category	Months 1 to 6 2020/21	Months 7 to 12 2020/21 (H2)	2021/22
Allocations and Budgets	Budgets were set based on 2019/20 actual expenditure at Month 11, uplifted for inflation. Allocations were adjusted retrospectively to achieve a breakeven position against actual expenditure, on each service line, and including expenditure in response to the pandemic	Financial Envelope for HWE ICS provided by NHSE. The CCG's allocation within this has been set against NHSE estimations of budgets required. "Top-ups" are provided through the ICS for growth and COVID-19 expenditure to achieve breakeven positions. Financial performance will be measured against a breakeven control total	
Contracting and Commissioning	Contracting and commissioning stood down. No invoicing for NHS Non-Contracted Activity (NCAs)		
NHS providers	Block payments above £250k mandated from commissioners to providers, top-ups made by NHSE to allow providers to breakeven against shortfall in income and COVID-19 expenditure	Block payments above £500k continue. Ability to adjust these payments to recognise newly-commissioner services not in the baseline in 2019/20. Requirement to top-up mental health providers to achieve MHIS. Providers supported within the overall ICS financial envelope	
Independent Sector	Nationally commissioned		Commissioning returned to CCGs, working with main providers.
Non-NHS Providers	"Light touch" contract management to support sustainability and recovery	Expectation that support to providers is phased out and normal activity resumes	
Primary Care	Protected income at 2019/20 levels. COVID-19 expenditure is reimbursed	Additional requiremens of Care Home DES and Additional Roles Reimbursement Scheme have been included in the CCG's baseline budgets	
Efficiencies and QIPP	No requirements to deliver efficiencies and all QIPP schemes deferred	Expectation that a level of efficiency will be delivered, although no formal efficiency reporting	

The total allocation received by the CCG during the financial year 2021/22 was £1,029.237m. This included the CCG's annual allocation and retrospective top-up and COVID allocations. This is shown in the table below:

Allocation Received	Total £'000
Programme	885,587
Devolved Commissioning	92,316
Running Costs	12,349
Cumulative Surplus *	8,499
Retrospective CCG Top-up and COVID-19 funding **	26,711
Service Development Funding (SDF)	4,225
TOTAL	**1,029,687**

* The CCG is not authorised to spend the cumulative surplus

** The allocation received for the Hospital Discharge Programme (HDP) of £23.051m is included within the COVID-19 funding allocation

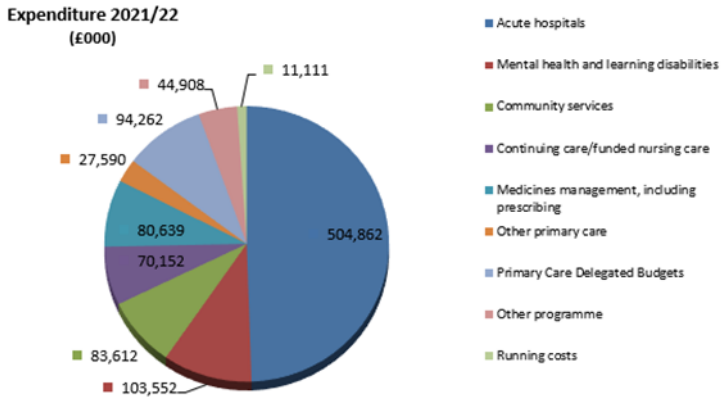
The CCG met the statutory requirement to keep spend within the resources allocated and maintain the 1% cumulative surplus of £8.499m. Of the total available resource of £1,029.687m, the CCG spent and distributed £1,020.688m, and maintained the cumulative surplus of £8.499m

The table below shows the source of the £8.499m cumulative surplus.

Source of Surplus 2021/22	Value £'000
Return of prior year cumulative surplus	8,499
Surplus from other CCG budgets	0
Cumulative Reported Surplus in 2021/22*	8,499

**Cumulative surplus to be returned to the CCG in 2022/23*

Details of how the CCG spent its allocation during 2021/22 is shown in the chart below and the categorisation of spend is consistent with the categories utilised for reporting to the Finance and Performance Committee.



Directorate	Annual Expenditure £m	%
Acute hospitals	504.9	49.5%
Mental health and learning disabilities	103.6	10.1%
Community services	83.6	8.2%
Continuing care/funded nursing care	70.2	6.9%
Medicines management, including prescribing	80.6	7.9%
Other primary care	27.6	2.7%
Primary Care Delegated Budgets	94.3	9.2%
Other programme	44.9	4.4%
Running costs	11.1	1.1%
Grand Total	1,020.7	100%

NHS E/I 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 allowed 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 2021/22.

Hospital Discharge Programme

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

In response to the COVID-19 pandemic and the need to ensure hospital beds were available to those who needed them most, the government introduced new hospital discharge arrangements based on the expanding of Discharge to Assess (DTA) model. Health and Care systems were financially supported by NHS E/I under the Hospital Discharge Programme (HDP) to ensure people who no longer needed to stay in hospital were discharged safely from hospital to the most appropriate place and continue to receive the care and support they needed after they left hospital. Any expenditure incurred by the system under this programme represented the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to four weeks following discharge from hospital with reimbursed by NHS E/I. The programme ensured Social Care needs assessments and NHS Continuing Healthcare (CHC) assessments of eligibility were made in a community setting and did not take place during the acute hospital inpatient stay.

For the financial year 2021/22, the total amount spent by the CCG under the Hospital Discharge Programme was £23.051m.

Mental Health Investment Standard

A very important requirement in the 2021/22 planning guidance related to the Mental Health Investment Standard (MHIS), under which all CCGs are required to increase their spending on mental health services by at least the percentage increase on the CCG's programme allocation growth. In 2021/22 the CCG's programme allocation growth was 4.23% However, during the year the CCG received additional funding to manage the impact of a higher NHS staff pay award. The adjusted MHIS target after allowing for this increase was a growth in expenditure of 4.85%.

In addition, the CCG received non recurrent allocations such as Department for Work and Pensions funding for improved access to psychological therapies and national funding such as service development (£2.867m) and spending reviews (£2.849m).

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

- Continued expansion and growth in both community and specialist perinatal mental health services e.g., increasing access to women who can access the service
- Expansion of IAPT services to people with Long Term Conditions, such as diabetes, respiratory and MSK. Development of Long Covid pathways
- Embedding the 24/7 CAMHS Crisis helpline

- Crisis resolution and home treatment team
- Early intervention in psychosis – support for people in the "At Risk Mental State" group
- Adult eating disorders day treatment
- Individual placement and supports (employment support)
- Annual physical health check for adults with serious mental illness
- Improving the therapeutic offer in inpatient care to support a reduction in length of stay and better outcomes
- Core 24 standard for psychiatric liaison
- GP health checks and vaccination rates for the people on the GP Learning Disabilities register
- Increased focus on delivering the nationally set trajectory for the reduction of Out of Area Placements to zero
- Commitment as a system to reducing the number of suicides across Hertfordshire and maintain effective suicide bereavement support services

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

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

CCGs are required to confirm their spending meets the Mental Health Investment Standard and to publish a formal declaration on whether in 2021/22 Herts Valleys CCG's spending on mental health services increased by at least 4.85%

The CCG's target spend for the Mental Health Investment Standard in 2021/22 was £83.287m compared to actual reported spend of £84.722m. The CCG therefore considers that it did meet the requirements of the Mental Health Investment Standard.

Description	£000 unless stated otherwise
2021/22 Mental health spending	123,040
Less spending on Learning disability and dementia	(30,775)
Less spending covered by allocations received	(7,543)
2021/22 spending funded by general allocation	84,722
2020/21 spending funded by general allocation*	79,438
Increase in spending	5,284
Increase in spending (%)	6.65%
Has the Mental Health Investment Standard being Met?	**Yes**

* There was a national re-categorisation exercise that took place in 2021/22, the net effect of which resulted in a change in the spending reported under MHIS. The previously published spending for 2020/21 was £83.550m.

Financial outlook for 2022/23

In recognition of the impact of the COVID-19 pandemic, NHS E/I maintained the same financial framework that was introduced in the second half of 2020/21 (H2) during 2021/22. However, all NHS organisations will transition out of the emergency financial regime during 2022/23.

The financial envelope for Hertfordshire and West Essex (HWE) Integrated Care Board (ICB) has been provided by NHS E/I and comprises of the adjusted CCG allocation, based on agreed spend, including costs incurred as a response to managing the pandemic, with allowances for inflation and policy priorities. This will be delegated to the respective CCGs for the 3-month period before the establishment of the ICB, which will occur on 1 July 2022 in line with the Health and Care Bill having received royal assent.

The commissioning of services from NHS and non-NHS providers will return to a negotiated contractual basis, with the development of Aligned Payment Incentive Agreements (APIA) for contracts with NHS Providers above £30m.

The requirement for the CCG to continue to increase funding within Mental Health in line with their allocation growth continues and Herts Valleys CCG is planning to meet the Mental Health Investment Standard (MHIS) in 2022/23.

Performance process

The CCG has a robust performance management regime for its internal performance against national and local targets as well as key clinical and financial indicators. These targets and indicators are monitored on a monthly basis by the Executive Team and the Finance Committee, with each target having an identified senior lead. This is reported to each Governing Body meeting in public, to provide an open and transparent view of performance in all areas of the business.

Commissioning Activities

A key priority for the CCG is to ensure that maximum value for money is being achieved through effective commissioning arrangements, as the majority of the CCG's expenditure is spent on commissioning healthcare services. Whilst healthcare providers are required to deliver a continuous programme of efficiency and productivity improvements, the CCG also must demonstrate that it is properly considering the health needs of the local population and commissioning those services that address those needs.

An analysis of the key contracts by value is as follows:

Provider	Outturn 2021/22 £'000
West Herts Hospitals Trust	291,296
Herts Partnership NHS FT	89,791
Hertfordshire County Council	64,992
Royal Free NHS FT	60,383
Central London Community Health NHST	53,470

The CCG continues to ensure it achieves value for money in all of its contracting activities through its performance management framework including the monitoring of a range of key indicators and performance reviews with all key service providers.

Audit Arrangements

External audit services are provided by BDO LLP.

The total fee for 2021/22 was £58.8k excluding VAT.

Internal Audit services are provided by RSM UK.

The total fee for 2021/22 was £44k, excluding VAT.

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.

ACCOUNTABILITY REPORT

Dr Jane Halpin
Accountable Officer

Date signed: 21 June 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 2021/22, 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)

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

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

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 2021 to the date this report was signed (21 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 is currently vacant. In anticipation of the CCG transitioning towards the ICS, this vacancy was not advertised in 2021-22. However, the HVCCG board has been meeting in common with ENHCCG and WECCG throughout 2021-22, 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 142 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. 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 2021/22.

Statement of Disclosure to Auditors

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

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; 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: 21 June 2022

GOVERNANCE STATEMENT

Introduction and context

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

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

As at 1 April 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.[25]

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 develop transition to an Integrated Care System (ICS) and Health and Care Partnerships (HCPs) for Hertfordshire and West Essex. This is in line with the **white paper**

[25] The Board, Renumeration Committee and Primary Care Commissioning Committee met in Common with East and North Hertfordshire CCG and West Essex CCG for most of 2021/22

and the NHS Long Term Plan sets out evidence demonstrating the effectiveness of Integrated Care working.

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

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

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 NHS E/I.

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

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 2021-22, the CCG has sustained its continuous improvement approach to governance and risk management. The integrated governance protocol was reviewed and updated to clarify 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 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. Risk management training is also mandatory for all managers and staff. As of 31 March 2022, the risk management training compliance for the CCG was 90.16%.

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 . Since May 2021 these reports 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, with additional meetings convened in 2021/22 specifically for this purpose. 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 in 2021/22, noting where any have been closed or added and the current assurance summary. 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 2021/22, published on the CCG website.

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 the end of March 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 in Q4.*	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 by Q3.*	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 during 2021/22, with the introduction of additional mitigations each time a new threat is identified under unprecedented system pressures. The target of 8 is not achieved in 2021/22.*	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 will be achieved upon successful submission of the 2021/22 DSPT.*	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. Preparations for the 2021-22 toolkit submission are in progress and a positive outcome is anticipated. 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 has an improved current risk score of 12 from Q4, 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 throughout 2021/22, 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 is reporting 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 end of March 2022.	

Red (High)	Amber (Significant)	Yellow or Green (Low)
4	5	3

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

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. With the national Hospital Discharge Programme ending on 31 March 2022, the CCG has been negotiating with partners to establish a system MDT approach to replace this. 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 2021/22 due to unprecedented system pressures and operational challenges at the acute trust.*	The WHTH RTT position for 18 weeks has deteriorated during 2021/22, as reported in the performance analysis section above. 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 during 2021/22 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 during 2021/22.*	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.
Risk that children and young people eligible for CYPCC will not receive a package of care to meet their assessed need in a timely and continuous way. *The current risk score of 16 reflects short timescales for establishment and mobilisation of a new service.*	HCT gave notice for the remaining care package and the Children and Young People Continuing Care (CYPCC) assessment and review service in October 2021. HVCCG is taking over responsibility for these elements of the service and arrangements with HCT for the equipment and consumables service, with the governance arrangements and workforce requirements in place for HVCCG to deliver the service from 1 April 2022. Weekly internal MDT meetings and bi-weekly partnership meetings with HCT have been in place to monitor progress against key actions and risks. There is communications team engagement across HCT and HVCCG to ensure effective patient communications. Additional support is being offered to the family with the remaining care package. Key staff to manage the process over the short and medium term are in place.

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."

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. RSM currently 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/I to support CCGs.

The organisation received reasonable assurance for this audit in 2021/22, 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 2021-22 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 is required to complete and publish a Data Security and Protection Toolkit (DSPT) assessment by 30 June 2022 and is on course to meet all mandatory assertions.

Business Critical Models

The CCG can confirm that an appropriate framework and environment continued to be in place during 2021/22 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.	Full documentation to be released to CCG in Q1 2022/23

SHREWD Transforming Systems	QA process is as follows: • 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	Upon set up and if there are any 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

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 2021-22.

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. In 2021-22 HVCCG's assessment outcome is not expected until end of June 2022.

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 2020/21: Fraud, Bribery and Corruption[26].

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 RSM to provide the counter fraud provision by way of a nominated lead local counter fraud specialist (LCFS). The LCFS is accredited by the NHS Counter Fraud Authority and qualified to undertake the duties of that role.
- The CCG Audit 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.

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

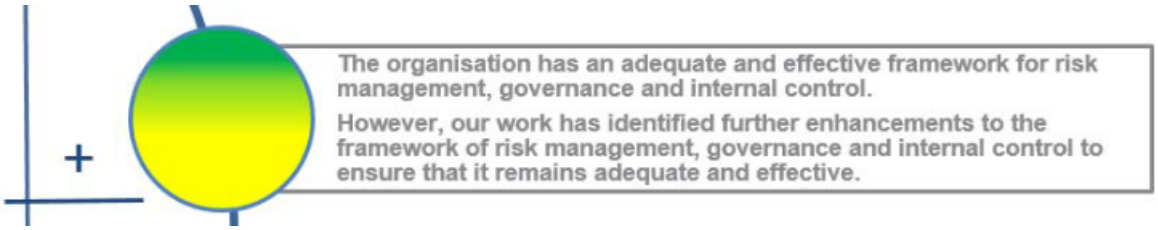
- An executive member of the board is proactively and demonstrably responsible for tackling fraud, bribery, and corruption. This responsibility has been assigned to the Chief Finance Officer.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

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.

For the 12 months to 31 March 2022, our Head of Internal Audit opinion for Herts Valleys CCG is as follows:



During the year, 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:

	Taking account of the issues identified, the board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action is needed to strengthen the control framework to manage the identified risk(s).
	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. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

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 reported to both the Audit Committee and the Finance Committee.

One high priority and 5 medium priority management actions were recommended. These 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. This additional capacity will support with completing the outstanding reviews.

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

During 2021/22, there were a total of 29 management actions open (one high, 20 medium and eight low). 23 management actions (16 medium and seven low) had been implemented, one management action (one medium) had been superseded, two management actions (one

high and one low) were in progress with new revised dates agreed with management, and three management actions (three medium) were not due at the time of this opinion.

Based on the work RSM have undertaken to date on the CCG's system of internal control, RSM 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: 21 June 2022

PART TWO: REMUNERATION AND STAFF REPORT

REMUNERATION REPORT

The information on pages 142 and 143 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 2021/22 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 AND ALLOWANCES (AUDITED SECTION)

HERTS VALLEYS CCG

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

Table 1:Single total figure

			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**

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

TABLE 2: SALARIES AND ALLOWANCES IN PREVIOUS YEAR (2021/22)

			2020-21					
Name	**Role**	**Note**	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100**	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
			£000	**£**	**£000**	**£000**	**£000**	**£000**
Jane Halpin	Accountable Officer (from 1 June 2020) - 30.56%	1,6,7	**40-45**	**0**	**0**	**0**	**0**	**40-45**
David Evans	Interim Accountable Officer (to 31 May 2020) /Interim Managing Director (Managing Director (from 1 July 2020)		**125-130**	**7,300**	**0**	**0**	**30-32.5**	**160-165**
Alan Pond	Chief Finance Officer (from 1 August 2020) - 30.56%	1,7	**25-30**	**0**	**0**	**0**	**12.5-15**	**40-45**
Elke Taylor	Acting Chief Finance Officer (to 31 July 2020)		**35-40**	**0**	**0**	**0**	**15-17.5**	**50-55**
Diane Curbishley	Director of Nursing & Quality (to 31 July 2020)	2	**265-270**	**0**	**0**	**0**	**17.5-20**	**285-290**
Jane Kinniburgh	Director of Nursing & Quality (from 1 August 2020) - 30.56%	1,6,7	**25-30**	**0**	**0**	**0**	**0**	**25-30**
Rachel Joyce	Director of Clinical & Professional Services (from 1 October 2020) - 30.56	1,7	**20-25**	**0**	**0**	**0**	**15-17.5**	**35-40**
Avni Shah	Acting Director of Commissioning (to 30 November 2020)/ Director of Primary Care Transformation (from 1 December 2020) - 30.56	1,7	**85-90**	**0**	**0**	**0**	**45-47.5**	**130-135**
Lynn Dalton	Director of Primary Care (to 18 October 2020)		**50-55**	**4,900**	**0**	**0**	**35-37.5**	**90-95**
Francis Shattock	Director of Performance & Delivery(from 1 March 2021) - 30.56%	1,7	**0-5**	**0**	**0**	**0**	**0-2.5**	**0-5**
Dr Nicolas Small	GP Director and CCG Chair	3	**140-145**	**0**	**0**	**0**	**£NIL**	**140-145**
Dr Trevor Fernandes	GP Director & Deputy Clinical Chair		**85-90**	**0**	**0**	**0**	**£NIL**	**85-90**
Dr Daniel Carlton-Conway	GP Director	3	**105-110**	**0**	**0**	**0**	**£NIL**	**105-110**
Dr Corinne Ciobanu	GP Director	3	**100-105**	**0**	**0**	**0**	**£NIL**	**100-105**
Dr Rami Eliad	GP Director		**85-90**	**0**	**0**	**0**	**£NIL**	**85-90**
Dr Asif Faizy	GP Director	3	**100-105**	**0**	**0**	**0**	**£NIL**	**100-105**
Dr Catherine Page	GP Director		**85-90**	**0**	**0**	**0**	**£NIL**	**85-90**
Dr Richard Pile	GP Director		**65-70**	**0**	**0**	**0**	**£NIL**	**65-70**
Stuart Bloom	Lay Member	4	**10-15**	**0**	**0**	**0**	**0**	**10-15**
Alison Gardner	Lay Member	4,5	**10-15**	**0**	**0**	**0**	**0**	**10-15**
Paul Smith	Lay Member	4	**10-15**	**0**	**0**	**0**	**0**	**10-15**
Thelma Stober	Lay Member	4	**10-15**	**0**	**0**	**0**	**0**	**10-15**

Note 1- Upon appointment to the Hertfordshire and West Essex Joint Executive Team (JET), the member's 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 the member's total remuneration across Hertfordshire and West Essex CCGs and ICS is disclosed in the table below.

Note 2 - On 1 August 2020 a joint appointment across the ICS and its 3 CCGs was made to the post of Director of Nursing & Quality. As a consequence the Director of Nursing & Quality role in each CCG, including Herts Valleys CCG became redundant. A redundancy payment was made to Diane Curbishley in line with contractural entitlements.The remuneration disclosed includes £35,000-£40,000 basic pay for the period in office, £160,000 in respect of a compulsory redundancy payment, £55,000-£60,000 for payment in lieu of contractural notice and £5,000-£10,000 for payment of accrued and untaken leave.

Note 3 - Where a GP Board member is working under a "contract for services" and the GP is set up on the payroll system to satisfy HMRC rulings, the position is pensionable under the "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 4 - As Lay members do not receive pensionable remuneration, there will be no entries in respect of pension benefits.

Note 5 - Alison Gardner was also a Lay Member of East & North Hertfordshire CCG Board in 2020-21 for Patient and Public Involvement. The remuneration disclosed above relates only to Herts Valleys CCG.

Note 6 - Jane Halpin and Jane Kinniburgh are not members of the NHS pension scheme.

Note 7 - The JET members are on the payrolls of the Hertfordshire and West Essex CCGs as shown below:

JET Board member	Payroll
Jane Halpin	West Essex CCG
Alan Pond	E & N Hertfordshire CCG
Rachel Joyce	E & N Hertfordshire CCG
Jane Kinniburgh	West Essex CCG
Avni Shah	Herts Valleys CCG
Frances Shattock	West Essex 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 (from 1 June 2020)	140-145	0	0	0	0	140-145
Alan Pond	Chief Finance Officer (from 1 August 2020)	90-95	0	0	0	45-47.5	135-140
Rachel Joyce	Director of Clinical & Professional Services (from 1 October 2020)	70-75	0	0	0	50-52.5	120-125
Jane Kinniburgh	Director of Nursing & Quality (from 1 August 2020)	80-85	0	0	0	0	80-85

Avni Shah	Acting Director of Commissioning (to 30 November 2020)/ Director of Primary Care Transformation (from 1 December 2020)	**115-120**	**0**	**0**	**0**	**57.5-60**	**175-180**
Frances Shattock	Director of Performance & Delivery (from 1 March 2021)	**10-15**	**0**	**0**	**0**	**0-2.5**	**10-15**

FAIR PAY DISCLOSURE (AUDITED ELEMENT OF REMUNERATION REPORT)

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.

PENSIONS BENEFITS 2021/22 (SUBJECT TO AUDIT)

Table 2:Pensions Benefits (Subject to Audit)

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	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	25-30	326	17	352	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

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.

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	65-70	95-100	1068	57	1151	0
Rachel Joyce	Director of Clinical & Professional Services	2.5-5	0-2.5	50-55	110-115	1013	54	1093	0
Jane Kinniburgh	Director of Nursing & Quality	0	0	0	0	0	0	0	0
Avni Shah	Director of Primary Care Transformation	2.5-5	5-7.5	35-40	70-75	519	55	595	0
Frances Shattock	Director of Performance & Delivery	0-2.5	0	0-5	0	2	9	23	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.

HERTS VALLEYS CCG

Table 2:Pensions Benefits (Subject to Audit)

Relating to the period 1 April 2020 to 31st March 2021			Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
Name	**Title**	**Note**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£00**
Jane Halpin	Accountable Officer (from 1 June 2020) - 30.56%	1,2	0	0	0	0	0	0	0	0
David Evans	Interim Accountable Officer (to 31 May 2020)/Interim Managing Dircetor (1-30 June 2020)/ Managing Director (from 1 July 2020)	3	0-2.5	0	10-15	0	101	13	134	0
Alan Pond	Chief Finance Officer (from 1 August 2020) - 30.56%	1	0-2.5	0-2.5	10-15	15-20	195	15	217	0
Elke Taylor	Acting Chief Finance Officer (to 31 July 2020)		0-2.5	0-2.5	40-45	95-100	799	17	880	0
Diane Curbishley	Director of Nursing & Quality (to 31 July 2020)		0-2.5	0	45-50	135-140	959	29	1,011	0
Jane Kinniburgh	Director of Nursing & Quality (from 1 August 2020) - 30.56%	1,2	0	0	0	0	0	0	0	0
Rachel Joyce	Director of Clinical & Professional Services (from 1 October 2020) - 30.56%	1	0-2.5	0-2.5	5-10	15-20	135	14	155	0
Avni Shah	Acting Director of Commissioning (to 30 November 2020)/ Director of Primary Care Transformation (from 1 December 2020) - 30.56%	1	2.5-5	2.5-5	25-30	50-51	349	33	399	0
Frances Shattock	Director of Performance & Delivery (from 1 March 2021) - 30.56%	1	0-2.5	0	0-5	0	0	0	1	0
Lynn Dalton	Director of Primary Care (to 18 October 2020)	4	0-2.5	5-7.5	25-30	75-80	0	0	0	0
Dr Nicolas Small	GP Director and CCG Chair	5	0	0	0	0	0	0	0	0
Dr Trevor Fernandes	GP Director & Deputy Clinical Chair		0	0	0	0	0	0	0	0
Dr Daniel Carlton-Conway	GP Director	5	0	0	0	0	0	0	0	0
Dr Corinne Ciobanu	GP Director	5	0	0	0	0	0	0	0	0
Dr Rami Eliad	GP Director		0	0	0	0	0	0	0	0
Dr Asif Faizy	GP Director	5	0	0	0	0	0	0	0	0
Dr Catherine Page	GP Director		0	0	0	0	0	0	0	0
Dr Richard Pile	GP Director		0	0	0	0	0	0	0	0
Stuart Bloom	Lay Member	6	0	0	0	0	0	0	0	0
Alison Gardner	Lay Member	6	0	0	0	0	0	0	0	0
Paul Smith	Lay Member	6	0	0	0	0	0	0	0	0
Thelma Stober	Lay Member	6	0	0	0	0	0	0	0	0

Notes

Note 1 - Where members have been appointed to the Hertfordshire and West Essex Joint Executive Team (JET), the disclosures above only relate to the CCG's proportion of pension benefits based on 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 - CETV calculation is not applicable as the member is over the NRA in the existing scheme.

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

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 particularly 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).

calculation of the real increase in CETV. This is more likely to affect the 1995 Section and the 2008 Section. The benefits and CETV do not currently allow for a future potential adjustment for the McCloud judgement.

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	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021 (bands of	Lump sum at pension age related to accrued pension at	Cash Equivalent Transfer Value at 1 April 2020	Real increase in Cash Equivalent Transfer	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
Jane Halpin	Accountable Officer (from 1 June 2020)	0	0	0	0	0	0	0	0
Alan Pond	Chief Finance Officer (from 1 August 2020)	2.5-5	0-2.5	65-70	90-95	959	48	1068	0
Rachel Joyce	Director of Clinical & Professional Services (from 1 October 2020)	2.5-5	0-2.5	45-50	110-115	884	46	1013	0
Jane Kinniburgh	Director of Nursing & Quality (from 1 August 2020)	0	0	0	0	0	0	0	0
Avni Shah	Acting Director of Commissioning (to 30 November 2020)/ Director of Primary Care Transformation (from 1 December 2020)	2.5-5	2.5-5	30-35	65-70	453	42	519	0
Frances Shattock	Director of Performance & Delivery (from 1 March 2021)	0-2.5	0	0-5	0	0	1	2	0

Payments to past members (subject to audit)

There were no payments made in 2020-21 to any individual who had previously been a director of the CCG.

OFF-PAYROLL ENGAGEMENTS

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

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

Number of existing engagements as of 31 March 2022	**10**
Of which…	
Number that have existed for less than one year at time of reporting	2
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	1
Number that have existed for four or more years at time of reporting	7

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

Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	7
Of which…	
Number assessed as caught by IR35	7
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	1

Number of engagements re-assessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35	0

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

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

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	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	20

EXPENDITURE ON CONSULTANCY (NOT SUBJECT TO AUDIT)

The total spend on consultants in 2021/22 is shown on page 183 of the accounts.

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

There are no exit packages for 2022-21. In 2021-20, there was one exit package totalling £226,362.

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 2020/21	Number of employees who were relevant union officials during 2021/22	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, 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 2021).

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.

Throughout 2021/22, 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.

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 2021 (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%

EMPLOYEE BENEFITS (SUBJECT TO AUDIT)

Employee benefits and staff numbers (subject to audit)

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**

Employee benefits	2020-21 Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	12,874	11,174	1,700
Social security costs	1,316	1,316	0
Employer Contributions to NHS Pension scheme	1,944	1,944	0
Apprenticeship Levy	44	44	0
Termination benefits	226	226	0
Total employee benefits expenditure	**16,404**	**14,704**	**1,700**

Average number of people employed (subject to audit)

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

	2020-21 Total Number	Permanently employed Number	Other Number
Total	237.6	209.6	28.0

Exit Packages (subject to audit)

There are no exit packages for 2021-22. In 2020-21, there was one exit package totalling £226,362.

HR shared service model

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

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

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

Staff Policies

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

Whistleblowing

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

No action was considered necessary

During 2021/22, the CCG introduced Freedom to Speak Up Champions to help keep the CCG safe and supported. Including the Lay Member there are 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 31 March 2022 is 93.04%. Non-compliance is being addressed via system alerts to relevant staff and their managers, OLM workshops and regular mandatory training reporting to Directors. The OLM system is fully operational and managers can view a dashboard of their teams' compliance in real time on My ESR.

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

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

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 scheme has continued to gain momentum in 2021/22 with 11 staff now taking part in the Apprenticeship programme. The CCG will continue to encourage staff to take up further opportunities.

Health and safety

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

During 2021/2022 the CCG obtained professional health and safety guidance through Hertfordshire County Council who also delivered health and safety training for CCG managers and staff. The CCG also completed its Fire Risk Assessment in line with its Annual Plan. Staff Mental Health First Aiders were formally trained online and existing first aiders refreshed their training virtually to ensure their skills were up to date. The CCG ensured compliance with The Health and Safety (Display Screen Equipment) Regulations 1992 by issuing additional guidance to staff to reduce the risk of developing related health problems, particularly while working from home. The CCG also enabled staff to reclaim the costs of any equipment bought to enable effective working from home following a DSE assessment.

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

Employee consultation and communications

Joint Partnership Forum

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

This year the forum has worked to address key issues that were raised in previous years' national staff surveys, which included opportunities for flexible working patterns and improving wellbeing. Other actions taken 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 which aims to empower staff from Black, Asian or minority ethnic backgrounds to engage with the organisation in a meaningful way and to discuss ways in which the experience and opportunities within the CCG can be improved and co-produce our Race equality action plan. Our organisation promotes diversity and inclusion training and has held a number of popular lunch and learn bitesize workshops which 146 staff across Herts and West Essex CCGs have attended

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

PART THREE: PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

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 2021/22.

EXTERNAL AUDIT OPINION

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS HERTS VALLEYS CLINICAL COMMISSIONING GROUP

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY 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 year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Changes in Taxpayers' Equity, the Statement of Financial Position, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as interpreted and adapted by the 2021-22 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2021-22.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Herts Valleys Clinical Commissioning Group as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2021-22; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for opinion on financial statements

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

Conclusions relating to going concern

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

Emphasis of matter - basis of preparation of financial statements

As explained in Note 1.1 to the financial statements The Health and Social Care Act 2022 will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to Hertfordshire and West Essex ICB.

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

Other information

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

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

We have nothing to report in this regard.

Opinion on regularity

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

Basis for opinion on regularity

We carried out our work on regularity in accordance with Practice Note 10 (Revised 2020) issued by the Public Audit Forum. Our responsibilities in this respect are further described in the Auditor's other responsibilities section of our report. We believe the evidence obtained from this work, in conjunction with the evidence we have obtained in our audit of the financial statements, is sufficient and appropriate to provide a basis for our opinion on regularity.

Opinion on information in the Remuneration and Staff Report

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

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

Matter on which we are required to report by exception

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

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

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

Responsibilities of the Accountable Officer

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

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

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

We have undertaken our work in accordance with the Code of Audit Practice issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Other matters on which we are required to report by exception

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

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

Responsibilities of the Accountable Officer

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

Auditor's other responsibilities

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

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

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

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

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

Our procedures included the following:

- inquiring of management, the CCG's head of internal audit, the CCG's local counter fraud specialist and those charged with governance, including obtaining and reviewing supporting documentation in respect of the CCG's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the CCG's controls relating to Managing Public Money requirements;
- discussing among the engagement team and involving relevant internal and or external specialists, including specialist expertise to support our testing of IT General Controls regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: expenditure recognition, posting of unusual journals and use of management estimates and judgements;
- obtaining an understanding of the CCG's framework of authority as well as other legal and regulatory frameworks that the CCG operates within, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the CCG. The key laws and regulations we considered in this context included the National Health Service Act 2006, as amended by Section 27 of the Health and Social Care Act 2012, whereby the CCG must ensure that its revenue resource allocation in any financial year does not exceed the amount specified by NHS England; and
- performing procedures designed to gain assurance over the accuracy and completeness of exit packages and whether any such severance arrangements that included characteristics that could be defined as special severance payments, if identified, received the required HM Treasury approval.

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

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

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

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

Certificate

We certify that we have completed the audit of NHS Herts Valleys Clinical Commissioning Group for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Members of the Governing Body of NHS Herts Valleys Clinical Commissioning Group, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015.

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

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

25 June 2022

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

ACCOUNTS 2021/22

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

	Note	2021-22 £'000	2020-21 £'000
Revenue from contracts with customers		(617)	(616)
Other operating income		(41)	(44)
Total operating income		**(658)**	**(660)**
Staff costs	2	16,211	16,404
Purchase of goods and services	3	1,003,381	973,841
Provision expense	3	1,159	1,540
Other operating expenditure	3	595	412
Total operating expenditure		**1,021,346**	**992,197**
Net operating expenditure		**1,020,688**	**991,537**
Total Comprehensive Expenditure for the year ended 31 March 2022		**1,020,688**	**991,537**

The notes on pages 180 to183 form part of this statement.

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

	General fund £'000
Changes in taxpayers' equity for 2021-22	
Balance at 1 April 2021	**(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)**

	General fund £'000
Changes in taxpayers' equity for 2020-21	
Balance at 1 April 2020	**(81,293)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21	
Net operating expenditure for the financial year	(991,537)
Net Recognised NHS Clinical Commissioning Group Expenditure for the financial year including balance brought forward from previous year	**(1,072,830)**
Net funding	1,008,600
Balance at 31 March 2021	**(64,230)**

The notes on pages 180 to 183 form part of this statement.

Statement of Financial Position as at 31 March 2022

	Note	31 March 2022 £'000	31 March 2021 £'000
Current assets:			
Trade and other receivables		3,700	5,820
Cash		581	179
Total current assets		**4,281**	5,999
Current liabilities			
Trade and other payables	6	(71,669)	(65,915)
Provisions		(4,173)	(4,314)
Total current liabilities		**(75,842)**	(70,229)
Net Current Liabilities		**(71,561)**	(64,230)
Non-current Liabilities			
Provisions		(67)	0
Total non-current liabilities		**(67)**	0
Assets less Liabilities		**(71,628)**	(64,230)
Financed by Taxpayers' Equity			
General fund		(71,628)	(64,230)
Total Taxpayers' Equity		**(71,628)**	(64,230)

The notes on pages 180 to 183 form part of this statement.

The financial statements on pages to were approved by the Audit Committee (on behalf of the Board) on 22nd June 2022 and signed on its behalf by:

Accountable Officer
Jane Halpin

Statement of Cash Flows for the year ended 31 March 2022

	Note	**2021-22 £'000**	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,020,688)	(991,537)
Decrease in trade and other receivables		2,120	335
Increase / (Decrease) in trade and other payables	6	5,754	(18,398)
Provisions utilised		(1,234)	(431)
Increase in provisions		1,160	1,540
Net Cash Outflow from Operating Activities		**(1,012,888)**	(1,008,491)
Net Cash Outflow before Financing		**(1,012,888)**	**(1,008,491)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,013,290	1,008,600
Net Cash Inflow from Financing Activities		**1,013,290**	1,008,600
Net Increase in Cash	5	**402**	**109**
Cash at the beginning of the financial year		**179**	70
Cash at the end of the financial year		**581**	179

The notes on pages 180 to 183 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups (CCGs) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the GAM 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

The Health and Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to Hertfordshire and West Essex ICB.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022, on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

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

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

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

1.4 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.

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

1.4.2 Retirement Benefit Costs

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

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

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 **Revenue**

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

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

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

The Department of Health and Social Care GAM does not require the following IFRS Standard and Interpretation to be applied in 2020-21:

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

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

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

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

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

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

2. Employee benefits

2.1 Employee benefits

	2021-22 Total £'000	2020-21 Total £'000
Salaries and wages	13,066	12,874
Social security costs	1,184	1,316
Employer contributions to NHS Pension scheme	1,915	1,944
Apprenticeship Levy	46	44
Termination benefits	0	226
Gross employee benefits expenditure	**16,211**	**16,404**

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

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

b) Full actuarial (funding) valuation

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

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

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

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

3. Operating expenses

	2021-22 Total £'000	Restated (Notes 1,2 and 3) 2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	17	18
Services from foundation trusts	208,971	204,155
Services from other NHS trusts	428,246	425,073
Purchase of healthcare from non-NHS bodies	157,066	144,660
Purchase of social care	14,809	14,017
Prescribing costs	78,879	78,001
GPMS/APMS and PCTMS	108,104	98,604
Supplies and services – clinical	26	17
Supplies and services – general	2,497	3,259
Consultancy services	30	113
Establishment	3,080	4,244
Premises	807	1,225
Audit fees (Note 1)	71	64
Other non statutory audit expenditure		
• Other services (Note 2)	13	12
Other professional fees (Note 3)	449	197
Legal Fees	80	32
Education and training	196	106
Non cash apprenticeship training grants	41	44
Total purchase of goods and services	**1,003,381**	**973,841**
Provision expense		
Provisions	1,159	1,540
Total provision expense	**1,159**	**1,540**
Other operating expenditure		
Chair and Non Executive Members	216	212
Expected credit loss on receivables	0	(2)
Other expenditure	379	202
Total other operating Expenditure	**595**	**412**
Total operating expenses	**1,005,135**	**975,793**

Note 1

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

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

£1million. Note 2

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

Note 3

Other professional fees includes the sum of £44k for Internal Audit Fees (2020-21 £44k). Internal Audit fees is shown net of VAT

 4. Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	23,148	279,629	23,303	285,660
Total Non-NHS Trade Invoices paid within target	22,646	276,369	23,010	276,394
Percentage of Non-NHS Trade invoices paid within target	**97.83%**	**98.83%**	98.74%	96.76%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	724	656,337	1,897	676,736
Total NHS Trade Invoices Paid within target	680	655,011	1,858	674,120
Percentage of NHS Trade Invoices paid within target	**93.92%**	**99.80%**	97.94%	99.61%

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

	2021-22 £'000	2020-21 £'000
Balance at 1 April	179	70
Net change in year	402	109
Balance at 31 March	581	179
Made up of:		
Cash with the Government Banking Service	580	178
Cash in hand	1	1
Balance at 31 March	**581**	**179**

6. Trade and other payables	**Current 31 March 2022 £'000**	Current 31 March 2021 £'000
NHS payables: revenue	1,776	9,868
NHS accruals	965	1,063
Non-NHS and Other WGA payables: Revenue	11,087	3,833
Non-NHS and Other WGA accruals	50,312	48,212
Non-NHS and Other WGA deferred income	938	556
Social security costs	195	184
Tax	262	213
Other payables and accruals	6,134	1,986
Total Trade and Other Payables	**71,669**	**65,915**

Other payables include £927k (£187k employees and £740k GP Practices) outstanding pension contributions at 31 March 2022 (£785k: £195k employees and £590k GP Practices - 31 March 2021).

7. Financial instruments

7.1 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.

7.1.1 Credit risk

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

7.1.2 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.

7.2 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2022 £'000	Financial Liabilities measured at amortised cost 31 March 2021 £'000
Trade and other payables with NHSE bodies	320	566
Trade and other payables with other DHSC group bodies	2,495	24,547
Trade and other payables with external bodies	67,460	39,849
Total at 31 March	**70,275**	**64,962**

8. Operating segments

The CCG consider they have only one segment in 2021-22 and 2020-21: Commissioning of healthcare services.

9. 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
- additional out of hospital capacity under the Hospital Discharge Programme for 2021-22. This is shown as Covid 19 spend.

The CCG's share of the income and expenditure handled by the pooled budget for 2021-22 and 2020-21 were:

Equipment Service 2021-22			**Mental Health and Learning Disabilities** (Note 1)		**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

Note 1

The contribution of the CCG also included £89,074k (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

This included £7,106k (2020-21 £23,273k) 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. This CCG's allocation was increased by NHS England to cover all these costs, again in compliance with the revised financial regime.

Equipment Service 2020-21			**Mental Health and Learning Disabilities**		**Better Care Fund**		**Hospital Discharge Programme Covid-19**		**All Pooled Funds**
	Total Pooled-Budget 2020-21 £000	Herts Valleys CCG Contribution 2020-21 £000	Total Pooled-Budget 2020-21 £000	Herts Valleys CCG Contribution 2020-21 £000	Total Pooled-Budget 2020-21 £000	Herts Valleys CCG Contribution 2020-21 £000	Total Pooled-Budget 2020-21 £000	Herts Valleys CCG Contribution 2020-21 £000	Total Herts Valleys CCG Contribution 2020-21 £000
Contribution	5,956	1,449	373,552	91,375	24,502	12,908	41,453	41,453	147,185
Expenditure	6,079	1,479	373,727	91,470	24,117	12,528	41,453	41,453	146,930
Total Variance:	(123)	(30)	(175)	(95)	385	380	0	0	255

10. Related party transactions

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

The CCG received no revenue or capital payments from any charitable funds.

2020-21 comparators are shown on the following page.

10a. Related Party Transactions 2020-21

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.

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:

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

	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	2,057	0	46	0
Direct Local Health Ltd - (GP Federation) Dr R Eliad & Dr A Faizy	1,952	0	0	0
Fairbrook Medical Centre - Dr C Page	1,788	0	0	0
Garston Medical Centre - Dr R Eliad	1,367	0	0	0
Haverfield Surgery - Dr C Ciobanu	439	0	0	0
Herts Health Ltd - (GP Federation) - Dr N Small	1,028	0	32	0
Maltings Surgery - Dr D Carlton-Conway	2,163	0	0	0
Parkbury House Surgery - Dr R Pile	2,487	0	0	0
Schopwick Surgery - Dr N Small	1,759	0	0	0
Stahfed - (GP Federation) Dr D Carlton-Conway and Dr R Pile	1,343	0	73	0
Vine House Health Centre - Dr A Faizy	1,243	0	0	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.

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
Bedfordshire Hospitals 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

The CCG received no revenue or capital payments from any charitable funds.

11. Events after the end of the reporting period

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

12. 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:

	2021-22 Target £000	**2021-22 Performance £000**	2020-21 Target £000	2020-21 Performance £000
Expenditure not to exceed income	1,021,846	1,021,346	992,276	992,197
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	1,021,188	1,020,688	991,616	991,537
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	12,349	11,111	12,608	12,310

Accessibility Report

Filename: 06N_HVCCG_ANNUAL_REPORT_AND_ACCOUNTS____for_website___signatures_removed.pdf

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

Summary

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

- Needs manual check: 1
- Passed manually: 1
- Failed manually: 0
- Skipped: 1
- Passed: 13
- Failed: 16

Detailed Report

Document

Rule Name	Status	Description
Accessibility permission flag	Passed	Accessibility permission flag must be set
Image-only PDF	Passed	Document is not image-only PDF
Tagged PDF	Failed	Document is tagged PDF
Logical Reading Order	Needs manual check	Document structure provides a logical reading order
Primary language	Passed	Text language is specified
Title	Passed	Document title is showing in title bar
Bookmarks	Passed	Bookmarks are present in large documents
Color contrast	Passed manually	Document has appropriate color contrast

Page Content

Rule Name	Status	Description
Tagged content	Failed	All page content is tagged
Tagged annotations	Failed	All annotations are tagged
Tab order	Failed	Tab order is consistent with structure order
Character encoding	Passed	Reliable character encoding is provided
Tagged multimedia	Passed	All multimedia objects are tagged
Screen flicker	Passed	Page will not cause screen flicker
Scripts	Passed	No inaccessible scripts
Timed responses	Passed	Page does not require timed responses
Navigation links	Passed	Navigation links are not repetitive

Forms

Rule Name	Status	Description
Tagged form fields	Passed	All form fields are tagged
Field descriptions	Passed	All form fields have description

Alternate Text

Rule Name	Status	Description
Figures alternate text	Failed	Figures require alternate text
Nested alternate text	Failed	Alternate text that will never be read
Associated with content	Failed	Alternate text must be associated with some content
Hides annotation	Failed	Alternate text should not hide annotation
Other elements alternate text	Failed	Other elements that require alternate text

Tables

Rule Name	Status	Description
Rows	Failed	TR must be a child of Table, THead, TBody, or TFoot
TH and TD	Failed	TH and TD must be children of TR
Headers	Failed	Tables should have headers
Regularity	Failed	Tables must contain the same number of columns in each row and rows in each column

Summary	Skipped	Tables must have a summary

Lists

Rule Name	Status	Description
List items	Failed	LI must be a child of L
Lbl and LBody	Failed	Lbl and LBody must be children of LI

Headings

Rule Name	Status	Description
Appropriate nesting	Failed	Appropriate nesting

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