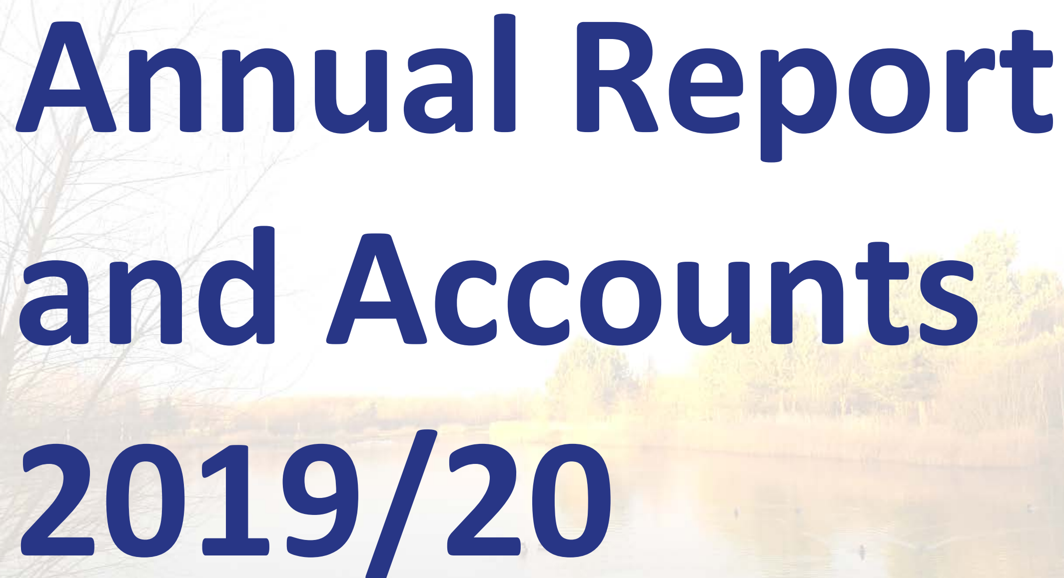
Rushcliffe
Clinical Commissioning Group



Annual Report and Accounts 2019/20

About this report

This annual report and accounts for the year ending 31 March 2020 has been prepared, as directed by NHS England, in accordance with the Health and Social Care Act 2012 c. 7 Schedule 2 s.17 CCG Annual Report Directions (Chapter A1 of Part 2 of the National Health Service Act 2006 as amended by 14Z15 of the Health and Social Care Act 2012 Reports by clinical commissioning groups). Clinical commissioning groups (CCGs) are statutorily required to produce an annual report and accounts and to comply with the requirements as laid out in the Department of Health and Social Care (DHSC) Group Accounting Manual. The structure of this report therefore follows that outlined in the guidance and includes:

- **A Performance Report** – this section of the report includes an overview of our organisation, its purpose, a summary of how we have performed over the last year and the key risks and issues we have faced. This section also includes a more detailed ***Performance analysis,*** which provides a further detailed analysis as to how we have performed this year and provides information as to how the CCG has met its statutory duties across a number of key areas.
- **An Accountability Report** – the purpose of this section is to meet key accountability requirements to Parliament. The accountability report includes a ***corporate governance report***, which includes details of our governing body and member GP practices, the statement of Accountable Officer's responsibilities and our governance statement, which describes how our governance and decision-making arrangements have operated over the past year. This section also includes a ***remuneration and staff report***, which describes our remuneration policy for senior managers and also provides further information on the CCG's workforce.
- **Annual Accounts 2019/20** – Appendix A provides the CCG's financial statements for the year 2019/20.

Key Organisational Changes

On 1 April 2020, NHS Rushcliffe CCG merged with the other CCGs in Nottingham and Nottinghamshire (NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Nottingham City CCG) to become the Nottingham and Nottinghamshire CCG. Key information related to these CCGs is still accessible via the new CCG's website at https://nottsccg.nhs.uk/ and this address is therefore provided, where necessary, throughout this report.

Whilst this report is predominantly focussed on how the CCG has performed as a single entity during 2019/20, where appropriate and considered more informative to the reader, reference is made to the joint working arrangements in place across the Nottingham and Nottinghamshire CCGs in preparation for the merger.

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Performance Report

Performance Overview

Welcome and introduction from the Accountable Officer

Welcome to the 2019/20 Annual Report and Accounts for NHS Rushcliffe Clinical Commissioning Group ("**the CCG**"). Our annual report aims to be a clear and informative document; outlining the performance of the CCG throughout the year. The report describes how we have continued to work closely with our health and social care partners to ensure continuous improvements in the quality of services provided for our patients and citizens. It also explains some of the challenges we have faced over the year and how we have worked to overcome them.

Dr Amanda Sullivan
Accountable Officer

As you'll read more about further on in the report, this will be the CCG's last annual report, as on 1 April 2020 the six CCGs in Nottingham and Nottinghamshire (NHS Rushcliffe CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG, NHS Nottingham City CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG) merged to create a single organisation - NHS Nottingham and Nottinghamshire CCG. As such, we have spent a great deal of 2019/20 preparing for this move; both in terms of fully integrating the individual organisations and in undertaking a robust application process with NHS England to show our suitability as a single CCG. In particular, this process involved demonstrating the backing from our member GP practices for the move, which I'm pleased to say, was strongly supported as a logical next step in being able to drive forward the changes needed within the local health and care system. Indeed, one of the key drivers to the creation of the new CCG was to create a powerful clinical voice that can advise on and lead improvements in the services available to local patients and service users.

Whilst this has been, and continues to be, an exciting time for our organisation; it has also been a significant period of change for our staff. The merger has required a significant staffing re-structure and necessitated changes to usual working practices in order to fully align our commissioning and other business activities and I would like to acknowledge the hard work and dedication of staff during this transition.

I would also like to highlight that the CCG's Clinical Chair, Dr Stephen Shortt, will continue to clinically lead the new organisation, alongside Dr James Hopkinson, who is a colleague with whom we have already worked closely with over the years as James was previously the Clinical Chair of NHS Nottingham North and East CCG. We very much look forward to continuing our journey as a new CCG under their joint clinical leadership.

In addition to the merger, this year has seen other progress towards some of the expectations set out in the NHS Long Term Plan (published in 2019). Notably, we have supported the establishment of the Rushcliffe Primary Care Network (PCN), three groups of neighbouring GP practices working closely together with community, mental health, social care, pharmacy, hospital and voluntary services to build

on the core of current primary care services and enable greater provision of proactive, personalised, co-ordinated and more integrated health and social care. We have also supported the development of the South Nottinghamshire Integrated Care Partnership (ICP), which brings together local commissioners and health and care providers to improve local services for the people of Nottingham and make sure they are sustainable. Our Nottingham and Nottinghamshire Commissioning Strategy 2020-22 (detailed further later on in this report) recognises the important role these groups play in supporting a shift towards health and care that is increasingly preventative and delivered at a neighbourhood level.

At the time of finalising this report, the NHS continues to face unprecedented challenges in dealing with the COVID-19 pandemic and there remains considerable pressure on frontline NHS staff. We, like all other organisations in the health and care sector, have had to act quickly; reconfiguring our systems and processes in order to respond quickly, whilst simultaneously adapting to the new ways of working instigated by the social distancing measures put in place by the government.

CCGs have had a critical role in coordinating and enabling a system response to the pandemic; ensuring that support and guidance is provided to our member GP practices and that required service changes can be quickly enacted. The healthcare system in Nottinghamshire has come together to pool resources and work together where able to effectively do so, such as implementing local COVID-19 testing. Other ways in which we have collaborated closely with partners includes working with the local authorities in Nottingham and Nottinghamshire to introduce a comprehensive package of support for care homes and in providing training and support to their staff; particularly in the area of infection, prevention and control. Going forwards, we will also have a role in supporting our local Public Health colleagues to successfully implement the national Test and Trace Programme.

At this time, the CCG is starting to refocus its COVID-19 incident management systems and activities towards the restoration of local services. This will include the services needed to respond to the long term impact on physical and mental health caused not only by the virus itself, but by the other factors we know have impacted on everyone’s daily lives. We continue to work with partners as a healthcare system to bring local services back on line, whilst also ensuring that patients are provided with the high quality service they should expect.

About us

Clinical commissioning groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced primary care trusts on 1 April 2013. Reporting to NHS England, we are a membership organisation, comprised of local GP practices, and accountable to local people. We maintain our authorisation by demonstrating to NHS England how we are meeting our responsibilities through a detailed assurance process.

We work from Easthorpe House in Ruddington. However, the provider organisations delivering the services we commission operate from numerous locations in the area, including GP practices, health centres, community venues, hospitals and in people’s own homes.

We commission (plan and buy) healthcare services that meet the needs of local people. The services CCGs are responsible for commissioning include:

- Most planned hospital care.
- Rehabilitative care.
- Urgent and emergency care (including out of hours).
- Most community health services.

- Mental health services (including psychological therapies).
- Services for people with learning disabilities.
- Maternity and newborn services.
- Children's healthcare services (mental and physical health).
- NHS continuing healthcare.
- Infertility services.

We commission healthcare from a number of providers. Our main acute (secondary care) provider is Nottingham University Hospitals NHS Trust and for mental health, learning disabilities and community services, our key provider is Nottinghamshire Healthcare NHS Foundation Trust. We also commission services from NHS organisations outside of our area and from independent and voluntary organisations. Since 1 April 2015, we have also taken on full delegated responsibility for commissioning primary medical services for our local population.

In order to make the best decisions for our population, we have to understand the health problems affecting people living locally, and commission services that will deliver the most benefit to these people. We are also responsible for making certain that the healthcare provided is of a high standard, delivers quality improvements and offers value for money, and that systems are in place to make sure people are looked after in the best way possible.

The level of funding we receive from NHS England is set by the Government through a comprehensive spending review process. This takes into account all the funding available for allocation across the public sector. A formula is then applied to adjust funding accordingly with the demographics and health needs of the local population.

Our member GP practices

As at 31 March 2020, NHS Rushcliffe CCG has 12 member GP practices. A list of the GP member practices is provided within the *Members Report* section of this annual report.

Our Governing Body

Our Accountable Officer is Dr Amanda Sullivan, who has a joint appointment as Accountable Officer for the six Nottingham and Nottinghamshire CCGs, and as explained in the introduction of this report, up until 31 March 2020 our Clinical Chair was Dr Stephen Shortt.

The Governing Body membership also includes the Chief Finance Officer, Chief Nurse and Chief Commissioning Officer, an independent secondary care doctor and independent lay members. A full Governing Body membership list and information on any registered interests are provided in the *Members Report* section of this report.

Our structure

We are a dynamic, clinically-led membership organisation with a proven governance structure to ensure the effective delivery of our strategic objectives. We have a well-established history of commissioning health services in collaboration with our neighbouring CCGs and during the last year, we have fully aligned our governance and staffing arrangements with the other Nottingham and Nottinghamshire CCGs; creating a joint Executive Management Team and operating a framework that enabled each organisation to maintain its individual statutory and accountability requirements whilst facilitating joint

working in order to help address local health needs and align our commissioning activities across the whole of Nottingham and Nottinghamshire.

The aim of this approach was to establish a single strategic commissioning organisation and consequently, there has been a significant focus throughout 2019/20 to apply and prepare for merger from 1 April 2020. From which time, NHS Rushcliffe CCG will be formally disestablished.

At the end of 2019/20, the CCG directly employed 100 staff although collectively, the Nottingham and Nottinghamshire CCGs have a combined staffing structure of 448. The structure is divided into a number of directorates that have responsibilities in the areas of: commissioning and contracting, finance, quality and governance. Clinical expertise to commissioning activities is provided from GP Advisors, appointed from the Nottingham and Nottinghamshire CCGs' member GP practices.

Together, the Nottingham and Nottinghamshire CCGs are of sufficient scale to employ most key functions in-house. However, a contractual arrangement is in place with Arden and Greater East Midlands Commissioning Support Unit to provide a number of specialist services, including recruitment services, technical procurement services and contract management support. The CCG commissions IT provision and technical support through the Nottinghamshire Health Informatics Service, hosted by Sherwood Forest Hospitals NHS Foundation Trust.

Our partners

We know that making a difference to the health and wellbeing of local people cannot be done in isolation, and we recognise that working with other organisations can bring opportunities to do things better, on a larger scale, and more efficiently. We are proud to be part of the Nottingham and Nottinghamshire Integrated Care System (ICS), which brings together all of the health and care organisations in Nottingham and Nottinghamshire with the purpose of taking collective responsibility for managing resources, delivering NHS standards and improving the health of our local population. Working together in this way means we can provide better and more joined-up care for patients, ensuring that investment is made in what we know works best in our communities, such as focussing on preventing illnesses, reducing health inequalities and providing more services closer to people's homes. More information on the ICS can be found at https://healthandcarenotts.co.uk.

In addition, we continue to build on our well-established networks and relationships with partners, in particular Nottinghamshire County Council (including public health and social care) and we are active members of the Nottinghamshire County Health and Wellbeing Board, which is statutorily responsible for producing a Joint Strategic Needs Assessment (JSNA) and for developing a Joint Health and Wellbeing Strategy based on the evidence this provides. You can read more about this work in the *Performance Analysis* section of this report.

Our local population

We serve the 128,524 people who are registered with our member GP practices. There is a lower proportion of young adults (ages 20 to 40) in the population compared to England; the proportion aged 50 and older is higher than England.

The Rushcliffe CCG area covers some of the least deprived populations in Nottinghamshire. This is reflected in the health outcomes for the population, which are almost all similar to or significantly better than England. Life expectancy and mortality rates for cancers, circulatory disease and respiratory disease are all better than or close to the England rate.

Our strategic objectives

During the year, the Nottingham and Nottinghamshire CCGs have worked together to develop a commissioning strategy for 2020-22; encompassing our now achieved key objective of establishing our new organisation by 1 April 2020 and ensuring the alignment of our commissioning journey to national and local plans, including the NHS Long Term Plan, the Nottingham and Nottinghamshire Health and Wellbeing Strategies and the priorities defined by the Nottingham and Nottinghamshire ICS:

- Better outcomes.
- Better experience for our staff and citizens.
- Better use of resources.

We recognise that commissioning needs to evolve; ensuring robust and strategic commissioning at a system level, with better coordinated and integrated delivery at a local level and a focus on services being personalised. A key focus of our strategy is therefore on supporting the required shift towards health and care that is increasingly preventative and delivered within communities, rather than in an acute setting.

Our strategic objectives encapsulate our intention and aspirations for local healthcare and provide the basis for prioritisation and decision-making. They have enabled the development of actionable work programmes that will help us to commission high quality, patient centred services and improve health outcomes for the Nottingham and Nottinghamshire populations. The CCGs' Commissioning Strategy 2020-22 can be found on our website at https://nottsccg.nhs.uk/.

Our Performance Summary

Through the mechanisms detailed in the *Performance Analysis* section of this report, we have maintained a robust and consistent focus on our performance during the year. We have continued to achieve many national performance targets, including all mental health standards. However, 2019/20 has been a challenging year for us in terms of delivering against national urgent and emergency care targets. We are working closely with partners across the health and social care community to improve performance in these areas through implementation of robust recovery plans. Improving performance against these standards will continue to be a focus for the coming year.

Performance against some of the core NHS access standards, particularly those relating to planned care, has been impacted by the required national response to the COVID-19 pandemic.

The CCG has a responsibility to manage our finances carefully to make sure we are able to deliver our everyday commitments, as well as to invest in securing the delivery of continuous improvements in the quality of services provided for our patients and citizens. Many factors can influence how much we have to spend, for example, the national economy, a major incident, unexpected increased demand for local health services, or projects taking longer than planned. It is therefore important that we have contingency plans in place to ensure that we can flex our finances accordingly.

The CCG achieved all of its statutory financial duties for the 2019/20 year and you can read more about these and other key statutory duties in the *Performance Analysis* section of this report. For full details of our accounts please see the *Annual Accounts* section of this report.

Our Principal Risks

We have a clear and integrated approach to risk management, combined with defined ownership of risk at all levels within the organisation. Identifying and assessing risks at both strategic and organisational levels is a well-embedded process within the CCG.

Our Risk Management Policy clearly sets out how the organisation will identify, manage and monitor its strategic and organisational risks in a consistent, systematic and co-ordinated manner. Organisational risks arising from our day-to-day activities are monitored through the Corporate Risk Register and strategic risks are monitored through our Governing Body Assurance Framework.

The main risks identified by the CCG and monitored through the Corporate Risk Register during 2019/20 related to the potential for non-delivery of our financial plan, the possible workforce impacts of the significant organisational change due to the alignment of the six Nottingham and Nottinghamshire CCGs, the sustainability of some GP practices due to primary care workforce issues and the potential for poor patient experience at some of our main providers. At the time of finalising this report, we have also identified a number of organisational risks that have arisen in response to the COVID-19 pandemic.

For more information on how we manage risk within the CCG, see the *Governance Statement* contained within this report.

Performance Analysis

Introduction

This section of the report describes our performance measures in more detail and shows the extent to which we have monitored and delivered against these in 2019/20.

Monitoring Performance

We are required to report on some key national health targets and performance standards, many of which are drawn from the NHS Constitution, or are derived from national priorities. We also monitor ourselves against local targets that we have established to improve the quality of services and health outcomes for our population. These are delivered through the service contracts we hold with local health organisations providing NHS services. We meet regularly with our providers to review the achievement of national and jointly agreed local measures to help ensure services perform well and meet the health needs of our patients and citizens.

Responsibility for performance management ultimately sits with the Governing Body; however, this duty has been delegated to our Quality, Safeguarding and Performance Committee to ensure consistent scrutiny and any issues are escalated to the Governing Body as necessary. Particular areas of focus for underperformance include reviewing the underlying causal factors and remedial actions in place, the potential impact of underperformance on the quality of services and the CCG's approach to support the delivery of recovery plans (eg. the use of contractual levers). The Integrated Performance Reports to our Governing Body set out the CCG's performance against all required standards and are available on our website at https://nottsccg.nhs.uk/. These governance arrangements are underpinned by the CCG's Performance Management Framework, which recognises that securing high quality services for patients requires the robust assessment of key performance and outcome indicators.

NHS England has a statutory duty to conduct performance assessments of CCGs to assess their capability, ensure that they are complying with statutory responsibilities and are also performing in a way that is delivering improvements to patients. Previously, this duty has been enacted through the CCG Improvement and Assessment Framework; however, this was replaced in 2019 by the NHS Oversight Framework for 2019/20, an aligned approach developed by NHS England and NHS Improvement to support system working. This new approach will place a greater emphasis on system performance across integrated care systems and in ensuring consistent expectations of their constituent organisations.

Urgent and Emergency Care

Based on historical performance, the most challenging performance targets for the CCG are the NHS Constitution targets for urgent and emergency care. The vast majority of residents use the Accident and Emergency Department at Nottingham University Hospitals NHS Trust (NUH) when they need to access urgent and emergency care. However, some of these services are also delivered at the Urgent Care Centre in the City. The national standard requires that 95% of attending patients have a maximum 4-hour wait in the Accident and Emergency Department from arrival to admission, transfer or discharge.

Since August 2016, an Accident and Emergency Local Delivery Board has been in place with responsibility for oversight of the urgent and emergency care pathway, with a clear aim of improving performance against the national Accident and Emergency waiting time standard. The Board has been

established in line with national guidance and its membership includes senior leaders from across the health and social care community. The Board is chaired by NUH's Chief Executive.

During 2019/20, NUH has been trialling nationally proposed changes to the access standards for emergency and urgent care. The proposed new standards have been developed following a review by the NHS National Medical Director of the core set of NHS access standards, in the context of the model of service described in the NHS Long Term Plan. Results from the trial will contribute to the national review. Further information can be found on NHS England's website at https://www.england.nhs.uk/clinically-led-review-nhs-access-standards/.

East Midlands Ambulance Services NHS Trust (EMAS) provides all ambulance services within Nottingham and Nottinghamshire. In 2017, changes were made to the way in which ambulance services report data and these changes were introduced to focus on making sure the best, high quality, most appropriate response is provided for each patient first time. Call handlers are now given more time to assess 999 calls that are not immediately life-threatening, which enables them to identify patients' needs better and send the most appropriate response. Category 1 calls are those for people with life-threatening illnesses or injuries; category 2 relates to emergency calls; category 3 relates to urgent calls; and category 4 relates to less urgent calls.

Below is a table summarising the CCG's annual performance in these areas for 2019/20. Where relevant, recovery action plans are in place, which are being continually reviewed and updated to improve performance.

More detail in terms of our approach to improve performance can be found in the *Governance Statement* contained within this report.

NHS Constitution Standard	Target	2019/20	Commentary
A&E waiting time			
Percentage of patients who spent four hours or less in A&E	**>95%**	**72.01%**	*This has remained a significant area of focus during 2019/20. Performance against this standard has been consistently below target throughout the year.* *The figure reported is annualised for 2019/20 and reflects the performance against this standard at CCG level.*
Ambulance clinical quality			
Category 1 Average Response Time	**<00:07:00**	**00:09:33**	*Performance at a Trust level against the majority of these standards has been below target throughout the year.* *The figures reported are for the end of period at March 2020.*
Category 1 90th Centile Response Time	**<00:15:00**	**00:15:00**	
Category 2 Average Response Time	**<00:18:00**	**00:28:19**	
Category 2 90th Centile Response Time	**<00:40:00**	**00:51:53**	
Category 3 90th Centile Response Time	**<02:00:00**	**05:19:09**	
Category 4 90th Centile Response Time	**<03:00:00**	**02:32:20**	

Planned Care – Access to Treatment

In England, patients have the right to start consultant-led treatment for non-urgent conditions within a maximum of 18 weeks from referral by their GP. In addition, patients waiting for diagnostic tests should wait fewer than six weeks from referral and all patients who have their operations cancelled (on or after the day of admission) should be offered another date within 28 days.

Nottingham University Hospitals NHS Trust (NUH) is our main provider of acute services, although many residents in Nottingham and Nottinghamshire also access these services at the Nottingham NHS

Treatment Centre. For certain referrals, patients can also choose to be treated locally by independent providers such as The Park BMI and Ramsey Woodthorpe.

Below is a table summarising the CCG's annual performance in 2019/20 for key NHS Constitution Standards relating to waiting times for diagnostic tests and planned treatment. Performance against the referral to treatment and diagnostic test waiting times are measured at CCG level, whereas performance against the cancelled operations standard is measured at provider level.

NHS Constitution Standard	Target	2019/20	Commentary
Referral to treatment pathways			
Percentage incomplete patients <18 weeks	**>92%**	**88.08%**	*The figure reported is the end of period position as at March 2020. Performance against this standard has been impacted by the national response to the COVID-19 pandemic, which has required a period of suspension of most elective services in order to release capacity to respond.*
Diagnostic test waiting times			
Percentage of patients waiting six weeks or more for a diagnostic test	**<1%**	**11.46%**	*The figure reported is the end of period position as at March 2020. This is a significant variation to the performance reported in February 2020, which was 0.5%. Performance against this standard has been impacted by the national response to the COVID-19 pandemic, which has required a period of suspension of all non-urgent diagnostics tests in order to release capacity to respond.*
Cancelled operations			
Number of cancelled operations rebooked beyond 28 days	**0**	**51**	*The figure reported is the cumulative performance for the first three quarters of 2019/20. Reporting against this indicator has been suspended nationally in response to the COVID-19 pandemic.*

Cancer Care – Access to Treatment

There are a range of waiting time indicators for access to cancer treatment, depending on the access route, stage of illness and the treatment needed.

Cancer diagnostics and treatment is primarily provided by Nottingham University Hospitals NHS Trust (NUH). NUH is a regional cancer centre offering specialist cancer diagnostic and treatment services, and as such, it receives a relatively high number of tertiary referrals from surrounding areas, which can in some instances impact on the Trust's performance. Some diagnostic and treatment services are also provided by the Nottingham NHS Treatment Centre. Sometimes very small numbers of patients go through these pathways and not every target will be met every month.

Below is a table summarising the CCG's annual performance against the key indicators for 2019/20. Performance against all of these indicators is measured at CCG level. Where relevant, recovery action plans are in place, which are being continually reviewed and updated to improve performance.

NHS Constitution Standard	Target	2019/20	Commentary
Cancer two week waits			
All cancer two week wait	**>93%**	**94.33%**	*Figures reported are for Q4 2019/20.*
Two week wait for breast symptoms (where cancer was not initially suspected)	**>93%**	**89.29%**	*Performance against the two week wait standard for breast symptoms has been at target throughout the year, with a slight dip in performance at year due to small numbers of patients.*
Cancer 31 and 62 day waits			
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	**>96%**	**91.75%**	*The figures reported are for Q4 2019/20.Performance against these standards has been variable during the year and has been impacted at the end of the year as a result of patients choosing not to attend appointments due to concerns relating to COVID-19.*
62-day wait for first treatment following an urgent GP referral	**>85%**	**80.20%**	

Other National Priorities

Additional targets have been set nationally, including targets to improve mental health services, services for children and young people and continuing healthcare assessments. To deliver these targets we work closely with our providers and member GP practices. Below is a table summarising the CCG's performance in some of these areas for 2019/20. Performance against all of these indicators is measured at CCG level. Where relevant, recovery action plans are in place, which are being continually reviewed and updated to improve performance.

National Indicator	Target	2019/20	Commentary
Estimated diagnosis rate for people with dementia			
Dementia diagnosis rate	**>67%**	**73.11%**	*The figure reported is the end of period position as at March 2020.*
Improved Access to Psychological Therapy (IAPT)			
Percentage of population entering therapy	**>5.5%**	**6.54%**	*Performance is measured on a rolling three-month basis and the figure shown is as at March 2020.*
Percentage recovery rate	**>50%**	**61.00%**	*Performance is measured on a rolling three-month basis and the figure shown is as at March 2020.*
Percentage of people that wait six weeks or less from referral to first treatment	**>75%**	**84.21%**	*The figure reported is the end of period position as at March 2020.*
Percentage of people that wait 18 weeks or less from referral to first treatment	**>95%**	**97.37%**	*The figure reported is the end of period position as at March 2020.*
First episode of psychosis – referral to treatment pathway			
Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	**>56%**	**88.0%**	*The figure reported is the end of period position as at March 2020.*
Children waiting less than 18 weeks for a wheelchair			
Percentage of children that received equipment in less than 18 weeks of being referred to the wheelchair service.	**>92%**	**100%**	*Performance is measured on a quarterly basis and the figure shown is as at Q3 2019/20. Reporting against this indicator has been suspended nationally in response to the COVID-19 pandemic.*
Continuing Care			
% of full NHS Continuing Healthcare assessments taking place in acute hospital setting	**<15%**	**4%**	*Performance is measured on a quarterly basis and the figure shown is as at Q4 2019/20.*

National Indicator	Target	2019/20	Commentary
% of full NHS Continuing Healthcare eligibility decisions made by the CCG within 28 days	>85%	79%	*Performance is measured on a quarterly basis and the figure shown is as at Q4 2019/20.*

Performance against financial duties

CCGs receive an allocation of funds for 'programme costs', which is money to be used directly for commissioning healthcare services. During 2019/20 the CCG had recurrent (continuing) and non-recurrent (for one year only) programme resources of £179.2 million. We have a statutory financial duty not to spend more than our allocation, and in 2019/20, we were not required to deliver a control total surplus.

At the end of the financial year, the CCG is also expected to manage its closing cash balance down to a limit of less than 1.25% of the cash requested and drawn down from NHS England in March.

We also receive a separate allocation of money to be used for the running costs of the CCG, which in 2019/20 was £2.739 million. These costs are those associated with keeping our CCG running, and do not cover the delivery of healthcare.

The Better Payment Practice Code (BPPC) 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. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

Responsibility for financial management ultimately sits with the Governing Body; however, oversight of this has been delegated to our Finance and Turnaround Committee to ensure consistent scrutiny, with issues escalated to the Governing Body as necessary. These governance arrangements are underpinned by a robust approach to financial turnaround, delivered via weekly meetings of a Financial Recovery Group, which is chaired by the Chief Finance Officer. The Finance Reports to our Governing Body set out the CCG's latest financial position and are available on our website at https://nottsccg.nhs.uk/.

The key financial duties that were set and achieved for 2019/20 are summarised below and the full financial statements for the year can be found in the *Annual Accounts* section of this report.

Key Financial Duty	Target	Delivery
Keep within revenue resource limit	£179,182,000	✓
Achieve control total surplus	£0	✓
Cash balances within agreed limit	£82,663	✓
Remain within running cost allowance	£2,739	✓
Achieve BPPC targets	>95%	✓

Our Statutory Duties

The statutory duties and powers of CCGs are set out within NHS England's '*The functions of Clinical Commissioning Groups*' (March 2013). The responsibility for discharging our key statutory duties rests with the Governing Body and, as such, we have established an Annual Reporting Framework which ensures that the appropriate assurances on the delivery of key duties are received in a timely manner. Further assurance is provided through our Governing Body Assurance Framework, which identifies high-level risks with the potential to impact on the delivery of strategic objectives and statutory duties. It also details the controls and actions in place to mitigate such risks.

The following sections focus specifically on how we are meeting some of these duties:

Improving quality

CCGs must exercise their functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness. The CCG places quality at the heart of its functions and organisations that we commission services from must meet essential standards of quality and safety as defined by the Care Quality Commission (CQC). We also set our own local standards, which include reductions in avoidable harm, such as pressure ulcers, falls (in particular repeat fallers), urinary tract infections and venous thromboembolism.

The Nottingham and Nottinghamshire CCGs have established a collaborative approach to quality, establishing our joint Quality Strategy 2019-2022, which clearly reflects our ongoing commitment to ensuring a high quality health service for our local populations and our need to work closely with our system partners (as part of the Nottingham and Nottinghamshire ICS) to fully deliver the requirements of the NHS Long Term Plan and consistent, equitable quality of care.

We use a number of dashboards and tools that we have developed to ensure continuous improvements in quality outcomes are being secured. This includes a joint Primary Care Quality Framework, which sets out our approach to monitoring and assuring quality and improvement in primary medical services. We work closely with our providers throughout the year to ensure that standards are met; providing challenge and support in areas where patient care can be improved.

Continuous quality improvement is promoted and encouraged through a range of mechanisms, which includes the completion of Equality and Quality Impact Assessments (EQIAs) as an essential requirement of the CCG's decision-making processes. We also have robust mechanisms in place to monitor quality standards, including the monitoring of serious incidents, patient and staff feedback, infection prevention and control, safeguarding processes and clinical outcomes.

The Governing Body has delegated responsibility for a range of quality functions, including the requirement to improve the quality of commissioned services, to the Quality, Safeguarding and Performance Committee. This committee also has delegated responsibility for overseeing and managing performance against the standards set out in the NHS Constitution and any other nationally set, or locally agreed, performance indicators. You can read more about the work of this committee in the *Governance Statement* section of this report.

Reducing health inequalities

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. A person's chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and access services. Nationally, addressing health inequalities is a recognised factor in addressing the prevention of avoidable illness and in improving overall health outcomes (NHS Long Term Plan, 2019). As part of the Health and Social Care Act 2012, CCGs are legally required to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved. This means that health inequalities must be properly taken into account when we make commissioning decisions for our population. We do this by ensuring that the consideration of inequalities is firmly embedded within our strategic plans and key business activities, examples of which include:

- Developing our Commissioning Strategy 2020-22 in line with the needs of the local population.
- Ensuring that the new CCG's key deliverables (developed for 2020/21) have a specific focus on health inequalities in order to lead the system in developing new models of care; supporting and implementing evidence-based new ways of working for our local populations.
- Establishing a clear decision-making framework to ensure that investment, disinvestment and service change decisions are made following a reasonable evaluation of available evidence. This includes an assessment of the health requirements of the local community.
- Ensuring that proposals to change or remove a service, policy or function clearly demonstrate the impact on reducing health inequalities.

We also fulfil this duty through our continued commitment to working with our system partners to help address the wider determinants of health (see section below on working with the Health and Wellbeing Board).

At the time of finalising this report, we recognise the need to understand the impact of COVID-19 on health inequalities across Nottingham and Nottinghamshire and have set a clear deliverable for 2020/21 to develop and implement appropriate restoration and recovery plans to work to address these inequalities.

Working with the Health and Wellbeing Board

We are active members of the Nottinghamshire County Health and Wellbeing Board; a statutory partnership established to lead and advise on work to improve the health and wellbeing of the population of Nottinghamshire and specifically to reduce health inequalities. This Board brings us together with Nottinghamshire County Council to address county-wide issues where a collaborative approach between partners is essential. Other local organisations include the Nottinghamshire Police Crime Commissioner, Healthwatch Nottinghamshire and NHS England.

In particular, Health and Wellbeing Boards are statutorily responsible for producing a joint strategic needs assessment (JSNA) for their local population. A JSNA is the means by which a range of information (including local and national data) is utilised to identify the current health and wellbeing needs of local communities and to highlight health inequalities. This information is then used to inform the development of a health and wellbeing strategy to address these specific factors.

As such, the Joint Health and Wellbeing Strategy 2018-22 was launched in 2018 and has four ambitions, which are:

- To give everyone a good start in life
- To have healthy and sustainable places
- To enable healthier decision making
- To work together to improve health and care services

Going in to the next year, the new CCG intends to review its working arrangements with the Health and Wellbeing Board (as well as our other strategic partners) to ensure maximum effectiveness in the context of reducing health inequalities.

Engaging People and Communities

The NHS belongs to all of us and we welcome the active participation of patients, carers, community

representatives and groups and the public in planning, delivering and evaluating services that we commission. The CCG recognises that to improve local health services we need to involve local people in the work that we do and ensure that we actively seek out the views of those most affected by service change and those in hard to reach communities.

The Nottingham and Nottinghamshire CCG's aligned arrangements (as described in the *Our structure* section of this report) have been established to ensure the closer alignment of our commissioning activity across Nottingham and Nottinghamshire. This has also meant the closer alignment of our patient and public involvement activity; however, we continue to recognise the specific needs of different patient groups and communities within each of the distinct populations, and we adapt our approach to engagement accordingly.

Our Communications and Engagement Strategy 2019-21 sets out our approach for involving local people in our commissioning activity. The key principles which underpin our approach to communications and engagement are:

- Be clear, open, honest, consistent and accountable
- Use plain language and be accessible to all
- Target our communications and engagement for the audience we want to reach
- Provide clear, consistent messages about who we are and what we do
- Encourage and support on-going dialogue with internal and external audiences
- Provide quality and cost effective information
- Use best practice and share knowledge with our partners across the health and care system
- Align our communications and engagement with our partners whenever we can
- Use insight to develop communications and engagement approaches
- Systematically evaluate the effectiveness of our communications and engagement activity.

The CCG has established a Patient and Public Engagement Committee (PPEC) to steer our patient and public involvement and provide oversight of our engagement plans; ensuring engagement activities are appropriately planned, shaped and delivered. We benefit from good links with our local Healthwatch, the health and social care consumer champion, which helps us to further understand and respond to the concerns of our population. We also ensure compliance with the Local Authority's health scrutiny requirements in relation to proposals on service change. As part of the Nottingham and Nottinghamshire Integrated Care System (ICS) we are also working more closely than ever before with our NHS partners, local councils and the voluntary sector.

You can read more about how we involve patients, carers, community groups and the public in all stages of our commissioning processes via the *Get involved* section of our website, which provides more information on how patients, carers, community groups and the public can get involved in shaping NHS services. Our 2019/20 Annual Engagement Report is available on our website at https://nottsccg.nhs.uk/ and this also provides further information as to how the CCG is meeting its statutory duties in relation to patient and public engagement.

Equality, Diversity and Inclusion

The CCG recognises and values the diverse needs of the population we serve and is committed to reducing health inequalities and improving the equality of health outcomes for our population. We are committed to embedding equality and diversity considerations into all aspects of our work and in ensuring the provision of high quality and accessible healthcare, underpinned by a diverse and well-supported workforce that is representative of the population we serve.

We recognise that equality is about ensuring that access to opportunities is available to all and that no one should have poorer life chances because of the way they were born, where they come from, what they believe, or whether they have a disability. We believe that diversity is about recognising and valuing differences by being inclusive, regardless of age, disability, gender re- assignment, marriage or civil partnership status, pregnancy and maternity, race, religion or belief, sex, or sexual orientation. Also, we believe that our employees are essential to the provision of high quality healthcare and we are committed to maintaining a working environment that promotes their health and wellbeing.

The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires the CCG to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations. These are often referred to as the three general aims of the PSED. Having due regard requires the CCG to give proper consideration to removing or minimising disadvantages, taking steps to meet people's needs, tackling prejudice and promoting understanding. In practice, this requires the CCG to embed equality, diversity and inclusion considerations into all of its relevant business activities.

A further requirement of the PSED is for the CCG to analyse and measure its equality performance and prepare associated information for publication each year. We are also required to prepare and publish equality objectives and set out how progress towards achieving those objectives will be measured.

The following is a summary of the work undertaken by the CCG during 2019/20 to ensure that we meet the requirements of the PSED:

Better health outcomes

We commission and procure services with the aim of meeting the health needs of our local community and work with providers of health services to ensure that individual people's health needs are assessed in appropriate and effective ways. We also commission actions to improve transitions between services and to ensure that all health promotion services reach and benefit our local communities.

It is essential for the CCG to fully understand the health needs of the population we serve, and this has been addressed by continuing to develop the Joint Strategic Needs Assessment (JSNA) in conjunction with the Local Authority.

The CCG has worked with Nottinghamshire County Council Public Health colleagues to ensure that JSNA chapters consider the protected characteristic groups defined by the Equality Act and also other disadvantaged groups. The JSNA identifies where inequalities exist, describes the future health and wellbeing needs of the CCG's population and has informed equality considerations in the CCG's commissioning intentions.

The CCG is committed to putting the voice of patients and the public at the heart of commissioning activities. This includes involving people in how decisions are made, how services are designed and how they are reviewed. The CCG has several engagement mechanisms that are intended to ensure that the diverse needs of the people living in Rushcliffe effectively inform the services commissioned. The CCG is

also committed to continuing to improve communications with local people to deliver targeted and tailored messaging that reaches the right people more effectively.

Commissioning intentions

The CCG commissions health services for its population from a range of local NHS, independent and voluntary providers; equality considerations are a routine factor in all procurement exercises.

The CCG uses the national NHS Standard Contract, which mandates NHS providers to implement the NHS Equality Delivery System Toolkit. This is addressed in more detail below, but in summary it helps NHS organisations to deliver better outcomes for patients and communities, and better working environments for staff, which are personal, fair and diverse with equality of opportunity and treatment those needs relate to a disability, impairment or sensory loss.

Equality and Quality Impact Assessments

Impact assessments are an integral part of service planning and policy development, and as such, they are required to be completed whenever the CCG plans, changes or removes a service, policy or function. The process requires careful consideration of the likely impact of activities on different people, communities or groups. It involves assessing the consequences of strategies, policies, procedures and functions on different people, communities or groups, and making sure that any negative consequences are minimised or eliminated, and opportunities for promoting equality are maximised.

The CCG's approach brings together equality and quality impact considerations into a single EQuality Impact Assessment (EQIA), which prevents equality and quality risks from being considered in isolation. The EQIA is an assessment of whether proposed changes could have a positive, negative or neutral impact on people's different protected characteristics and our approach ensures that we understand both the individual and collective impacts of our decision-making. The assessments help to ensure that we do not disadvantage people from protected characteristic groups by the way that health services are commissioned. The EQIA process also considers the impacts on people from relevant inclusion health groups and other disadvantaged groups (e.g. carers, homeless people and people experiencing economic or social deprivation). Their completion provides the CCG with a better understanding of the communities it serves.

The CCG has access to in-house equality, diversity and inclusion expertise to ensure that appropriate advice and support can be accessed when EQIAs are completed.

Completing EQIAs is not a statutory requirement, but the CCG believes that they are central to being a transparent and accountable organisation. They are treated as 'live' documents, and are revisited at key stages of scheme development and implementation, particularly following the conclusion of any patient and public engagement and consultation activities to inform decision-making.

Inclusive Leadership and Workforce

The CCG's Governing Body and senior leaders are committed to promoting equality and ensuring that equality-related impacts and risks are identified and managed. All members of the Governing Body and its committees are required to sign declarations of compliance with the Professional Standards Authority for Health and Social Care's Standards for members of NHS Boards and Clinical

Commissioning Group Governing Bodies in England. This commits them to promoting equality and human rights in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible. CCG managers are expected to work to the Code of Conduct for NHS Managers, which requires managers to ensure that no one is unlawfully discriminated against because of their protected characteristics or economic status.

The CCG is committed to developing a more representative workforce at all levels. The Workforce Reports to our Governing Body set out the CCG's workforce demographics and are available on our website at https://nottsccg.nhs.uk/. We operate a fair, inclusive and transparent recruitment and selection processes and obtain and maintain a range of workforce accreditations (e.g. Mindful Employer, Disability Confident Scheme) to help demonstrate that the CCG promotes equality of opportunity. The CCG is also working to the requirements of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES), which aim to ensure that employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace and to compare the workplace experiences of disabled and non-disabled staff. The new CCG has committed to the development of a strategy during 2020/21 to proactively increase workforce diversity, which will be monitored via the Governing Body Workforce Reports.

All staff are responsible for treating everyone with dignity and respect and must not discriminate or encourage others to discriminate. The CCG's leadership team is committed to ensuring that staff are supported to work in culturally competent ways within a work environment that is free from discrimination. All staff are expected to complete mandatory Equality and Diversity Awareness training and pertinent information is often communicated to staff through our internal communication processes. To reinforce this basic equality training the CCG is also committed to introducing a staff cultural competence development programme, which is responsive to the diversity of the local population.

The CCG is committed to maintaining a working environment that promotes the health and wellbeing of the whole workforce through a suite of human resources policies, and the development of an agile working model to improve the health, wellbeing and productivity of staff has been identified by the new CCG as a key deliverable during 2020/21.

The NHS Equality Delivery System

The current process for analysing and measuring equality performance is through the NHS Equality Delivery System (EDS2). It enables the CCG to obtain, analyse and grade the evidence required to demonstrate its equality performance and that due regard has been given to the PSED. It helps to deliver better outcomes for patients and communities, and better working environments for staff, which are personal, fair and diverse with equality of opportunity and treatment for all. The EDS2 process is also a framework for providing the Governing Body with an annual equality assurance report on the CCG's due regard for the PSED.

EDS2 has recently been reviewed and a revised version - EDS3 - has been subsequently developed. It is expected that EDS3 will be piloted during 2020 in certain areas, including Nottingham and Nottinghamshire. Therefore the CCG was not expected to use EDS2 during 2019 to assess and report on its equality performance.

Equality Objectives

The PSED's requirement for the CCG to have measurable equality objectives helps to prioritise actions to improve patient and staff experience that are outcome-focused and ambitious yet realistically achievable. Equality objectives also help to demonstrate that the CCG is serious about reducing inequality and advancing equality of opportunity.

Work has been ongoing within the CCG to develop appropriate equality objectives for the new NHS Nottingham and Nottinghamshire CCG. This work has been identified as a key deliverable for the new CCG during 2020/21.

During 2019/20, work has also been ongoing to ensure that the new CCG fulfils its statutory equality requirements and progresses the equality agenda for the benefit of its population and staff. This has included:

- Finalising an Equality, Diversity and Inclusion (EDI) Policy. This will demonstrate the new CCG's due regard to the PSED, by requiring equality, diversity and inclusion considerations to be embedded into all aspects of its work, including commissioning processes and employment practices. It will bring together the predecessor CCGs' arrangements for meeting the PSED into a unified approach and will outline a consistent approach to assessing equality performance.
- Establishing an Equality and Diversity Steering Group. Its main aim will be to assess how well equality and diversity considerations are aligned across the new CCG, so its membership will be drawn from relevant commissioning areas and will also include representation from functions such as quality, engagement and communications and human resources.
- Establishing an internal equality performance reporting timetable, covering all aspects of the specific equality duties, which will enable the provision of an annual equality assurance report to the new Governing Body and subsequent publication. This will be underpinned by a periodic assurance reporting timetable to relevant committees on progress against addressing equality priority areas and monitoring achievement of agreed equality objectives.

Sustainable Development

CCGs are expected to report annually on sustainability matters; however, due to the impact of COVID-19 on our ability to compile this data, we are currently unable to provide the information required in line with the national guidance (available at www.sduhealth.org.uk/delivery/measure/reporting.aspx).

The CCG takes its corporate responsibilities seriously and recognises that it needs to set the highest standards in the way in which we work with our staff, our patients and our partners. Going into 2020/21, the new CCG has identified the development of its Green Plan, outlining its aims and objectives for environmental sustainability, as one of its key deliverables. The development, implementation and monitoring of this work will be overseen by the CCG's Audit and Governance Committee.

Emergency Preparedness, Resilience and Response (EPRR)

The NHS needs to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 (CCA 2004) and the NHS Act

2006 (as amended). The CCA 2004 specifies that responders will be either Category 1 (primary) or Category 2 responders (supporting agencies). NHS England, acute and ambulance service providers, Public Health England and Local Authorities are Category 1 responders and CCGs are Category 2 responders. In order to carry out its responsibilities, the CCG has relevant plans and a 24/7 on call structure in place. A self-assessment is carried out each year by the CCG (as with all NHS Category 1 and Category 2 responders) in order to provide assurance on compliance against core standards for EPRR. For 2019/20 the level of compliance for the Nottingham and Nottinghamshire CCGs was 'Compliant'.

As part of the approach being taken to co-ordinate and manage the health response to the COVID-19 national emergency, it was agreed that CCGs should be the local system leaders for health within the Local Resilience Forum (LRF), representing health at any COVID-19 related Strategic Co-ordinating Group (SCG), Tactical Co-ordination Group (TCG) or system wide meetings. These responsibilities were formally delegated to CCGs from NHS England and NHS Improvement, in accordance with the CCA 2004.

Performance Report signed by:

Dr Amanda Sullivan, Accountable Officer
23 June 2020

Accountability Report

Corporate Governance Report

Members Report

As at 31 March 2020, the CCG has 12 GP member practices. These are as follows:

Practice Name
Belvoir Health Group
Castle Healthcare Practice
East Bridgford Medical Centre
East Leake Medical Group
Gamston Medical Centre
Keyworth Medical Practice
Musters Medical Practice
Orchard Surgery
Radcliffe-on-Trent Health Centre
Ruddington Medical Centre
St Georges Medical Practice
West Bridgford Medical Centre

Composition of the Governing Body

The Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance (its main function).

The Governing Body is clinically led, and as described in the introduction section of this annual report, Dr Stephen Shortt fulfilled the role of Chair and Clinical Leader up until 31 March 2020 (Dr Shortt continues to jointly lead the new CCG with Dr James Hopkinson). Its membership also includes the organisation's Accountable Officer, Chief Finance Officer, Chief Nurse and Chief Commissioning Officer. Membership also includes five independent members, comprising four lay members and a secondary care doctor. Since July 2019, meetings of the Governing Body have been convened by a lay member, in line with the move to meeting 'in common' arrangements (more of which you can read about in the *Governance Statement* section of this report).

The Governing Body may also co-opt observers and attendees with speaking rights to attend meetings as required.

The following shows people who were members of the CCG Governing Body from 1 April 2019 to 31 March 2020:

- Dr Stephen Shortt* – Chair and Clinical Leader
- Dr Amanda Sullivan* – Accountable Officer
- Stuart Poynor* – Chief Finance Officer (from 1 May 2019)
- Rosa Waddingham* – Chief Nurse (from 1 January 2020)
- Lucy Dadge* – Chief Commissioning Officer (from 1 July 2019)
- Jon Towler* – Lay Member (from 1 July 2019)
- Dr Adedeji Okubadejo* – Secondary Care Doctor (from 1 July 2019)
- Susan Clague* – Lay Member
- Susan Sunderland* – Lay Member (from 1 July 2019)
- Eleri De Gilbert* – Lay Member (from 1 July 2019)
- Ian Blair – Lay Member (to 30 June 2019)
- Professor Chris Hawkey (to 30 June 2019)
- Jonathan Bemrose – Chief Finance Officer (to 30 April 2019)
- Elaine Moss – Chief Nurse (to 31 December 2019)
- Dr Jeremy Griffiths – GP Representative (to 30 June 2019)
- Dr Gavin Derbyshire – GP Representative (to 30 June 2019)

** As at the time of finalising this annual report, these individuals are members of the new CCG's Governing Body.*

Full biographies of our Governing Body members are available on the *About us* section of our website at https://nottsccg.nhs.uk/.

You can read more about the work of the Governing Body and its committee structure in the *Governance Statement* contained within this report.

The Audit and Governance Committee

The following lay members attended as members of the Audit and Governance Committee throughout the year and up to the signing of our annual report and accounts:

- Sue Sunderland (Chair from 1 June 2019)
- Eleri De Gilbert (from 1 June 2019)
- Jon Towler (from 1 November 2019)
- David Heathcote (from 1 June 2019 to 31 October 2019)
- Ian Blair (Chair to 3 May)
- Sue Clague (to 30 May 2019)

Other committee memberships

The *Governance Statement* contained within this report provides full details on all of the Governing Body's committees, including their memberships. Details regarding the CCG's Remuneration and Terms of Service Committee can also be found in the *Remuneration and Staff Report* section.

Managing conflicts of interest

We are committed to ensuring that our organisation inspires confidence and trust, avoiding any potential situations of undue bias or influence in decision-making and protecting the NHS, the CCG, and individuals involved from any appearance of impropriety.

The CCG has a publically available Register of Declared Interests that captures the declared interests of all members and attendees of the Governing Body and its committees, along with all other employees of the CCG. We also maintain a Register of Procurement Decisions and a Register of Gifts, Hospitality and Sponsorship. These documents can be found on our website at https://nottsccg.nhs.uk/. Further details on how we manage conflicts of interest are detailed in the *Governance Statement* within this report.

Ensuring a culture of openness and transparency

As part of our arrangements for ensuring a culture of openness and transparency in our business transactions, we also have arrangements in place to enable our staff (or others temporarily working for the CCG) to raise concerns in confidence. These arrangements are detailed in our Raising Concerns (Whistleblowing) Policy, which sets out the CCG's statement of intent with regard to creating a supportive culture for its workforce and its zero tolerance of harassment or victimisation of anyone raising a genuine concern under the policy. The Policy describes key roles and responsibilities with regard to whistleblowing and includes details on the CCG's independent 'Freedom to Speak up Guardian' and the local Counter Fraud Specialist (if the concern relates specifically to fraud corruption or bribery).

In particular, the Policy sets out the internal procedure for raising concerns, which includes timelines for dealing with the issue and the level of information that may be reported back to the individual who reported the concern. Where individuals may not want to raise concerns internally, or might not be satisfied that with the way a concern has been addressed internally, the Policy also sets out the procedure for making an external disclosure and links to information on the Public Interest Disclosure Act (PIDA). The Policy also provides contact details for independent organisations that are able to provide support and advice.

Whilst biannual assurance reports confirming the embedment of whistleblowing arrangements are provided to the CCG's Audit and Governance Committee, It can be difficult to comment specifically as to the effectiveness of the arrangements, as concerns may be raised with line managers and handled satisfactorily at this stage, and are therefore not reported centrally. As at the time of finalising this report, the CCG is not aware of any concerns raised externally.

Personal data related incidents

We are committed to reporting, managing and investigating all information governance incidents and near-misses. We actively encourage staff to report all incidents and near misses to ensure that learning can be collated and disseminated within the organisation. We did not report any serious incidents involving information, confidentiality or security between 1 April 2019 and 31 March 2020.

Two personal data related incident was reported during 2019/20; however, this was not rated as being serious in nature and was managed in line with our incident reporting and management procedures. One incident involved the accidental publishing of bank account details for the Rushcliffe Primary Care Network (PCN) on the CCG's website. The error was highlighted quickly after publication and the details removed. The PCN were notified and advised to contact its bank for further advice. The other incident involved a member of staff sending a small number of patient details to an unsecure email account; however, this was to the correct individual within one of our provider organisations. The recipient was informed immediately of the error and the email was deleted.

Summary of personal data related incidents in 2019/20:

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	2
V	Other	0

Complaints

During 2019/20 the CCG received 13 complaints for investigation, of which a small number were upheld. The outcome of the complaints we upheld lead to service improvements including a revision and update to a hospital administration process and refresher training for service staff in areas including referral processes and internal communication. The complaints we receive are about the services we commission, but sometimes the CCG leads on a complaint investigation because the complaint involves a number of different local health providers.

As an organisation we welcome complaints as a valuable source of learning and recognise that lessons learnt as a result of complaint investigations give us an opportunity to make improvements where we can to the services we deliver. All our complaints are handled in line with the statutory NHS Complaint Handling Guidelines. During 2019/20, no complaints were referred to the Parliamentary and Health Service Ombudsman.

Statement of disclosure to auditors

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

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

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

Modern Slavery Act

Whilst the CCG does not meet the requirements for producing an annual Slavery and Human Trafficking Statement (as set out in the Modern Slavery Act 2015), the Governing Body fully supports the Government's objectives to eradicate modern slavery and human trafficking. The Governing Bodies of the Nottingham and Nottinghamshire CCGs have therefore agreed to demonstrate their commitment to the Act and have agreed a joint statement during 2019/20. The statement is published on our website at https://nottsccg.nhs.uk/

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Amanda Sullivan to be the Accountable Officer of NHS Rushcliffe CCG

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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.

Signed by:

Dr Amanda Sullivan, Accountable Officer
23 June 2020

Governance Statement

Introduction and context

NHS Rushcliffe CCG ("**the CCG**") is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. 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 2019, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 (as amended).

We are a clinically-led organisation, with effective involvement from member practice GPs and other clinicians, who we work with to innovate and commission new and re-designed services. This approach ensures that the organisation is well placed to understand the needs of our diverse population and to develop and redesign healthcare services to address these needs. We are committed to ensuring that patient engagement and involvement is at the centre of all our decision-making processes.

We are responsible for commissioning the majority of healthcare services for our population; including elective hospital care and rehabilitation care, maternity services, urgent and emergency care, community services and mental health and learning disability services. Since 1 April 2015, we have also taken on full delegated responsibility for commissioning primary medical services within our area.

We have a well-established history of commissioning health services in collaboration with our neighbouring CCGs; and in 2018/19 this was formalised by establishing joint commissioning functions, governance and staffing arrangements with the other CCGs in Greater Nottingham (NHS Nottingham City CCG, NHS Nottingham West CCG and NHS Nottingham North and East CCG; hereafter referred to as "**the Greater Nottingham CCGs**"). During early 2019/20, these joint working arrangements were extended across the whole of Nottinghamshire to also include NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG to help address local challenges, deliver better health outcomes and improve the quality and consistency of local health services (collectively, the six CCGs are hereafter referred to as "**the Nottingham and Nottinghamshire CCGs**").

This approach aligned with plans to create a single, strategic commissioning organisation as part of the Nottingham and Nottinghamshire Integrated Care System (ICS). Consequently, there has been a significant focus throughout 2019/20 to apply and prepare for merger from 1 April 2020 when the Nottingham and Nottinghamshire CCGs will become NHS Nottingham and Nottinghamshire CCG. From which time, NHS Rushcliffe CCG will be formally disestablished.

Scope of responsibility

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

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement. My role of Accountable Officer is a joint appointment across the six Nottingham and Nottinghamshire CCGs.

Governance arrangements and effectiveness

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

The CCG has established a Constitution, supported by a set of Standing Orders and Standing Financial Instructions, which together set out how the organisation will ensure that it is well governed and accountable to both its member GP practices and its local population. The Constitution sets out the statutory framework that the CCG operates within, its arrangements for demonstrating accountability and transparency and procedures for making decisions. The Standing Orders set out the arrangements for Governing Body meetings and the appointment processes for all Governing Body members and the Standing Financial Instructions set out the arrangements for managing the CCG's financial affairs. The CCG has also established a Scheme of Reservation and Delegation, which sets out those decisions that are reserved for the membership as a whole and the decisions that are delegated to the Governing Body, its committees, and individuals employed by the organisation.

As part of the CCG's commitment to openness and accountability, meetings of the Governing Body are held in public and members of the public may ask questions in advance of each meeting, which will be verbally responded to at the meeting. In line with good governance practice, the Governing Body is supported by an annual cycle of business that sets out a coherent overall programme for meetings. The Governing Body's forward plan is a key mechanism by which appropriately timed governance oversight, scrutiny and transparency can be maintained in a way that doesn't place an onerous burden on those in executive roles or create unnecessary or bureaucratic governance processes.

The Governing Body is led by an elected GP in the role of the CCG's Clinical Chair. Its membership includes the organisation's Accountable Officer, Chief Finance Officer, Chief Commissioning Officer and Chief Nurse. Membership also includes five independent members, comprising four lay members and a secondary care doctor. The Governing Body may also co-opt observers and attendees with speaking rights to attend meetings as required. Since July 2019, meetings of the Governing Body have been convened by a lay member, in line with a move to meetings being held 'in common' across the Nottingham and Nottinghamshire CCGs.

As part of their role as members of the Governing Body, the independent members provide an external view of the work of the CCG that is removed from the day-to-day running of the organisation. This brings insight and impartiality to the Governing Body and provides constructive challenge to discussions at meetings of the Governing Body and its committees in order to support the robustness of decision making arrangements.

The Governing Body has approved and keeps under review the Terms of Reference for all of its committees. The committees demonstrate how they have discharged their responsibilities (as set out within their terms of reference) by reporting to the Governing Body's meetings. This is performed

through the submission of formal minutes, specific assurance reports and other appropriate updates as necessary.

The aligned governance arrangements between the Nottingham and Nottinghamshire CCGs were formally agreed by each CCG's Governing Body in May and June 2019 and was fully in place by July 2019. This consisted of aligning the CCGs' Constitutions, committee terms of reference and procedures for making decisions (eg. schemes of reservation and delegation), along with operating a 'meetings in common' approach for the Governing Bodies and their committees. This approach facilitated joint working across the CCGs, whilst continuing to ensure that each organisation had clear accountability arrangements in place. In addition, a joint Executive Management Team was established across the six CCGs, along with joint appointments of independent Governing Body members.

During the year, the Nottingham and Nottinghamshire CCGs' Governing Bodies have also held joint development sessions, working towards the CCGs' proposal to create a single, strategic commissioning organisation from 1 April 2020.

The CCG has established robust arrangements for managing conflicts of interests in such a way as to ensure that they do not affect the integrity of decision-making processes. These include the maintenance and publication of a Register of Declared Interests for all employees and appointees of the CCG. Governing Body members, and those of its committees, are also asked to declare any conflict of interest with regard to agenda items at the start of each of their meetings.

The Governing Body met on 11 occasions during 2019/20, meeting 'in common' with the Governing Bodies of each of the Nottingham and Nottinghamshire CCGs from July 2019. All meetings were quorate, in accordance with the CCG's Standing Orders

Membership and attendance for the Governing Body during 2019/20

Name	No. of eligible meetings attended during the year	Comment
Dr Amanda Sullivan, Accountable Officer	10/11	-
Dr Stephen Shortt, CCG Clinical Chair	10/11	-
Jon Towler, Lay Chair of the Governing Body	9/9	*Membership commenced July 2019*
Sue Clague, Lay Member	10/11	-
Eleri De Gilbert, Lay Member	8/9	*Membership commenced July 2019*
Sue Sunderland, Lay Member	8/9	*Membership commenced July 2019*
Dr Adedeji Okubadejo, Independent Secondary Care Doctor	8/9	*Membership commenced July 2019*
Lucy Dadge, Chief Commissioning Officer	8/9	*Membership commenced July 2019*
Stuart Poynor, Chief Finance Officer	10/11	*Membership commenced May 2019*
Rosa Waddingham, Chief Nurse	3/3	*Membership commenced January 2020*

Name	No. of eligible meetings attended during the year	Comment
Elaine Moss, Chief Nurse	6/8	*Membership ceased December 2019*
Jonathan Bemrose, Chief Finance Officer	1/1	*Membership ceased April 2019*
Ian Blair, Lay Member	2/2	*Membership ceased June 2019*
Dr Jeremy Griffiths, GP Representative	2/2	*Membership ceased June 2019*
Dr Gavin Derbyshire, GP Representative	2/2	*Membership ceased June 2019*
Professor Chris Hawkey, Secondary Care Doctor	2/2	*Membership ceased June 2019*

The Governing Body has appointed the following committees:

Audit and Governance Committee – This statutory committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the organisation, in so far as they relate to finance. The Committee also has responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities. This includes reviewing the integrity of the CCG's financial statements, the adequacy and effectiveness of all risk and control related disclosure statements, and ensuring that the organisation has effective whistle blowing and anti-fraud systems in place.

The Committee scrutinises every instance of non-compliance with the CCG's Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions and monitors compliance with the CCG's policies relating to standards of business conduct. The Committee is responsible for approving the CCG's annual report and accounts and also has duties relating to the regulatory requirements for information governance and monitoring progress against the CCG's overarching Policy Work Programme.

The Audit and Governance Committee meets no less than six times per year at appropriate times in the reporting and audit cycle and its membership is comprised solely of Governing Body Lay Members. Members are supported by the CCG's internal auditors, external auditors and local counter fraud specialist.

The Audit and Governance Committee has met on eight occasions during the year, meeting 'in common' with the Audit and Governance Committees of the Nottingham and Nottinghamshire CCGs since July 2019. All meetings were quorate, in accordance with the Committee's terms of reference.

Key activities of the Committee during 2019/20

During the year, the Audit and Governance Committee has:

- Scrutinised reports from the CCG's internal and external auditors, which will culminate in the receipt of year-end opinions and conclusions in June 2020.
- Scrutinised the CCG's Register of Tender Waivers, which sets out all contracts that have been awarded without a competitive tender process.

- Received comprehensive assurance reports demonstrating the arrangements in place for risk management, standards of business conduct and information governance. These reports have also detailed the progress and effectiveness of joint working arrangements being implemented for these areas across the six Nottingham and Nottinghamshire CCGs, whilst providing assurance that each CCG has continued to meet their individual statutory responsibilities.
- Received updates from the CCG's Counter Fraud service on progress in achieving the NHS Counter Fraud Authority Standards for NHS Commissioners.
- Overseen the due diligence element of the CCGs' merger application, ensuring that robust work had been undertaken to formally identify the staff, assets and liabilities that would transfer from the six existing CCGs into the new organisation on 1 April 2020. This also included receiving assurance that processes were in place to ensure the preservation of organisational memory following the transition process.
- Approved the CCG's Annual Report and Accounts 2018/19 and overseen preparation work for the Annual Report and Accounts process 2019/20.

Membership and attendance for the Audit and Governance Committee during 2019/20

Name	No. of eligible meetings attended during the year	Comments
Sue Sunderland, Lay Member (Chair)	6/6	*Chair from June 2019*
Eleri de Gilbert, Lay Member	6/6	*Membership commenced June 2019*
Jon Towler, Lay Member	2/3	*Membership commenced November 2019*
David Heathcote, Lay Member	3/3	*Membership from June to October 2019*
Ian Blair, Lay Member	1/2	*Chair and member to May 2019*
Sue Clague, Lay Member	2/2	*Membership ceased May 2019*

Remuneration and Terms of Service Committee – This statutory committee has been established to make recommendations to the Governing Body in relation to the remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it; and any determinations about allowances payable under pension schemes established by the CCG. The committee meets on an 'as required' basis, with a minimum of one meeting per year, and its membership is comprised entirely of Governing Body Lay Members. As such, its remit excludes considerations in relation to lay member remuneration, fees and allowances, which are instead approved by non-conflicted members of the Governing Body. The Remuneration and Terms of Service Committees of the six CCGs have met 'in common' throughout 2019/20. All meetings were quorate, in accordance with the Committee's terms of reference.

Key activities of the Committee during 2019/20

There have been eight meetings of the Remuneration and Terms of Service Committee during the year. At these meetings, the Committee:

- Agreed a protocol to support consistent and robust decision-making on remuneration and the process and principles to be undertaken when making recommendations to the Governing Body.
- Endorsed the timeline and recruitment approach to appointing key roles to the new CCG, following the merger process (from 1 April 2020). This included members of the new CCG's Executive Management Team and GP Governing Body members. The Committee also supported the proposed salary offers to these roles, following a robust review performed against national guidance and benchmarking data.
- Endorsed a small number of proposed redundancies following the restructuring exercise undertaken to align the six CCGs.
- Approved a number of key human resource policies; which included policies on organisational change, sickness absence, capability and staff appraisals.

Membership and attendance for the Remuneration and Terms of Service Committee during 2019/20

Name	No. of eligible meetings attended during the year	Comment
Jon Towler, Lay Member (Chair)	7/8	-
Sue Sunderland, Lay Member	8/8	-
Sue Clague, Lay Member	7/8	-
Eleri De Gilbert , Lay Member	5/8	-

Primary Care Commissioning Committee – This committee was established following the issuance of a formal delegation agreement from NHS England to empower the organisation to commission primary medical services for its local population. The committee operates as the corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers. Meetings of the Primary Care Commissioning Committee are scheduled on a monthly basis. The committee's membership consists of senior managers and independent members, which includes three lay members and an independent GP. Meetings are held in public in line with the requirements of the delegation agreement, albeit where necessary, confidential sessions may also be held. The Primary Care Commissioning Committee has met on 11 occasions during the year, meeting in common with the Primary Care Commissioning Committees of the other Nottingham and Nottinghamshire CCGs since June 2019. All meetings were quorate, in accordance with the Committee's terms of reference.

Key activities of the Committee during 2019/20

During the year, the Committee has:

- Received regular contract management updates, detailing the contractual changes occurring in practices across the area and providing assurance that any changes were in accordance with national primary care guidance.

- Reviewed quarterly reports on the quality of local Primary Care services; receiving assurance that the CCG has comprehensive quality monitoring processes in place with regard to member GP practices and that practices needing enhanced support from the CCG were being identified in a timely manner.
- Received comprehensive updates on local PCN development, including agreement of the organisation's response to the national consultation on the draft outline PCN specifications.
- Scrutinised assurance reports on demand management in primary care and primary care workforce challenges; in particular, the work being performed at system level to address the local issues regarding GP recruitment and retention.
- Approved and overseen a review performed to align Local Enhanced Services (LES) across Nottinghamshire.
- Received a monthly update on the position of the primary care delegated budget.
- Scrutinised primary care risks from the Corporate Risk Register monthly, with a particular focus on major risks, new risks, and risks that had increased in score. This included reviews of the effectiveness and progress of mitigating actions.

Membership and attendance for the Primary Care Commissioning Committee during 2019/20

Name	No. of eligible meetings attended during the year	Comment
Eleri De Gilbert, Lay Member (Chair of the meeting)	9/10	*Membership commenced June 2019*
Sue Sunderland, Lay Member	5/5	*Membership commenced November 2019*
Shaun Beebe, Lay Member	8/10	*Membership commenced June 2019*
Dr Ian Trimble, Independent GP Advisor	8/10	*Membership commenced June 2019*
Dr Amanda Sullivan, Accountable Officer	2/11	-
Lucy Dadge, Chief Commissioning Officer	11/11	-
Andrew Morton, Operational Director of Finance	5/10	-
Rosa Waddingham, Chief Nurse	7/10	*Membership commenced June 2019*
David Heathcote, Associate Lay Member	5/5	*Membership ceased October 2019*
Sharon Pickett, Associate Director of Primary Care	3/11	*Apologies received due to long-term absence.*
Ian Blair, Lay Member	1/1	*Membership ceased May 2019*
Jonathan Bemrose, Chief Finance Officer	1/1	*Membership ceased May 2019*

Name	No. of eligible meetings attended during the year	Comment
Sue Clague, Lay member	1/1	*Membership ceased May 2019*
Elaine Moss, Chief Nurse	0/1	*Membership ceased May 2019*

Additional attendees are invited to attend meetings of the Primary Care Commissioning Committee to assist with committee business. During 2019/2020, these have included representatives from the Nottinghamshire Local Medical Committee and NHS England.

Strategic Commissioning Committee - The Strategic Commissioning Committee exists to evaluate, scrutinise and quality assure the clinical and cost effectiveness of business case proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services. This includes the assessment of any associated equality and quality impacts arising from proposals and feedback from patient and public engagement/consultation activities where necessary. The Committee also ensures that the CCG's procurement responsibilities are appropriately discharged, including oversight of annual procurement plans.

The Committee has met on 11 occasions during 2019/20, meeting 'in common' with the Strategic Commissioning Committees of the other Nottingham and Nottinghamshire CCGs since July 2019. All meetings were quorate, in accordance with the Committee's terms of reference.

Key activities of the Committee during 2019/20

During the year, the Strategic Commissioning Committee has:

- Approved the organisation's 'Ethical Decision-making Framework', which sets out the key principles to be considered when making commissioning and de-commissioning decisions and ensures that a fair, transparent, consistent and evidenced based approach is in place.
- Reviewed and endorsed a number of organisational strategies, plans and policies. This included the Nottingham and Nottinghamshire CCGs' Commissioning Strategy 2020-22 and the Nottingham and Nottinghamshire 2019-24 Five Year System Plan.
- Received and approved a number of business cases requesting new investment or recurrent funding in local services. Investments exceeding the Committee's financial threshold (as set out in the CCG's Standing Financial Instructions) were also scrutinised by the Committee prior to requesting formal approval by the Governing Body.
- Scrutinised a number of service benefit reviews (SBRs) undertaken to review the effectiveness of existing commissioned contracts and set out options appraisals and recommendations; for example, a new service contract award, service change or to de-commission, in advance of the contract expiring. In particular, the Committee has focussed on the work being performed via SBRs to align commissioning activity across Nottingham and Nottinghamshire.

Membership and attendance for the Strategic Commissioning Committee during 2019/20

Name	No. of eligible meetings attended during the year	Comment
Jon Towler, Lay Member (Chair)	10/11	-
Dr Amanda Sullivan, Accountable Officer	10/11	-
Stuart Poynor, Chief Finance Officer	7/11	-
Lucy Dadge, Chief Commissioning Officer	7/11	-
Rosa Waddingham, Chief Nurse	3/3	*Membership commenced January 2020*
Dr Hugh Porter, GP Advisor	6/11	-
Dr James Hopkinson, GP Advisor	9/11	-
Dr Hilary Lovelock, GP Advisor	6/10	*Membership commenced August 2019*
Sue Sunderland, Lay Member	11/11	-
Jasmin Howell, Associate Lay Member	8/11	-
Neil Moore, Associate Director of Procurement and Commercial Development	10/11	-
Gary Thompson, Director of Special Projects	8/11	-
Dr Thilan Bartholomeuz, GP Advisor	0/1	*Membership ceased July 2019*
Elaine Moss, Chief Nurse	0/6	*Membership ceased December 2019.*

Quality, Safeguarding and Performance Committee – The Quality, Safeguarding and Performance Committee exists to scrutinise arrangements for ensuring the quality of CCG commissioned services, scrutinise the robustness of safeguarding arrangements, and to oversee the development, implementation and monitoring of performance management arrangements. The Committee also monitors equality performance in relation to health outcomes, patient access and experience, and promotes a culture of continuous quality improvement.

The Committee met on nine occasions during 2019/20, meeting 'in common' with the Quality, Safeguarding and Performance Committees of the other Nottingham and Nottinghamshire CCGs since June 2019. All meetings were quorate, in accordance with the Committee's terms of reference.

Key activities of the Committee during 2019/20

During the year, the Committee has:

- Received regular integrated Performance and Quality reports that provide information on the CCG's performance against a range of performance and quality indicators and the actions being taken where required standards have not been met. During the year, the Committee has also assessed

the fitness for purpose of its reporting arrangements in these areas to ensure alignment with the developing plans towards becoming a strategic commissioner.

- Scrutinised a number of assurance reports that demonstrate how the CCG is meeting its statutory responsibilities to improve quality in commissioned services. This has included detailed reports on safeguarding, infection prevention and control, medicines management, care homes and nursing homes and patient experience.
- Maintained a focus on provider organisations where significant quality concerns have arisen, initiating appropriate actions as required and escalating key issues and concerns to the Governing Body.
- Received updates on the work and progress of the Local Maternity and Neo-natal System (LMNS).
- Received assurance around the embedment of the Equality and Quality Impact Assessment (EQIA) process across the Nottingham and Nottinghamshire CCGs.
- Scrutinised risks (relating to its duties) from the Corporate Risk Register at every meeting, with a particular focus on new risks, major risks and risks that had increased in score. This included reviews of the effectiveness and progress of mitigating actions.

Membership and attendance for the Quality, Safeguarding and Performance Committee during 2019/20

Name	No. of eligible meetings attended during the year	Comment
Eleri De Gilbert, Lay Member (Chair)	9/9	-
Rosa Waddingham (attending as Chief Nurse from January 2020 and Deputy Chief Nurse prior to this)	7/9	-
Stuart Poynor, Chief Finance Officer	5/7	*Membership commenced August 2019*
Sue Clague, Lay Member	9/9	-
Jasmin Howell, Associate Lay Member	6/9	-
Dr Thilan Bartholomeuz, GP Advisor	2/8	*Membership commenced July 2019*
Dr Catriona Kennedy, GP Advisor	4/7	*Membership commenced August 2019*
Dr Om Sharma, GP Advisor	1/4	*Membership commenced November 2019*
Sarah Carter, Director of Transition Operations	3/7	*Membership commenced August 2019*
Andy Hall, Associate Director of Performance and Information	8/9	-
Mindy Bassi, Chief Pharmacist	7/9	-
Nina Ennis, Associate Director of Joint Commissioning and Planned	7/7	*Membership commenced August 2019*

Name	No. of eligible meetings attended during the year	Comment
Care		
Maxine Bunn, Associate Director of Commissioning, Contracting and Performance – Mental Health, Learning Disabilities and Community Services	7/7	*Membership commenced August 2019*
Danni Burnett, Associate Director of Nursing and Outcomes	8/8	*Membership commenced July 2019*
Dr Margaret Abbott, GP Advisor	2/4	*Membership commenced July 2019 and ceased October 2019*
Elaine Moss, Chief Nurse	2/6	*Membership ceased December 2019.*

Finance and Turnaround Committee - The Finance and Turnaround Committee exists to scrutinise arrangements for ensuring the delivery of the CCG's statutory financial duties, including the achievement of the CCG's Financial Recovery Plan and QIPP targets.

The Committee met on nine occasions during 2019/20, meeting 'in common' with the Finance and Turnaround Committees of the other Nottingham and Nottinghamshire CCGs since June 2019. All meetings were quorate, in accordance with the Committee's terms of reference.

Key activities of the Committee during 2019/20

During the year, the Finance and Turnaround Committee has:

- Reviewed and endorsed the Nottingham and Nottinghamshire CCGs' Joint Finance Strategy 2019/20 – 2023/24; which sets out how resources will be used to support the CCGs' shared objectives and ensure value for money in securing the provision of high quality and safe services.
- Maintained an ongoing focus on the Nottingham and Nottinghamshire CCGs' financial position, both individually and collectively, through the active scrutiny of monthly aligned finance reports. These reports detailed the latest financial position and forecast against delivery of the key statutory financial duties and targets. Monthly variances and emerging trends have been appropriately explored and remedial actions monitored.
- Monitored delivery of the Nottingham and Nottinghamshire CCGs' Financial Recovery Plan, including assurances that robust procedures are in place to ensure the development, implementation and monitoring of the CCGs' QIPP Programme and ensuring any in-year and forecast variance from the plan was suitably addressed.
- Received a monthly Cross Provider Report providing an overview of the financial and activity performance for the Nottingham and Nottinghamshire CCGs with a focus on the key contracts. This included progress on mitigating actions implemented to address key areas of pressure and challenge.
- Received an overview on the Contract Negotiation Strategy 2020/21 and endorsed the approach being taken in relation to negotiating contracts with the key acute, mental health and community providers.

- Scrutinised finance risks from the Corporate Risk Register monthly, with a particular focus on major risks, new risks, and risks that had increased in score. This included reviews of the effectiveness and progress of mitigating actions.

Membership and attendance for the Finance and Turnaround Committee during 2019/20

Name	No. of eligible meetings attended during the year	Comment
Shaun Beebe, Lay Member (Chair)	9/9	-
Amanda Sullivan, Accountable Officer	3/9	-
Stuart Poynor, Chief Finance Officer	8/9	-
Dr Stephen Shortt, GP Advisor	7/8	*Membership commenced July 2019*
Dr Mike O'Neill, GP Advisor	5/8	*Membership commenced July 2019*
Jon Towler, Lay Member	7/9	-
Sue Sunderland, Lay Member	7/9	-
Andrew Morton, Operational Director of Finance	9/9	-
Mark Sheppard, Associate Director of Commissioning (Acute)	7/9	-
Maxine Bunn, Associate Director of Commissioning – Mental Health , Community and Learning Disabilities	7/9	-
Gary Thompson, Director of Special Projects	1/9	-
Andy Hall, Associate Director of Performance and Information	9/9	-
Nina Ennis, Associate Director of Joint Commissioning and Planned Care	7/7	*Membership commenced August 2019*
Dr Gavin Lunn, GP Advisor	4/5	*Membership ceased December 2019*

Other Groups of the Governing Body

During early 2019/20, the Governing Bodies of the Nottingham and Nottinghamshire CCGs' established a **Merger Programme Board** to oversee and scrutinise an effective transition to a single CCG from 1 April 2020, ensuring all elements of the transition have been satisfactorily completed, including the formal establishment of the new CCG and the dissolutions of the current statutory organisations . Membership of the Programme Board comprised of lay, clinical and managerial members of the CCGs, with representation from NHS England.

The Programme Board was created as a 'task and finish group' for this specific purpose and as such met for the last time in March 2020. Going forward, required oversight of any residual areas of the technical merger process will be the responsibility of the new CCG's Audit and Governance Committee; with assurances on the realisation of the benefits of merger being incorporated into the appropriate committees' terms of reference as key duties for 2020/21.

The Governing Body has also established two advisory committees:

The Clinical Effectiveness Committee - The Clinical Effectiveness Committee is not a formal decision-making committee of the Governing Body, but exists to provide advice in relation to clinical policies, clinical pathways and referral guidelines, with the aim of meeting the health needs of the CCG's population within defined resources, whilst reducing unwarranted clinical variation and improving consistency of pathways. The membership of the meeting is comprised of GP Advisors, a secondary care doctor, public health representatives and members of the CCG's Senior Management Team. Meetings have been held 'in common' with the Clinical Effectiveness Committees of the other Nottingham and Nottinghamshire CCGs throughout 2019/20.

The Public and Patient Engagement Committee - This committee ensures that there is a clear mechanism in place for the views of patients, carers, community groups and the public to be fed into the decision-making processes of the CCG. The Committee is comprised of lay members, members of the CCG's Communications and Engagement Team and representatives from the voluntary and community sector and local communities and networks.

Emergency governance and decision-making arrangements

In March 2020, the Governing Body agreed interim governance arrangements to apply during the period of emergency response to the Covid-19 pandemic. These were then formally approved at the inaugural meeting of the new NHS Nottingham and Nottinghamshire CCG's Governing Body in early April 2020. The emergency governance arrangements were primarily designed around two key factors:

- To enable rapid, robust decision-making on urgent issues directly relating to the Covid-19 outbreak and its management; and
- To ensure that business-critical decisions not directly relating to the Covid-19 outbreak could continue to be made.

In March 2020, the scheduled meetings of the Quality, Safeguarding and Performance Committee and the Finance and Turnaround Committee were not held due to the CCG's requirement to focus its resources on its emergency response to the COVID-19 pandemic. However, weekly briefing sessions were established for Governing Body members to be kept abreast of key issues regarding the CCG's management of the COVID-19 outbreak; in particular, relating to finance; transformation; quality and statutory compliance; workforce; key risks and mitigations; and communications.

The arrangements confirmed that the scheduled meetings of NHS Nottingham and Nottinghamshire CCG's Audit and Governance Committee would be held virtually to enable scrutiny and approval of the Nottingham and Nottinghamshire CCGs' 2019/20 Annual Reports and Accounts.

Governance arrangements prior to alignment across the Nottingham and Nottinghamshire CCGs

As discussed in the introduction of this Governance Statement, the CCG had established joint governance arrangements with the Greater Nottingham CCGs in 2018/19, which remained in operation until May 2019. These arrangements included the following:

Information Governance, Management and Technology (IGM&T) Committee – This Committee was established in 2018 as a joint committee of the Nottingham and Nottinghamshire CCGs' Governing Bodies to oversee and scrutinise the information governance, business intelligence and information technology arrangements of the six CCGs. Its membership comprised of lay, clinical and managerial members of the CCGs; including the Caldicott Guardian and Senior Information Risk Owner.

The Committee met once during 2019/20 before being formally disestablished. At this meeting, the Committee received the year-end information governance assurance report and a Data Security and Protection Toolkit Submission Outcome Report; noting that the CCGs had demonstrated compliance against all mandatory assertions for the previous year.

Greater Nottingham Joint Commissioning Committee – This Committee existed to exercise, to the extent permitted under s.14Z3 of the NHS Act 2006 (as amended), the commissioning functions of the four Greater Nottingham CCGs. A formal delegation agreement was in place to set out the functions delegated to the joint committee. These were:

- Arranging for the provision of health services to secure improvement in the physical and mental health of the population; and the prevention, diagnosis and treatment of illness.
- Exercising commissioning related functions, including improving the quality of services, reducing inequalities, patient choice, promoting innovation and integration, and public involvement and consultation.

The joint committee held its meetings in public, in line with the CCGs' commitment to openness and accountability. Its membership comprised of lay, clinical and managerial members drawn from employees and appointees of the four Greater Nottingham CCGs and had an independently appointed chair.

The Committee was formally disestablished in May 2019 having met twice at the start of the year. At these meetings, the Committee scrutinised its routine reports on finance, performance and quality; as well as continuing to receive thematic reviews aligned to strategic priorities.

The Greater Nottingham Joint Commissioning Committee was authorised to appoint sub-committees for any agreed purpose that it is felt would be more effectively undertaken by a sub-committee. These included:

Quality and Performance Committee – This Committee existed to oversee a range of quality functions, including the requirement to improve the quality of commissioned services. It also has delegated responsibility for overseeing and managing performance against the standards set out in the NHS Constitution and any other nationally set, or locally agreed, performance indicators. Membership was comprised of lay, clinical and managerial members drawn from employees and appointees of the four Greater Nottingham CCGs.

The Committee met twice during 2019/20 and received assurances on the performance and quality of commissioned services, the organisation's arrangements for meeting the Public Sector Equality Duty (PSED) of the Equality Act 2010 and the work being performed to meet responsibilities in relation to research.

Finance Committee – This Committee had delegated responsibility for overseeing and managing all financial matters relating to the commissioning of services in the Greater Nottingham area, including the development and approval of the Greater Nottingham Financial Recovery Plan. Membership was comprised of lay, clinical and managerial members drawn from employees and appointees of the four Greater Nottingham CCGs.

The Committee met twice during 2019/20 and received routine reports covering the overall financial position, finance risks, statutory financial duties and Financial Recovery Plan delivery.

Attendance at these meetings was as follows:

Committee	Average Attendance of Members during 2019/20	Annual % of quorate meetings*
Greater Nottingham Joint Commissioning Committee	70%	100%
IGM&T Committee	55%	100%
Quality and Performance Committee	78%	100%
Finance Committee	68%	100%

**Appropriate deputies were were in attendance at these meetings when apologies were given by members.*

In addition to the committees described above, a **Clinical Commissioning Executive Group** was also established to make recommendations to the Joint Committee on commissioning strategies and plans. The Group also evaluated, scrutinised and quality assured the clinical and cost effectiveness of new investments, recurrent funding allocations and decommissioning and disinvestment proposals, with delegated authority to make decisions in accordance with the CCGs' Schedule of Delegated Authority. The Group met in April and May of 2019/20, before being formally disestablished.

Partnership Boards

The CCG's key health and social care partnership fora during 2019/20 have included:

- **The Health and Wellbeing Board** – The Nottinghamshire County Health and Wellbeing Board is a statutory partnership, set up to lead and advise on work to improve the health and wellbeing of the population of Nottinghamshire County and specifically to reduce health inequalities. The Board's membership includes members of Nottinghamshire County Council, the Local Police and Crime Commissioner, the five Nottingham County CCGs and the local Healthwatch. The Board leads on the development of the Joint Strategic Needs Assessment for Health and Social Care, which identifies the issues that need addressing across a broad range of health related behaviours, vulnerable groups and health and wellbeing outcomes and has responsibility for the delivery of the Joint Health and Wellbeing Strategy 2018-22. Further details on the Board and its work can be found at https://www.nottinghamshire.gov.uk/care/health-and-wellbeing/health-and-wellbeing-board.
- **Nottingham and Nottinghamshire Integrated Care System (ICS) Board** – The ICS Board is comprised of the senior leaders of all the health and care organisations in Nottingham and Nottinghamshire. The role of the Board is to provide leadership for, and delivery of, the overarching strategy and outcomes framework for the Nottingham and Nottinghamshire Integrated Care System.
- **Nottinghamshire County Safeguarding Children's Partnership** – This Board is a statutory partnership which ensures that services, agencies, organisations and the community are protecting children from

harm and safeguarding their wellbeing with a vision that 'children and young people in Nottinghamshire grow up in a safe and stable environment and are supported to lead healthy, happy and fulfilling lives.

- **Nottinghamshire County Safeguarding Adults Board** – This Board is a statutory partnership. Its role is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out within the Care Act that have been or who are at risk of being abused.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, compliance with relevant principles of the Code is considered to be good practice.

This Governance Statement is intended to demonstrate how the CCG had regard to the principles set out in the Code that are considered appropriate for CCGs during the financial year ending 31 March 2020, and up to the date of signing this statement.

Discharge of Statutory Functions

In light of the recommendations of the 2013 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 clearly allocated to lead directors, who 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

A fundamental element of good governance is ensuring a clear and integrated approach to risk management. As such; the Nottingham and Nottinghamshire CCGs' joint Risk Management Policy was prioritised for early development and approval in 2019/20 to ensure robust risk reporting and management arrangements were established, along with defined ownership of risk at all levels. The Policy clearly sets out the CCG's shared risk architecture and describes how strategic and organisational risks will be identified, managed and monitored in a consistent, systematic and co-ordinated manner.

Principal risks to the CCG's joint strategic objectives are monitored through the Governing Body's Assurance Framework; thus providing the CCG's Governing Body's with confidence that their decisions are supported by an internal control system that is functioning effectively.

Organisational risks arising from the CCG's day-to-day activities are monitored through the Corporate Risk Register; a live document, underpinned by a robust risk assessment and evaluation process. The Corporate Risk Register is recognised as being both reactive and proactive; reactive in ensuring that sufficient and timely management actions are being taken and that adequate resource to do so is in place, and proactive in anticipating further related risks and enabling the organisation to review where its internal controls may need to be strengthened.

The following key elements are explicitly identified within the Risk Management Policy as being essential for its successful implementation and in ensuring a risk aware culture:

- **Governing Body commitment to, and leadership of, the total risk management function** – This is demonstrated by Governing Body approval and ownership of the Risk Management Policy and the ongoing review of strategic and major organisational risks through regular and consistent Governing Body reporting.
- **Having defined individual roles and responsibilities in relation to risk management** – As the Accountable Officer, I am ultimately responsible for risk management within the CCG; however, all members of my Executive and Senior Leadership Team have a specific duty to ensure that appropriate mechanisms are in place within their areas of responsibility for identifying and highlighting new and emerging risks.
- **Embedding risk identification within business decision making processes** – Wide-spread employee participation in risk management processes is supported by ongoing support from in-house officers with specific risk management expertise. Risks are identified through an assortment of means, such as horizon scanning, external and self-assessments, formal risk assessments and during both committee and routine team meetings. How risks may impact on the public and other stakeholders is considered at the initial risk identification stage and then in more depth by senior managers to ensure that the correct approach to any communication is taken.

  Examples of how risk identification has been embedded within the CCG include:

  - Routine consideration of risk within planning, procurement and contract management arrangements.
  - Routine completion of equality, quality and privacy impact assessments as an integral part of service planning and policy development.
  - By fostering an open, supportive and 'fair blame' culture within the CCG in relation to incident and near miss reporting.
  - The CCG has a 'Freedom to speak up Policy' to encourage employees to highlight concerns; along with an independent 'Freedom to Speak up Guardian' whom staff can approach in confidence.
  - All Governing Body and committee papers being presented with identified risk implications and the actions being taken to mitigate these.
  - The Governing Body and its committees receiving regular Risk Reports and having 'risk identification' as a standing item on their agendas to ensure any risks identified during the course of meetings are captured, and transferred to the Corporate Risk Register, where appropriate.
- **Having standardised mechanisms in place to systematically assess, control and minimise** risk – All risks are assessed by defining qualitative measures of impact and likelihood, and scored methodically using the organisational risk scoring matrix. Risks and risk scores are initially subject to challenge from senior managers to ensure that the full consequences of the risk have been considered in relation to its actual impact on the CCG and to ensure that adequate resources are in place to enable effective risk mitigation. Risks are then prioritised for management action dependent on the current (residual) risk score.

- **Having effective reporting and scrutiny mechanisms for all risks, incidents and near misses** – The CCG is committed to the development of a learning culture and in ensuring that lessons learnt are shared and measures to prevent reoccurrence are promptly applied. All committees of the Governing Body are responsible for monitoring risks that relate to their terms of reference. All major operational risks are reported at every meeting of the Governing Body.
- **Ensuring the effectiveness of the Risk Management Policy** – The Audit and Governance Committee has delegated responsibility for monitoring how the framework is being implemented and is charged with providing assurance to the Governing Body on the effectiveness of the risk management arrangements. The Audit and Governance Committee is supported by the CCG's internal and external auditors in discharging this responsibility.

The Risk Management Policy was developed in recognition that well-managed risk taking can contribute positively to organisational performance, allowing for innovation and driving improvements. A fundamental aspect of the framework is the defined risk appetite, which is considered from the following two perspectives:

- **Risk taking** – which acknowledges where the CCG has the resources, skills and control environment in place to be innovative in pursuit of its strategic objectives; and
- **Risk tolerance** – which clearly sets out the boundaries of risk that the Governing Body is willing to accept.

Good risk management is not just about being risk averse, it is also about recognising the potential for events and outcomes to result in opportunities for improvement, as well as threats to success. A 'risk aware' organisation encourages innovation in order to achieve its objectives and exploit opportunities and can do so in confidence that risks are being identified and controlled by senior managers. With this in mind, the Nottingham and Nottinghamshire CCGs' Governing Bodies have agreed to the following joint risk appetite statement:

The Governing Bodies of the Nottingham and Nottinghamshire CCGs recognise that our long-term sustainability, and ability to improve quality and health outcomes for our populations, depends on the achievement of our strategic objectives and that this will involve a willingness to take and accept risks. It may also involve taking risks with our strategic partners in order to ensure successful integration and better health services for the people of Nottingham and Nottinghamshire.

The CCGs will endeavour to adopt a mature[1] approach to risk-taking where the long-term benefits could outweigh any short-term losses, in particular when working with strategic partners across the Nottingham and Nottinghamshire system. However, such risks will be considered in the context of the current environment, in line with the CCGs' risk tolerance and where assurance is provided that appropriate controls are in place and these are robust and defensible.

The CCGs will avoid[2] risks that could impact negatively on the health outcomes and safety of patients or in meeting the legal requirements and statutory obligations of the CCGs. We will also seek to minimise[3] any undue risk of adverse publicity, risk of damage to the CCGs' reputations and any risks that may impact on our ability to demonstrate high standards of probity and accountability.

In view of the changing landscape, the CCGs' risk appetite will not necessarily remain static. The

CCGs' Governing Bodies will have the freedom to vary the amount of risk we are prepared to take depending on the circumstances at the time. It is expected that the levels of risk the CCGs are willing to accept are subject to regular review.

[1] *Good Governance Institute Risk Appetite for NHS Organisations – definition of 'mature' is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.*
[2] *Good Governance Institute Risk Appetite for NHS Organisations – definition of 'avoid' is avoidance of risk and uncertainty is a key organisational objective.*
[3] *Good Governance Institute Risk Appetite for NHS Organisations – definition of 'minimal' is preference for ultra-safe delivery options that have a low degree of inherent risk.*

Capacity to Handle Risk

The CCG ensures its ongoing capacity to handle risk in a number of ways. The Risk Management Policy is owned by the Governing Body and its members provide leadership to the total risk management function. However, risk is considered to be the business of all staff, and managers are expected to lead by example by ensuring that risk management is acknowledged and embedded throughout the organisation as a fundamental part of our approach to good integrated governance.

All members of the Executive and Senior Leadership Team are accountable for the effective management of risk within their areas of responsibility. This includes ensuring that appropriate controls are in place and that appropriate risk identification and mitigating actions are progressed and monitored.

Risk awareness is a key element of the organisation's approach to risk management, ensuring that all staff understand and are able to discharge their roles and responsibilities in relation to risk. This approach is led by officers with in-house expertise in risk management and includes highlighting the need for risk assessments and explanation of, and subsequent support through, the risk management process.

Risk Assessment

The main risks identified by the CCG and monitored through the Corporate Risk Register during 2019/20 related to:

- **The potential impact of an ongoing period of organisational change due to the alignment of the six Nottingham and Nottinghamshire CCGs.** As a result of the restructuring process undertaken throughout 2019/20, it was identified that the period of change and uncertainty could impact in the following ways:
  - Staff could be become disengaged which could lead to low morale and reduced productivity.
  - Staff turnover could increase, leading to the loss of organisational memory.

  Whilst a robust organisational change process was in place during 2019/20, the likelihood of the risk has remained high given a staff restructuring exercise had only recently concluded across the Greater Nottingham CCGs in 2018/19. The Governing Bodies across these six CCGs reaffirmed their commitment to their combined workforce and a number of actions to increase staff communication and engagement have been implemented.
- **The potential for poor patient experience as a result of delays in patient assessment within the**

Accident and Emergency Department at Nottingham University Hospitals NHS Trust (NUH). The Trust has faced increased levels of demand within its A&E Department throughout 2019/20. Despite actions taken across system partners, the average number of daily ED admissions has steadily risen, resulting in increased waits for patients. Quality intelligence indicated low levels of patient harm resulting from these delays, enabling the focus of the risk to be changed from patient safety to patient experience in year.

The CCG noted that performance significantly improved during March 2020; correlating with social distancing requirements established in response to the Covid-19 pandemic. The likelihood of the risk was reduced accordingly.

- **The potential for non-delivery of the financial plan, due to deterioration in the underlying positions of the Nottingham and Nottinghamshire CCGs and unidentified or undeliverable QIPP schemes.** The Nottingham and Nottinghamshire CCGs have faced a significant financial challenge throughout this year and a risk was identified during April 2019, which related to the potential for non-delivery of the 2019/20 financial plan. The risk score was increased in-year in response to higher than expected levels of acute activity, non-delivery of QIPP schemes and the system-wide financial position. Mitigating actions have been a key focus of the Finance Committee at each of its monthly meetings.

  In response to the Nottingham and Nottinghamshire CCGs each forecasting to meet their statutory financial duties for 2019/20, the likelihood of the risk reduced in the period up to year-end; at which time, a correlating new financial risk was identified regarding the potential for non-delivery of the 2020/21 financial plan.

- **The potential for workforce capacity with General Practice to significantly reduce, impacting the sustainability of some GP Practices.** The Nottingham and Nottinghamshire CCGs identified a risk regarding workforce capacity within primary care. Practices have recognised the need to adapt workforce models to enable the sustained delivery of core services, whilst also ensuring sufficient capacity to deliver system and transformation requirements. However, lack of pace of change may present a risk that the CCGs' population access needs are not met, adversely impacting patient experience and/or outcomes.

  The introduction of Primary Care Networks (PCNs) during 2019/20 has contributed to the management of this risk, alongside implementation of the ICS Primary Care Workforce Strategy. Short-term mitigations, such as recruitment, training and development activities are in place, as well as, more recently, the introduction of local GP ‘hubs’ and Clinical Management Centres in response to the Covid-19 pandemic.

- **The potential for poor patient experience and patient safety concerns at Nottinghamshire Healthcare NHS Foundation Trust (NHCT) arose during 2019/20.** This risk was identified in October 2019, following the outcome of Care Quality Commission (CQC) inspections being published. The CCGs identified a lack of assurance regarding the culture and leadership at NHCT in response to the issues identified.

  The CCG’s Quality, Safeguarding and Performance Committee commissioned a number of ‘deep dives’ reviews into the Trust. A full risk scoping exercise was also undertaken between the CCG, CQC and Regulators to determine whether appropriate actions have been taken in response to the concerns identified. Governing Body and Committee level assurance requirements were increased during 2019/20.

Monitoring and support continues throughout the Covid-19 emergency response period and the delivery of high quality of services at NHCT will be a key priority for 2020/21.

Performance 'Risks'

The non-delivery of performance standards is not automatically assumed to be risks; however, areas of consistent under-performance are assessed to ensure that any risks of a detrimental impact on health outcomes, patient safety and patient experience are identified in a timely manner. During 2019/20, the main performance concerns identified related to:

- **Performance against the Emergency Department waiting time standards** – Nottingham University Hospitals NHS Trust (NUH) has been taking part in the national pilot of the new emergency care standards since May 2019, meaning that it is no longer required to report against the 4-hour waiting time standard. However, the former four-hour waiting time standard has consistently not been achieved by the Trust since June 2015 and the number of 12-hour 'decision to admit to admission' breaches has significantly increased in year. The vast majority of Greater Nottingham residents use the Emergency Department at Nottingham University Hospitals NHS Trust (NUH) when they need to access urgent and emergency care. Performance data indicates that the average number of daily Emergency Department admissions has steadily risen throughout the year, resulting in increased waits for patients.

  The ability of the Trust to respond depends upon a number of factors. These include effective patient flow, a properly staffed department and a reliance on social workers and community health teams to assess and arrange placements, or support in the home, for discharged patients who have ongoing health and social care needs.

  This has been a key focus for us in 2019/20 but despite the work that we have taken forward with partners to deliver improvements across the urgent care system, we have been unable to improve performance throughout most of the year. Performance in relation to Emergency Department waiting times will continue to be a key focus during 2020/21.

- **Performance against the Cancer: 62 day urgent referral to treatment standard** – Whilst this standard has been achieved for some cancers this year; performance across more complex specialties has meant that the standard has not been delivered overall during 2019/20. There is a range of national and local issues that have impacted performance, including continued growth in referrals, late referrals from surrounding cancer units, and difficulties recruiting to vacant consultant posts within individual tumour sites. The three main areas of pressure are within Urology, Lower GI and Head & Neck; the transfer of Treatment Centre activity has worsened the backlog in skin and Lower GI tumour sites.

  Recovery action plans are in place across all tumour sites and actions specific to particular cancers include the use of private sector capacity (where appropriate) to reduce waiting times for treatment and diagnostics. In addition, all patients that breach 104 days have root cause analysis and harm reviews completed. Performance in relation to all cancer targets is monitored by the CCG's Quality, Safeguarding and Performance Committee.

As at the time of finalising this governance statement, risk management has been identified as a critical function within the CCG's Business Continuity Plan and incident management response with regard to the current COVID-19 pandemic. We have established a specific Risk and Issues Log for this purpose, which reflects the potential risks identified and issues currently being managed. Risks have also been included on our Corporate Risk Register to ensure appropriate oversight and scrutiny, as per the risk management arrangements described in this report. These include potential risks relating to:

- Excess deaths.
- Challenges regarding restoration and re-setting of services.
- The impact of new Health and Safety and Infection, Prevention and Control (including PPE) requirements.

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 risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

The CCG has established a wide range of monitoring procedures in order to ensure that the organisation's system of internal control continues to operate effectively and that controls do not deteriorate over time. This includes contract monitoring arrangements and the work of a range of operational steering groups. It also includes the work of the Governing Body and its committees, particularly in relation to the scrutiny of the Governing Body Assurance Framework and progress against any gaps in controls and assurances that have been identified.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The organisation's arrangements for managing conflicts of interest have been independently reviewed by our internal auditors and provided an opinion of **significant assurance**.

Data Quality

The CCG recognises that good quality data is essential for the effective commissioning of services and underpins the delivery of high quality patient care. Data quality is central to the organisation's ongoing ability to meet its statutory, legal and financial responsibilities.

All of the organisation's main providers are required under their contract to have good quality data that is compliant with national standards and we undertake validation processes to ensure data is complete,

accurate, relevant and timely. We have responsibility for monitoring data quality of the services we commission and this is achieved through formal contract monitoring arrangements.

All committees of the Governing Body are responsible for assuring themselves of the quality of data informing their decisions, and this duty is built in to the specific committee terms of reference as necessary. This includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular person-identifiable information. It is supported by the Data Security and Protection Toolkit (DSPT); a self-assessment tool which is completed and submitted annually providing assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect personal and corporate information. The CCG has established an Information Governance Management Framework and a comprehensive suite of information governance policies, which outline the mechanisms in place to ensure that risks to confidentiality and data security are effectively managed and controlled. The roles of Caldicott Guardian and Senior Information Risk Owner (SIRO) have been assigned to appropriate members of the organisation's Executive Team. The CCG has also appointed a Data Protection Officer in line with the requirements of the EU General Data Protection Regulation (GDPR).

The Audit and Governance Committee is responsible for scrutinising the CCG's compliance with legislative and regulatory requirements relating to information governance and the extent to which associated systems and processes are effective and embedded. The Committee is supported in the achievement of these duties by an Information Governance Steering Group, which has been established to operationally drive forward the information governance agenda.

All staff are required to undertake the latest annual information governance training and have provided staff with a series of briefings to ensure they are aware of their information governance roles and responsibilities in relation to confidentiality, data protection and information security. There are processes in place for incident reporting and investigation of serious information incidents. We continue to develop information risk assessment and management procedures and an action plan has been established in order to fully embed an information risk culture throughout the organisation.

For 2019/20, we have completed a self-assessment against all mandatory assertions contained with the DSPT and have confirmed a satisfactory level of compliance, which has been independently reviewed and corroborated by our internal auditors. The CCG will submit its self-assessment by 30 June 2020, ahead of the nationally deferred timeframe of 30 September 2020, which was announced in recognition of the COVID-19 national emergency. There have been no serious incidents relating to data security during the year.

We will continue to develop information governance processes and procedures in line with the requirements of the law, the Data Security and Protection Toolkit and the national information governance agenda.

Business Critical Models

In line with the best practice recommendations of the 2013 MacPherson review; I can confirm that the CCG has an appropriate framework and environment in place to provide quality assurance of business critical models.

Third party assurances

I also receive assurance through reports from audits performed on other organisations that provide services to the CCG. For 2019/20, the CCG has received reports relating to:

- NHS Shared Business Services (SBS) Limited (employment services)
- NHS Shared Business Services (SBS) Limited (financial services)
- NHS Digital (processing of payments to General Practice)

The above reports have concluded that the respective services have designed and operated suitably effective controls for the period of 2019/20; however, a small number of exceptions have been noted with regard to the audits of SBS (employment services) and NHS Digital. The CCG is satisfied with the management responses provided in relation to these and the actions implemented to address any issues.

The CCG has also noted that whilst no exceptions were found as part of the sample testing for the SBS (financial services) audit, the closure of offices in India in March 2020 (as a result of the COVID-19 pandemic) overlapped with the testing timetable. Whilst this meant that the controls could only be tested up until 31 January 2020, no exceptions were found during this period and the organisation has confirmed that the tested controls remained in operation, and will continue to do so, until normal business practices are able to resume.

Control Issues

There have been no significant control issues identified during 2019/20.

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

The CCG's Governing Body has oversight of the appropriateness of the organisation's arrangements to exercise its functions effectively, efficiently and economically, and as Accountable Officer, I have overall executive responsibility for the use of resources.

The following key processes and review and assurance mechanisms have been established within the organisation in order to ensure that we meet our statutory duty to act effectively, efficiently and economically:

- Clear Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions have been set out to ensure proper stewardship of public money and assets. Clear policies in relation to the required standards of business conduct are also in place.
- A Procurement Policy is in place, which sets out the organisation's approach for establishing contracts that provide value for money in line with the principles of good procurement practice. The

policy clearly requires the CCG to ensure the delivery of improved efficiency and effectiveness in the provision of healthcare and non-healthcare services. The Audit and Governance Committee scrutinises all instances where requirements for formal competitive tendering or competitive quotations have been waived.

- Robust financial procedures and controls and effective financial management and financial planning arrangements have also been established, which are set out within the organisation's Standing Financial Instructions. The Chief Finance Officer provides monthly reports to every meeting of the Governing Body on financial performance, including performance against the organisation's statutory financial duties.
- Robust procedures have been implemented to control the development, implementation and monitoring of the CCG's local Quality, Innovation, Productivity and Prevention (QIPP) Programme, ensuring that all QIPP schemes are embedded within the organisation's operational commissioning plans. This work is overseen by the Finance and Turnaround Committee, which then provide assurance to the Governing Body in terms of in-year progress, advising on any significant risks that may affect the organisation in delivery of its QIPP programme.
- During the year the CCG introduced a recovery plan to support delivery of its financial position. This built on the controls and structure in place to deliver the CCG's QIPP Programme. As a consequence this process was overseen by the Finance and Turnaround Committee, which then provided assurance to the Governing Body in terms of in-year progress.
- A Remuneration and Terms of Service Committee is in place with responsibility for reviewing the remuneration and terms of service for key senior leaders within the CCG. Suitable arrangements have been established to ensure that no member of the Committee is involved in discussions and decisions about their own remuneration.
- The CCG has clear internal audit, external audit and counter fraud arrangements, which provide independent assurance to the organisation on a range of systems and processes that are designed to deliver economy, efficiency and effectiveness, including the organisation's annual accounts and reporting process.
- Financial risk pooling arrangements are in place, which ensures that the financial risks associated with high cost patients are shared across the six CCGs.

Delegation of functions

The CCG's Governing Body has approved the following external delegation of functions:

- On 1 April 2018, the four Greater Nottingham CCGs established the Greater Nottingham Joint Commissioning Committee and a formal delegation agreement was in place that set out the functions delegated to it. Whilst the decisions made by the joint committee were binding on the individual CCGs, they remained accountable for meeting their individual statutory duties and each CCG retains liability in relation to the exercise of the Delegated Functions. The joint committee was disestablished early in 2019/20 as part of the alignment of new governance arrangements across the Nottingham and Nottinghamshire CCGs.
- On 1 April 2015, the CCG took on responsibility for a number of delegated functions relating to the commissioning of primary medical services under a formal Delegation Agreement with NHS England.

In line with the Delegation Agreement, the CCG's Primary Care Commissioning Committee acts as the corporate decision-making body for the management of the delegated functions. The Committee is accountable to the Governing Body, which is fulfilled through the submission of its minutes.

- The CCG is currently party to two Section 75 Partnership Agreements with Nottinghamshire County Council relating to the Better Care Fund (BCF) and Integrated Community Equipment Loan Service (ICELS). Section 75 partnership agreements are legally provided by the NHS Act 2006 and allow budgets to be pooled between NHS organisations and local authorities. These are partnerships of equal control, whereby one partner can act as a 'host' to manage the delegated functions and pooled budgets, however both partners remain equally responsible and accountable for those functions being carried out in a suitable manner. Nottinghamshire County Council is acting as host in relation to the BCF Partnership Agreement and overall strategic oversight responsibility sits with the Nottinghamshire Health and Wellbeing Board.

Counter fraud arrangements

The CCG has established arrangements to prevent fraud, bribery and corruption, and to deal with it should it occur. An accredited Counter Fraud Specialist (CFS) is contracted to undertake counter fraud work proportionate to the CCG's identified risks. This work is delivered through the production and implementation of an organisational fraud, bribery and corruption risk assessment and work plan, developed in line with national standards.

The Chief Finance Officer has executive responsibility for the CCG's counter fraud arrangements, with the Audit and Governance Committee taking an oversight and scrutiny role in this area. In May 2020, the CCG submitted its completed self-review tool for the 'Standards for NHS Commissioners: Fraud, Bribery and Corruption' to the NHS Counter Fraud Authority, with an overall score of 'Green' in relation to the organisation's compliance with the standards.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit Opinion concluded that:

*"I am providing an opinion of **Significant Assurance** that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently"*

Whilst still separate statutory bodies, the Internal Audit Plan for 2019/20 was developed in recognition of the joint arrangements in place across the Nottingham and Nottinghamshire CCGs and all internal audit work was performed in consideration of both of these factors. During the year, internal audit issued the following reports:

Audit Report	Audit Objectives	Level of Assurance
Governance and Risk Management Ref 1920/NNCCGS/06	The purpose of this review was to evaluate the CCGs' overarching joint arrangements for governance and risk management.	Significant
Policy Management Ref 1920/NNCCGS/05	This review considered the governance arrangements in place to support the effective development and management of organisational policies.	Significant
Conflicts of Interest Ref 1920/NNCCGS/04	The purpose of this review was to evaluate the design and effectiveness of the Greater Nottingham CCGs' joint arrangements for managing conflicts of interest and gifts and hospitality.	Significant
Quality, Innovation, Productivity and Prevention (QIPP) Plans Ref 1920/NNCCGS/03	The overall objective of this review was to assess the adequacy of the CCGs' arrangements for managing their QIPP programme and also arrangements to embed a culture to support QIPP delivery.	Significant
Financial Management Arrangements	The purpose of this audit was to determine whether a robust, efficient and effective control environment is in place in relation to the CCG's financial management arrangements and the key financial systems tested. This included processes in place to ensure the integrity of data held on the general ledger and the organisation's financial monitoring and reporting arrangements.	Significant
Delegated Primary Care Medical Functions	This audit was focussed on determining whether a robust, efficient and effective control environment is in place in relation to commissioning and procurement of primary medical care services (as detailed within the Delegation Agreement between the CCG and NHS England).	Substantial*
Data Quality Framework	This review was designed to assess the arrangements in place to support data quality across a number of areas, including governance, policies, systems and processes and workforce skills.	Significant
Data Security and Protection Toolkit	The objective of this review was to provide an opinion on the framework established by the CCG to develop, deliver, maintain and monitor its data security and protection arrangements.	Significant

**'substantial' is the opinion specified by NHSE England for the audit of primary care commissioning arrangements.*

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 and the Executive and Senior Leadership Team within the CCG 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.

The Governing Body Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its strategic objectives have been reviewed.

I have been advised on the implications of the result of my review by the Governing Body, the Audit and Governance Committee and other committees as necessary and plans to address any weaknesses and to ensure continuous improvement of the system are in place.

Previous sections of this Governance Statement set out our approach to reviewing the ongoing effectiveness of the system of internal control, particularly in relation to the role of the Governing Body and its committees. I have also been informed by the broad range of internal and external assurances received by the CCG during the year as set out within the Governing Body Assurance Framework.

In addition to the above, I am also informed by the outcome of the 'NHS Oversight Framework' process operated by NHS England and NHS Improvement. The process is structured around a number of metrics, including leadership and workforce and finance and use of resources, which demonstrate how the CCG is performing.

Conclusion

My review of the effectiveness of governance, risk management and internal control has confirmed that:

- The CCG has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.
- There have been no significant control issues during 2019/20.

Remuneration and Staff Report

Remuneration Report

Remuneration and Terms of Service Committee

This statutory committee has been established to make recommendations to the Governing Body in relation to the remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it; and any determinations about allowances payable under pension schemes established by the CCG. In addition, the Governing Body has delegated a number of functions to the Committee relating to the Governing Body's duty to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance. These duties include approving all human resources policies for the CCG and overseeing compliance with the requirements set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, as necessary.

The Committee is comprised entirely of lay members from our Governing Body, so its remit excludes considerations in relation to lay member remuneration, fees and allowances (these are approved by non-conflicted members of the Governing Body).

The Committee met eight times during the year. Members of the Committee are as follows:

- Jon Towler (Chair)
- Sue Sunderland
- Sue Clague
- Eleri de Gilbert

Further details on the work of the Remuneration and Terms of Service Committee during 2019/20 are provided in the *Governance Statement* section of this report.

Policy on the remuneration of senior managers

For the purpose of this report, senior managers are defined as being 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group'. This means those who influence the decisions of the organisation as a whole, rather than the decisions of individual directorates or departments. As such, where this report discusses 'Senior Managers', we are referring to members of our Governing Body.

Our Remuneration and Terms of Service Committee has responsibility to review and make recommendations with regard to senior manager remuneration packages (excluding those of the members, as described in the previous section). For managerial roles, this is done on appointment in accordance with national guidance *Clinical Commissioning Groups: Remuneration guidance for Chief Officers (where the senior manager also undertakes the accountable officer role) and Chief Finance Officers* published by NHS England in 2012 and *Clinical Commissioning Group Guidance on Senior Appointments including Accountable Officers* published by NHS England in 2015. Remuneration for clinicians is commensurate with the responsibilities of their roles and sufficient to cover backfill costs

incurred by their employing organisations. Benchmarking data is also used from neighbouring CCGs and those in national peer groups.

The Committee reviews senior managers' pay on an annual basis, this includes consideration of both basic pay awards and cost of living increases. Our senior managers' pay is not subject to any Performance Related Pay considerations.

No senior managers of the CCG are paid more than £150,000 per annum.

The remuneration of the CCG's lay members is set in line with NHS Improvement's remuneration structure for NHS provider chairs and non-executive directors.

Standard contracts have been established for all senior manager posts, which differ depending on whether the post is appointed for a term of office (as is the case for some Governing Body roles, such as our lay members) or a permanent employment. Both contracts have standard terms and conditions, notice periods and termination payments, based on NHS Terms and Conditions of Service where relevant. Standard notice periods are currently three months.

Remuneration of Senior Managers 2019/20 (subject to audit)

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Dr Stephen Shortt – Chair and Clinical Leader	80-85	0	0	0	0	80-85
Amanda Sullivan – Accountable Officer	15-20	0	0	0	12.5-15	30-35
Jonathan Bemrose – Chief Finance Officer (to 30 April 2019)	0-5	0	0	0	0	0-5
Stuart Poynor – Chief Finance Officer (from 1 May 2020)	15-20	0	0	0	0	15-20
Professor Chris Hawkey – Secondary Care Doctor (to 30 June 2019)	0-5	0	0	0	0	0-5
Dr Adedeji Okubadejo – Secondary Care Doctor (from 1 July 2019)	0-5	0	0	0	0	0-5
Elaine Moss – Chief Nurse (to 31 December 2019)	10-15	0	0	0	5-7.5	15-20
Rosa Waddingham – Chief Nurse (from 1 January 2020)	0-5	0	0	0	12.5-15	15-20
Lucy Dadge – Chief	10-15	0	0	0	2.5-5	15-20

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Commissioning Officer (from 1 July 2019)						
Dr Jeremy Griffiths – GP Representative (to 30 June 2019)	5-10	0	0	0	0	5-10
Dr Gavin Derbyshire – GP Representative (to 30 June 2019)	0-5	0	0	0	0	0-5
Ian Blair – Lay Member (to 30 June 2019)	0-5	0	0	0	0	0-5
Susan Clague – Lay Member	0-5	0	0	0	0	0-5
Jon Towler – Lay Member (from 1 July 2019)	0-5	0	0	0	0	0-5
Susan Sunderland – Lay Member (from 1 July 2019)	0-5	0	0	0	0	0-5
Eleri De Gilbert – Lay Member (from 1 July 2019)	0-5	0	0	0	0	0-5

*****_Note: Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Officer through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual._

The salaries of the members below were allocated over a number of CCGs. The allocation to NHS Rushcliffe CCG is shown above. Their total remuneration is shown below (subject to audit):

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Amanda Sullivan – Accountable Officer	150-155	0	0	0	105-107.5	255-260
Jonathan Bemrose- Chief Finance Officer (to 30 April 2019)	10-15	0	0	0	0	10-15
Stuart Poynor – Chief Finance Officer (from 1 May 2019)	125-130	0	0	0	0	125-130
Rosa Waddingham – Chief Nurse (From 1 January 2020)	20-25	0	0	0	102.5-105	125-130
Lucy Dadge, Chief Commissioning Officer (from 1 July 2019)	120-125	0	0	0	30-32.5	150-155
Elaine Moss, Chief Nurse (to 31 December 2019)	90-95	0	0	0	50-52.5	145-150

Remuneration of Senior Managers 2018/29

2018/19 information

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100* £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Amanda Sullivan Accountable Officer	5-10	-	-	-	2.5-3	5-10
Sam Walters Accountable Officer (until September 2018)	55-60	-	-	-	42.5-45	100-105
Stephen Shortt Clinical Chair	80-85	-	-	-	-	80-85
Jeremy Griffiths, GP Representative	20-25	-	-	-	-	20-25
Gavin Derbyshire, GP Representative	5-10	-	-	-	-	5-10
Sheila Hyde, Lay Member (until May 2018)	0-5	-	-	-	-	0-5
Ann Greenwood, Lay Member (until 31 May 2018)	0-5	-	-	-	-	0-5
Ian Blair, Lay Member	5-10	-	-	-	-	5-10
Chris Hawkey, Secondary Care Doctor	0-5	-	-	-	-	0-5

Pension benefits as at 31 March 2020 (subject to audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2019	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2020	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Amanda Sullivan – Accountable Officer	5-7.5	7.5-10	55-60	125-130	953	107	1,103	0
Jonathan Bemrose-Chief Finance Officer (to 30 April 2019)	0	0	30-35	110-115	1,027	0	0	0
Stuart Poynor – Chief Finance Officer (from 1 May 2019)	0	0	30-35	85-90	1399	0	743	0
Rosa Waddingham – Chief Nurse (From 1 January 2020)	0-2.5	0	30-35	0	321	16	406	0
Lucy Dadge, Chief Commissioning Officer (from 1 July 2019)	0-2.5	0-2.5	25-30	60-65	491	30	550	0
Elaine Moss, Chief Nurse (to 31 December 2019)	0-2.5	15-17.5	55-60	185-190	1,348	0	0	0

Pension benefits as at 31 March 2019

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2018	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2019	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Amanda Sullivan Accountable Officer	2.5-5	2.5-5	45-50	110-115	775	155	953	0
Samantha Walters Accountable Officer (until September 2018)	5-7.5	12.5-15	50-55	120-125	659	180	986	0
Jonathan Bemrose Chief Finance Officer	2.5-5	0-2.5	50-55	130-135	850	152	1027	0
Nichola Bramhall Director of Nursing and Quality	2.5-5	10-12.5	35-40	110-115	590	164	772	0
Gary Thompson Chief Operating Officer	0-2.5	0	40-45	90-95	668	19	770	0

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This 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).

Compensation on early retirement of loss of office

There were no payments for loss of office made in 2019/20.

Payments to past members

There were no payments to past senior managers made in 2019/20.

Pay multiples (Subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid member in the organisation in the financial year 2019/20 was £150-155k. This was 29.83 times the median remuneration of the workforce which was £ 5,113.

	2019/20	**2018/19**
Band of highest paid director's total remuneration (£000)	150-155	£105,000 – 110,000
Median total remuneration[1] of the workforce	5,113	£33,222
Ratio	29.83*	3.16

**This increase can be attributed to the alignment of staffing structures across the Nottingham and Nottinghamshire CCGs during 2019/20. This has resulted in a headcount that is higher in the previous year, but a lower charge per member of staff, which has in turn meant that the median and the pay multiples are not comparative to those reported in 2018/19.*

During 2019/20 there were no employees paid greater than the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer's pension contributions and the cash equivalent transfer value of pensions.

Staff numbers

As described throughout this annual report, the Nottingham and Nottinghamshire CCGs aligned their staffing structures during 2019/20, as part of preparations for merger from 1 April 2020. As such, we have completely aligned our employment practices, human resource (HR) policies and other workforce functions, and in practice, have been operating as a single entity with regard to our staff for most of the year.

As at 31 March 2020, NHS Rushcliffe CCG directly employed 100 staff (by headcount); however, the Nottingham and Nottinghamshire CCGs have a combined workforce of 488 staff (by headcount). The breakdown of our combined workforce by gender is as follows:

	Male	Female	Total
Senior Managers (Members of the Governing Body)	4	6	10
Staff at grade VSM (not included in above)	26	18	44
Other members of staff	89	345	434
Total	**119**	**369**	**488**

Staff numbers and costs (subject to audit)

The following table shows the average number and costs of whole time equivalent (WTE) staff employed by NHS Rushcliffe CCG across the financial year:

	Number	Costs £'000
Permanent	77.8	3,058
Other	3.58	127
Total	**81.38**	**3,184**

Bi-annual Workforce Reports are presented to the Governing Body, which provide further analysis of the CCG's workforce profile, including for example, an analysis of staff by pay band. These can be found in the *Governing Body Meetings and Papers* section of our website at https://nottsccg.nhs.uk/.

Sickness absence

Sickness absence can be problematic for small organisations as it is more difficult to cover the absence of key individuals or to disseminate the work between teams. This can in turn, have a significant impact on the organisation's ability to deliver its key objectives and can lead to a decrease in staff morale and performance. The CCG has refreshed its sickness absence policy during the year and has enhanced its internal reporting mechanisms to ensure appropriate oversight of sickness absence and provide assurance that sickness absence management processes are being consistently applied.

Sickness absence data for NHS organisations can be found at the NHS Digital publication series on NHS Sickness rates.

Staff policies

The CCG has policies in place to provide guidance to all employees. We are committed to being a fair and inclusive employer, as well as maintaining a working environment that promotes the health and wellbeing of our employees. We have therefore taken positive steps to ensure that our policies deal with equality implications relating to recruitment and selection, pay and benefits, flexible working hours, training and development, and that we have policies around managing employees and protecting employees from harassment, victimisation and discrimination.

We are accredited under the Disability Confident employer scheme, which encourages us to think differently about disability and take action to improve how we recruit, retain and develop disabled people. As part of this, we operate a Guaranteed Interview Scheme, which ensures an interview for any candidate with a disclosed disability whose application meets all of the essential criteria for the post. We also have Mindful Employer status, which demonstrates our commitment to supporting mental wellbeing at work. These accreditations support the recruitment of a workforce that reflects the diversity of our population and help to ensure that specific needs of employees are identified and addressed, whilst promoting positive attitudes towards people with physical, sensory and mental impairments.

Our Management of Absence Policy supports disabled employees and states that in cases where the employee is disabled within the meaning of the Equality Act 2010, or where employees become disabled and wish to remain in employment, every effort will be made to make reasonable adjustments or find an alternative post. We also perform Equality Impact Assessments on all of our organisational policies to identify any potential adverse impacts on disabled people, such as barriers to access or inequality of opportunity, and ensure that appropriate actions are taken in response. We are not aware of any of our employees becoming disabled during 2019/20.

The CCG is also working to the requirements of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES), which aim to ensure that employees from black and minority ethnic backgrounds and those that identify as disabled have equal access to career opportunities and receive fair treatment in the workplace.

Trade Union Relationships

The CCG has a Recognition Agreement which provides a framework for successful partnership arrangements between the Trade Unions and the CCG in order to develop professional practice and

foster good employment relations. It provides methods whereby the CCG will recognise the recognised Trade Unions to support, represent and bargain for its members. We are a member of the Nottinghamshire/Derbyshire Joint Staff Partnership Forum, where the CCGs meet with regional Trade Union representatives.

Time off for Trade Union duties and activities is detailed in the CCG's Special Leave Policy. For members of a recognised Trade Union, Trade Union activities are unpaid. For Trade Union duties, training or acting as a Learning Representative payment is made in line with ACAS Code of Practice.

To date, none of the Trade Unions has approached the CCG to ask for any employees to be considered as a Trade Union representative.

Relevant union officials

Total number of employees who were relevant union officials during the relevant period:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
0	0

Percentage of time spent on facility time

The number of employees who were relevant union officials employed during the relevant period and time spent of their working hours on facility time:

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

Percentage of pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time:

Total cost of facility time	£0
Total pay bill	£3,184k
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:	0
(total hours spent on paid trade union activities by relevant	

union officials during the relevant period ÷ total paid facility time hours) x 100	

Employee consultation and engagement

As part of our preparation for merger from 1 April 2020, the Nottingham and Nottinghamshire CCGs developed a joint People Strategy 2019-2021 to set out our aims and ambitions for our workforce. The strategy recognises the role of our people in ensuring that the best, high quality healthcare is commissioned and delivered to our populations. It also acknowledged that the work needed to move towards being a single organisation would cause substantial changes for our staff that they would need to be fully supported through.

The CCG places a high importance on the delivery of effective communications, involvement and engagement with all of its employees. It discharges these duties through a variety of means, including:

- A staff communications framework: we have established a range of mechanisms for ensuring timely and transparent communications with our employees. These include a weekly e-newsletter, regular staff briefings and a comprehensive staff intranet, which includes access to staff policies as well as learning and development resources.
- A Staff Engagement Group: This Group is designed to engender an empowered, engaged and well-supported workforce. The Group advises on staff engagement and communication mechanisms and on the CCG's approach to staff training, personal development and performance appraisals. It inputs to the production of organisational policies and procedures and the analysis and action planning resulting from the annual staff survey. The Group also supports the healthy workforce agenda and seeks to harness different perspectives and encourage innovative ideas and feedback from employees on the organisation's working practices and the working environment.
- Participation in the national NHS staff survey: developing actions as required in response to the results.
- Engaging staff in the merger process: this included asking employees to help co-design the core values and behaviours needed to help drive the new CCG forward.

In addition to the People Strategy, we have also produced an Organisational Development Strategy 2019-21 that describes how we will build the right organisational culture for the new CCG. This includes the development of a new performance management process and competency and behavioural framework.

Health and safety

As with all employers, we are required to comply with health, safety and fire legislation. We are committed to a culture of health and safety awareness in our organisation and in providing a secure and healthy environment for our employees and any other individual who may come into contact with the organisation's activities. We ensure this by having robust arrangements in place for the delivery of all statutory and mandatory requirements in relation to health, safety and fire and by ensuring that all staff are sufficiently trained and instructed in these areas. The CCG has established a Health and Safety

Steering Group to ensure operational oversight and direction for these areas and to progress the health, safety and security agenda accordingly.

To support the wellbeing of staff, we have an occupational health service in place. Our Occupational Health Service is provided by COPE, an organisation that has extensive experience of successfully delivering flexible, bespoke, business-appropriate occupational health solutions to a wide range of clients in all sectors. COPE provide a comprehensive service to our staff that includes, flu vaccinations, ergonomic assessments, physiotherapy and staff wellbeing support.

At the time of finalising this annual report, the CCG has implemented measures to ensure the safety of its workforce in line with the national guidance on COVID-19. Whilst it is critical that the CCG is able to continue to discharge its key functions, as well as co-ordinate the local incident management response (as described in the introduction of this annual report), we have a responsibility to reduce workplace risk to the lowest reasonably practicable level by taking preventative measures to ensure that everybody's health and safety is protected. To ensure that we are doing all we can to protect staff, a COVID-19 specific health and safety risk assessment has been completed.

Expenditure on consultancy

Expenditure on consultancy in 2019/20 totalled £21,000.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Clinical Commissioning Groups must publish information on their highly paid and/or senior off-payroll engagements.

Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2020, for more than £245 per day and that last longer than six months are shown in the table below

	Number
Number of existing engagements as of 31 March 2020	**0**
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

New Off-Payroll engagements

New off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and March 2020, for more than £245 per day and that last longer than six months are shown below:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to the organisation) and are on the organisation's payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-Payroll Governing Body members/senior official engagements

Off-payroll engagements of Governing Body members and / or senior officials with significant financial responsibility between 1 April 2019 and 31 March 2020 are shown in the table below:

	Number
Number of off-payroll engagements of Governing Body, and / or senior officials with significant financial responsibility, during the financial year	**0**
Total number of individuals on-payroll and off-payroll that have been deemed 'Governing Body members, and/or, senior officials with significant financial responsibility' during the financial year. This figure includes both on-payroll and off-payroll engagements.	**16**

Exit Packages

Exit Package cost band (including any special payment element)	Number of Compulsory Redundancies Whole Numbers only	Cost of Compulsory redundancies £s	Number of Other agreed departures Whole Numbers only	Cost of other departures agreed £s	Total number of exit packages Whole Numbers only	Total cost of exit packages £s	Number of departures where special payments have been made Whole Numbers only	Cost of special payment element included in exit packages £s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	0	0	0	0	0	0	0	0

Analysis of Other Departures

	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	0	0

Accountability Report signed by:

Dr Amanda Sullivan, Accountable Officer
23 June 2020

Parliamentary Accountability and Audit Report

NHS Rushcliffe CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the *Annual Accounts* section of this report. An audit certificate and report is also included in *Annual Accounts* section of this report.

Appendix A – Annual Accounts

Signed by:

Dr Amanda Sullivan, Accountable Officer
23 June 2020

Entity name:	NHS Rushcliffe CCG
This year	2019-20
Last year	2018-19
This year ended	31-March-2020
Last year ended	31-March-2019
This year commencing:	01-April-2019
Last year commencing:	01-April-2018

NHS Rushcliffe CCG - Annual Accounts 2019-20

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(5,239)	(7,806)
Other operating income	2	(4,263)	-
Total operating income		**(9,503)**	**(7,806)**
Staff costs	4	3,184	2,878
Purchase of goods and services	5	182,084	171,199
Depreciation and impairment charges	5	-	-
Provision expense	5	122	144
Other Operating Expenditure	5	192	185
Total operating expenditure		**185,583**	**174,406**
Net Operating Expenditure		**176,080**	**166,600**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**176,080**	**166,600**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**176,080**	**166,600**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**176,080**	**166,600**

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Non-current assets:			
Property, plant and equipment	13	-	-
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		**-**	**-**
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	3,942	3,828
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	16	13
Total current assets		**3,958**	3,842
Non-current assets held for sale	21	-	-
Total current assets		**3,958**	**3,842**
Total assets		**3,958**	**3,842**
Current liabilities			
Trade and other payables	23	(16,791)	(18,095)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(204)	(228)
Total current liabilities		**(16,995)**	(18,324)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(13,037)**	**(14,482)**
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(13,037)**	**(14,482)**
Financed by Taxpayers' Equity			
General fund		(13,037)	(14,482)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(13,037)**	**(14,482)**

The notes on pages 5 to 27 form part of this statement

The financial statements on pages 1 to 4 were approved by the Audit & Governance Committee on 22nd June 2020 and signed on its behal

Amanda Sullivan
Chief Accountable Officer

31 March 2020

Changes in taxpayers' equity for 2019-20	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2019	(14,482)	0	0	**(14,482)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(14,482)**	**0**	**0**	**(14,482)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(176,080)	0	0	**(176,080)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	0	**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(176,080)**	**0**	**0**	**(176,080)**
Net funding	177,525	0	0	**177,525**
Balance at 31 March 2020	**(13,037)**	**0**	**0**	**(13,037)**

Changes in taxpayers' equity for 2018-19	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2018	(15,646)	0	0	**(15,646)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(15,646)**	**0**	**0**	**(15,646)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Impact of applying IFRS 9 to Opening Balances	0	0	0	0
Impact of applying IFRS 15 to Opening Balances	0	0	0	0
Net operating costs for the financial year	(166,600)	0	0	(166,600)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	0	0	0	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(166,600)**	**0**	**0**	**(166,600)**
Net funding	167,763	0	0	167,763
Balance at 31 March 2019	**(14,482)**	**0**	**0**	**(14,482)**

The notes on pages 5 to 27 form part of this statement

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(176,080)	(166,600)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(114)	(1,085)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(1,304)	(153)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(147)	(69)
Increase/(decrease) in provisions	30	122	144
Net Cash Inflow (Outflow) from Operating Activities		**(177,523)**	**(167,762)**
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	**0**
Net Cash Inflow (Outflow) before Financing		**(177,523)**	**(167,762)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		177,525	167,763
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**177,525**	**167,763**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**2**	**1**
Cash & Cash Equivalents at the Beginning of the Financial Year		**13**	**13**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**16**	**13**

The notes on pages 5 to 27 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 shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2019-20 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

The CCG was dissolved on 1 April 2020 and merged with Newark & Sherwood, Nottingham City, Nottingham North & East, Nottingham West, and Rushcliffe CCGs to form Nottingham & Nottinghamshire CCG. Whilst the CCG as an entity ceased to exist on that date and is not a going concern at 31 March 2020, the services provided by the CCG have continued within the successor body. In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG should be prepared on a going concern basis.

1.2 **Accounting Convention**

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

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Pooled Budgets**

Where the clinical commissioning group has entered into a pooled budget arrangement under section 75 of the NHS Act 2006, the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. If the Clinical Commissioning Group is in a jointly controlled operation, the Clinical Commissioning Group recognises:

- The assets the Clinical Commissioning Group controls;
- The liabilities the Clinical Commissioning Group incurs;
- The expenses the Clinical Commissioning Group incurs; and,
- The Clinical Commissioning Group’s share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a jointly controlled assets arrangement, in addition to the above, the Clinical Commissioning Group recognises:

- The Clinical Commissioning Group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The Clinical Commissioning Group’s share of any liabilities incurred jointly: and,
- The Clinical Commissioning Group’s share of the expenses jointly incurred.

1.5 **Operating Segments**

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

1.6 **Revenue**

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

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

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

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

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

Notes to the financial statements

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a 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 clinical commissioning group commits itself to the retirement, regardless of the method of payment.

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

1.8 **Other Expenses**

consideration payable.

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:
· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
. It is expected to be used for more than one financial year;
·The cost of the item can be measured reliably; and,
·The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,

· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.10.2 **Measurement**

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
· Land and non-specialised buildings – market value for existing use; and,
· Specialised buildings – depreciated replacement cost.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.11 **Intangible Assets**

1.11.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.11.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.11.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.12.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.12.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.13 **Cash & Cash Equivalents**

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

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

Notes to the financial statements

1.14 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation (except where immaterial), its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.55% (2018-19:1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.15 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.16 **Non-clinical Risk Pooling**

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

1.17 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

· Financial assets at amortised cost;
· Financial assets at fair value through other comprehensive income and ;
· Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.18.1 **Financial Assets at Amortised cost**

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

1.18.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.18.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Notes to the financial statements

1.18.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.19 **Financial Liabilities**

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

1.19.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.19.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.19.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.22 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.23 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 **Critical accounting judgements and key sources of estimation uncertainty**

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

1.24.1 **Critical accounting judgements in applying accounting policies**

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

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Maternity Pathway Costs

  The Clinical Commissioning Group prepays out Maternity Pathway Costs which span the end of the financial year.

1.24.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Partially Completed Healthcare Spells - the clinical commissioning group includes estimations for partially completed spells which span the end of the financial year. The provider trusts supply the clinical commissioning group with activity information on which to base the estimation value.

Prescribing Costs - the clinical commissioning group uses data from the Prescription Pricing Authority to include an accrual for 2 months of prescribing charges.

1.25 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 **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 Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2021 as adapted and interpreted by the FReM.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	-
Non-patient care services to other bodies	**5,036**	3,968
Patient transport services	**-**	-
Prescription fees and charges	**61**	87
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**143**	3,751
Recoveries in respect of employee benefits	**-**	-
Total Income from sale of goods and services	**5,239**	**7,806**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**-**	-
Other non contract revenue	**4,263**	-
Total Other operating income	**4,263**	**-**
Total Operating Income	**9,503**	**7,806**

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	2,897	-	-	-	-	143	-
Non NHS	-	2,139	-	61	-	-	-	-
Total	**-**	**5,036**	**-**	**61**	**-**	**-**	**143**	**-**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	-	-	-	-	-	-	-
Over time	-	5,036	-	61	-	-	143	-
Total	**-**	**5,036**	**-**	**61**	**-**	**-**	**143**	**-**

3.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not yet

	2018-19 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-
Later than 5 Years	-	-	-	-
Total	**-**	**-**	**-**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2019-20
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**2,220**	**127**	**2,347**
Social security costs	**291**	**0**	**291**
Employer Contributions to NHS Pension scheme	**547**	**0**	**547**
Other pension costs	**0**	**0**	**0**
Apprenticeship Levy	**0**	**0**	**0**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Gross employee benefits expenditure	**3,058**	**127**	**3,184**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	**3,058**	**127**	**3,184**
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	**3,058**	**127**	**3,184**

4.1.1 Employee benefits

	Total		2018-19
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**2,317**	**58**	**2,374**
Social security costs	**220**	**0**	**220**
Employer Contributions to NHS Pension scheme	**255**	**0**	**255**
Other pension costs	**0**	**0**	**0**
Apprenticeship Levy	**0**	**0**	**0**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**28**	**0**	**28**
Gross employee benefits expenditure	**2,820**	**58**	**2,878**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	**2,820**	**58**	**2,878**
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	**2,820**	**58**	**2,878**

4.1.2 Recoveries in respect of employee benefits

			2019-20	2018-19
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Total £'000**
Employee Benefits - Revenue				
Salaries and wages	**0**	**0**	**0**	**0**
Social security costs	**0**	**0**	**0**	**0**
Employer contributions to the NHS Pension Scheme	**0**	**0**	**0**	**0**
Other pension costs	**0**	**0**	**0**	**0**
Other post-employment benefits	**0**	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**	**0**
Total recoveries in respect of employee benefits	**0**	**0**	**0**	**0**

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**77.80**	**3.58**	**81.38**	**78.45**	**1.00**	**79.45**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	1	13,638	1	13,638
£25,001 to £50,000	1	28,416	-	-	1	28,416
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**28,416**	**1**	**13,638**	**2**	**42,054**

	2019-20 Departures where special payments have been made		2018-19 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2019-20 Other agreed departures		2018-19 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	1	13,638
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**1**	**13,638**

4.5 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
These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and
Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.
The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018 updated to 31 March 2019 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
The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.
The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,719	933
Services from foundation trusts	24,950	23,642
Services from other NHS trusts	77,984	65,998
Provider Sustainability Fund	-	-
Services from Other WGA bodies	-	-
Purchase of healthcare from non-NHS bodies	36,503	40,277
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	17,361	16,405
Pharmaceutical services	-	-
General Ophthalmic services	-	-
GPMS/APMS and PCTMS	16,338	16,500
Supplies and services – clinical	79	30
Supplies and services – general	3,209	2,311
Consultancy services	21	1
Establishment	2,649	2,474
Transport	-	0
Premises	1,147	2,311
Audit fees	36	36
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees	55	58
Legal fees	32	208
Education, training and conferences	1	13
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**182,084**	**171,199**
Depreciation and impairment charges		
Depreciation	-	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**-**	**-**
Provision expense		
Change in discount rate	-	-
Provisions	122	144
Total Provision expense	**122**	**144**
Other Operating Expenditure		
Chair and Non Executive Members	157	137
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	-	9
Expected credit loss on receivables	7	10
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	29	29
Total Other Operating Expenditure	**192**	**185**
Total operating expenditure	**182,398**	**171,528**

6.1 Better Payment Practice Code

Measure of compliance	**2019-20 Number**	**2019-20 £'000**	**2018-19 Number**	**2018-19 £'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10,216	94,605	13,442	102,662
Total Non-NHS Trade Invoices paid within target	9,766	92,525	13,136	100,702
Percentage of Non-NHS Trade invoices paid within target	**95.60%**	**97.80%**	**97.72%**	**98.09%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,366	130,001	2,643	113,412
Total NHS Trade Invoices Paid within target	2,326	129,607	2,615	113,284
Percentage of NHS Trade Invoices paid within target	**98.31%**	**99.70%**	**98.94%**	**99.89%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2019-20 £'000**	**2018-19 £'000**
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7 Income Generation Activities

There were no Income Generation Activities during the year (18/19: £nil)

8. Investment revenue

There was no Investment Income during the year (18/19: £nil)

9. Other gains and losses

There were no Other Gains and Losses during the year (18/196: £nil)

10. Finance costs

There were no Finance Costs during the year (18/19: £nil)

11. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	Land	Buildings	Other	2019-20 Total	Land	Buildings	Other	2018-19 Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	276	-	**276**	-	2,297	-	**2,297**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**276**	**-**	**276**	**-**	**2,297**	**-**	**2,297**

12.1.2 Future minimum lease payments

	Land	Buildings	Other	2019-20 Total	Land	Buildings	Other	2018-19 Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	-	-	**-**	-	-	-	**-**
Between one and five years	-	-	-	**-**	-	-	-	**-**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

12.2 As lessor

12.2.1 Rental revenue

	2019-20	2018-19
	£'000	£'000
Recognised as income		
Rent	-	-
Contingent rents	-	-
Total	**-**	**-**

[A general description of leasing arrangements]

12.2.2 Future minimum rental value

	2019-20	2019-20	2019-20	2018-19	2018-19
	£'000	£'000	£'000	£'000	£'000
	NHSE Bodies	Other DHSC Group Bodies	Non DH Group Bodies	DH Group Bodies	Non DH Group Bodies
Receivable:					
No later than one year	-	-	-	-	-
Between one and five years	-	-	-	-	-
After five years	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**

13 Property, plant and equipment

2019-20	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2019	-	-	-	-	-	-	-	-	-
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2020	-	-	-	-	-	-	-	-	-
Depreciation 01 April 2019	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2020	-	-	-	-	-	-	-	-	-
Net Book Value at 31 March 2020	-	-	-	-	-	-	-	-	-
Purchased	-	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	-	-	-	-	-	-	-	-	-
Asset financing:									
Owned	-	-	-	-	-	-	-	-	-
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	-	-	-	-	-	-	-	-	-

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2019	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2020	-	-	-	-	-	-	-	-	-

14 Intangible non-current assets
The CCG has no Intangible non-current assets at the year end (18/19: £nil)

15 Investment property
The CCG has no Investment Property at the year end (18/19: £nil)

16 Inventories
The CCG has no Inventories at the year end (18/19: £nil)

17.1 Trade and other receivables	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**	**Current 2018-19 £'000**	**Non-current 2018-19 £'000**
NHS receivables: Revenue	1,038	-	1,446	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	1,369	-	498	-
NHS accrued income	73	-	739	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	20	-	304	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	709	-	275	-
Non-NHS and Other WGA accrued income	741	-	559	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(9)	-	(16)	-
VAT	0	-	22	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	-	-	0	-
Total Trade & other receivables	**3,942**	**-**	**3,828**	**-**
Total current and non current	**3,942**		**3,828**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	**2019-20 Non DHSC Group Bodies £'000**	**2018-19 DHSC Group Bodies £'000**	**2018-19 Non DHSC Group Bodies £'000**
By up to three months	-	-	-	37
By three to six months	-	1	4	56
By more than six months	-	18	-	14
Total	**-**	**19**	**4**	**107**

17.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Other financial assets £'000**	**Total £'000**
Balance at 01 April 2019	(16)	-	**(16)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	7	-	**7**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(9)**	**-**	**(9)**

18 Other financial assets
The CCG has no Other Financial Assets at the year end (18/19: £nil)

19 Other current assets
The CCG has no Other Current Assets at the year end (18/19: £nil)

20 Cash and cash equivalents

	2019-20	2018-19
	£'000	£'000
Balance at 01 April 2019	13	13
Net change in year	2	1
Balance at 31 March 2020	**16**	**13**
Made up of:		
Cash with the Government Banking Service	16	13
Cash with Commercial banks	-	-
Cash in hand	-	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**16**	**13**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2020	**16**	**13**
Patients' money held by the clinical commissioning group, not included above	-	-

21 Non-current assets held for sale
The CCG has no Non-Current Assets Held for Sale at the year end (18/19: £nil)

22 Analysis of impairments and reversals
The CCG has no Impairments or Reversals at the year end (18/19: £nil)

23 Trade and other payables	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	3,823	-	1,954	-
NHS payables: Capital	-	-	-	-
NHS accruals	1,420	-	1,322	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	4,620	-	4,090	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	5,749	-	9,550	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	54	-	50	-
VAT	-	-	-	-
Tax	45	-	40	-
Payments received on account	-	-	0	-
Other payables and accruals	1,081	-	1,088	-
Total Trade & Other Payables	**16,791**	**-**	**18,095**	**-**
Total current and non-current	**16,791**		**18,095**	

Other payables include £218k outstanding pension contributions at 31 March 2020

24 Other financial liabilities
The CCG has no Other Financial Liabilities at the year end (18/19: £nil)

25 Other liabilities
The CCG has no Other Liabilities at the year end (18/19: £nil)

26 Borrowings
The CCG has no Borrowings at the year end (18/19: £nil)

27 Private finance initiative, LIFT and other service concession arrangements
The CCG has no Private Finance Initiatives, LIFT or other Service Concession Arrangements at the year end (18/19: £nil)

28 Finance lease obligations
The CCG has no Finance Lease Obligations at the year end (18/19: £nil)

29 Finance lease receivables
The CCG has no Finance Lease Receivables at the year end (18/19: £nil)

30 Provisions

	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	36	-	150	-
Continuing care	168	-	79	-
Other	-	-	(0)	-
Total	**204**	**-**	**228**	**-**
Total current and non-current	**204**		**228**	

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Agenda for Change £'000	Equal Pay £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2019	**-**	**-**	**-**	**-**	**-**	**-**	**150**	**79**	**-**	**228**
Arising during the year	-	-	-	-	-	-	33	90	-	**122**
Utilised during the year	-	-	-	-	-	-	(147)	-	-	**(147)**
Reversed unused	-	-	-	-	-	-	-	-	-	**-**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**36**	**168**	**-**	**204**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	36	168	-	**204**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**36**	**168**	**-**	**204**

31 Contingencies

	2019-20 £'000	2018-19 £'000

32 Commitments

32.1 Capital commitments

	2019-20	2018-19
	£'000	£'000
Property, plant and equipment	-	-
Intangible assets	-	-
Total	**-**	**-**

32.2 Other financial commitments

The NHS clinical commissioning group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2019-20	2018-19
	£'000	£'000
In not more than one year	2,017	1,829
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	**2,017**	**1,829**

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	Equity Instruments designated at FVOCI 2019-20 £'000	Total 2019-20 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	933		933
Trade and other receivables with other DHSC group bodies	901		901
Trade and other receivables with external bodies	39		39
Other financial assets	-		-
Cash and cash equivalents	16		16
Total at 31 March 2020	**1,889**	**-**	**1,889**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Other 2019-20 £'000	Total 2019-20 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	2,262		**2,262**
Trade and other payables with other DHSC group bodies	5,550		**5,550**
Trade and other payables with external bodies	8,880		**8,880**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2020	**16,692**	**-**	**16,692**

34 Operating segments

The CCG and consolidated group consider they have only one segment: Commissioning of Healthcare Services

35 Pooled budgets

The Clinical Commissioning Group entered into a pooled budget arrangement for Integrated Community Equipment Schemes with Nottinghamshire County Council. Under the arrangements, funds are pooled under section 75 of the NHS Act for Integrated Community Equipment Scheme activities.

The Pool is hosted by Nottinghamshire County Council. As a Commissioner of Healthcare Services, the Clinical Commissioning Group makes contributions to the pool.

	2019/20 £'000	2018/19 £'000
Balance at 1 April	**724**	**188**
Income		
Nottinghamshire County Council ASCH&PP	1,365	1,779
Nottinghamshire County Council CFCS	401	391
Nottinghamshire City Council ASCH & CYP	1,109	1011
Bassetlaw CCG	567	537
Nottingham City CCG	1,121	1,173
Nottinghamshire County CCG's	3,114	3,068
Continuing Health care funding	0	0
Other income	0	55
TOTAL INCOME	8,401	8,202
Expenditure		
Partnership Management & Administration costs	829	733
Contract delivery and collection costs	1,311	1,262
ICES Equipment	5,983	5,316
Continuing Healthcare Specialist Equipment	0	0
Minor Adaptations	119	166
Direct Payments	0	1
TOTAL EXPENDITURE	8,242	7,478
Balance at 31 March	159	724
Carry Forward by Partner		
Nottinghamshire City Council ASCH	247	215
Notts County Council - ASCH	645	403
Notts County Council - CYPS	56	61
Bassetlaw CCG	-86	16
Nottingham City CCG	-293	17
Nottinghamshire County CCG's	-410	12
Balance at 31 March	**159**	**724**

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
EAST LEAKE MEDICAL GROUP LE12 6JG	1,516	0	0	0
MUSTERS MEDICAL PRACTICE	1,061	0	0	0
LUDLOW HILL SURGERY	1,864	0	0	0

Details of related party transactions with other bodies are as follows:

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

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
NHS England	3,148	6,003	2,262	1,045
NHS Trusts	78,039	131	972	981
Foundation Trusts	27,353	0	2,009	454
Health Education England	0	0	0	0
Special Health Authorities	7	0	0	0
Other Group Bodies	995	0	1	0

38 Events after the end of the reporting period

The Rushcliffe Clinical Commissioning Group was dissolved on 31 March 2020, having merged with the Clinical Commissioning Groups of NHS Newark & Sherwood, NHS Nottingham City, NHS Nottingham North & East, NHS Nottingham West, and NHS Mansfield & Ashfield, with effect from 1 April 2020. This followed approval of the application at the NHS England and Improvement Regional Support Group on 23rd September, and again on 24th February 2020 to confirm that conditions had been met. The Department of Health and Social Care Group Accounting Manual directs that such changes should be accounted for as a 'transfer by absorption'. The new Nottingham & Nottinghamshire Clinical Commissioning Group will recognise all of the assets and liabilities received as at the date of the transfer, 1 April 2020.

39 Third party assets

The CCG has no Third Party Assets (18/19: £nil)

40 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2019-20 Target	**2019-20 Performance**	**2018-19 Target**	**2018-19 Performance**
Expenditure not to exceed income	185,586	185,583	174,408	174,406
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	176,083	176,080	166,602	166,602
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	2,939	2,744	2,763	2,742

41 Analysis of charitable reserves

The CCG has no Charitable Reserves at the year end (18/19: £nil)

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS NOTTINGHAM AND NOTTINGHAMSHIRE CLINICAL COMMISSIONING GROUP IN RESPECT OF NHS RUSHCLIFFE CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Rushcliffe Clinical Commissioning Group ("the CCG") for the year ended 31 March 2020 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2019/20.

Basis for opinion

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

Emphasis of matter- going concern basis of preparation

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that whilst the CCG is not a going concern due to its dissolution on 1 April 2020, the financial statements of the CCG have been prepared on a going concern basis because its services have continued to be provided by NHS Nottingham and Nottinghamshire CCG. Our opinion is not modified in respect of this matter.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 27, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

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

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 27, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCGs arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in December

2019 and updated in April 2020 as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Nottingham and Nottinghamshire CCG, in respect of NHS Rushcliffe CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Rushcliffe CCG for the year ended 31 March 2020 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Bostock
for and on behalf of KPMG LLP
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

25 June 2020