NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Annual Report and Accounts

2020/21

About this report

This annual report and accounts for the year ending 31 March 2021 have been prepared, as directed by NHS England, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012[1]). 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 ongoing Covid-19 pandemic response continues to significantly impact on public sector resources. It is for this reason that the requirements for the contents of 2020/21 annual reports been revised nationally; this means there may be some omissions against previous and future such publications.

The structure of this report therefore follows that outlined in the guidance and includes:

- ***Performance Report*** – This section of the report includes an overview of our organisation and its purpose, and provides a summary of how we have performed over the last year and the key risks and issues we have faced. This section also includes information as to how the CCG has met its statutory duties across a number of key areas.
- ***Accountability Report*** – The purpose of this section is to meet key accountability requirements to Parliament and to demonstrate compliance with best practice corporate governance requirements. 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*** – This section presents the CCG's financial statements for the year 2020/21.

Contact details

This document can be made available in large print and in other languages by request to the CCG's Communications and Engagement Team.

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[1] Part 1, Chapter A2, Section 14Z15: Reports by clinical commissioning groups

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Performance Report

Dr Amanda Sullivan

Accountable Officer

11 June 2021

Performance overview

Introduction

Welcome to the 2020/21 annual report for NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG). This section of the annual report provides a snapshot of our organisation, describing who we are, what we do, the challenges we have faced and how we have performed during the financial year ended 31 March 2021. For 2020/21, this section also includes information on how we have met some of our statutory responsibilities. This is due to the CCG's decision to omit a detailed 'Performance analysis' section from this annual report, due to the ongoing impact of the Covid-19 pandemic.

Accountable Officer's statement

This has been our organisation's first year of operation, following a successful merger of our six predecessor CCGs leading to the establishment of our new CCG on 1 April 2020; a time at which the NHS was facing its greatest ever challenge. The Covid-19 pandemic has had a devastating impact across our communities, our country and worldwide. The last 12 months has been an extraordinary period, with the majority of this time spent at the highest level of national NHS emergency preparedness and response.

Our response to the pandemic has required excellent collaboration across all health and care partners and the creation of new and improved ways of working in order to protect our local communities, and I would particularly like to acknowledge the invaluable contribution made to our response efforts by a huge number of volunteers from across our communities. However, I am acutely aware that many people reading this annual report will have lost loved ones over the last year to Covid-19, so I would like to take this opportunity to remember the people we have lost, including our health and care colleagues who have sadly passed away.

At the outbreak of the pandemic, we worked hard to secure the personal protective equipment (PPE) needed for our local workforce and we co-ordinated mutual aid across organisations when supply chains were initially being established. We set up and co-ordinated Covid-19 testing facilities and our quality and nursing teams were quick to focus on outbreak management and the provision of infection, prevention and control support to care homes. We also had a specific focus on proactively supporting members of our staff who were particularly vulnerable to Covid-19, including those who were shielding, those from black and Asian minority ethnic (BAME) backgrounds, and those with other risk factors.

Our initial response to the pandemic also required us to focus on preparing for large numbers of Covid-19 patients needing hospital care and respiratory support, which

meant that we needed to create the maximum possible inpatient and critical care capacity. To do this, we worked with partners to urgently discharge all hospital inpatients who were medically fit to leave, and all non-urgent treatments and operations were postponed, while ensuring that emergency admissions, cancer treatment and other clinically urgent care could continue unaffected. This approach enabled us to treat people with Covid-19 and deliver critical services during the peak periods of the pandemic. However, it has also inevitably resulted in significantly increased waiting times for elective diagnostics, treatments and surgeries and our focus, now that we are past the winter wave of Covid-19, is to accelerate the restoration and recovery of elective care for our population. You can read more about our work to address these challenges in the *Performance summary* section of this annual report.

As we maximise our elective capacity, we will be taking the opportunity to transform the delivery of services, building on what we have learned during the pandemic. We will also be expanding and improving primary care and mental health services and services for people with a learning disability and/or autism, and delivering improvements in maternity and urgent and emergency care. Our response to Covid-19 has also required us to introduce new services for our population, including a range of primary care, community and mental health services to address the long-term effects of coronavirus.

I am immensely proud of how our member GP practices came together to react and adapt to the challenges of Covid-19, in such a short space of time. The resulting changes have completely reshaped how General Practice is delivered. Around half of consultations are now undertaken remotely, following clinical triage, with face-to-face consultations provided where appropriate. GP practices were also able to respond to the increased risk to vulnerable people of flu and Covid-19 co-circulating during the winter period, which saw a record number of people being vaccinated against flu this year. GP Practices are also working together with partners through Primary Care Networks to improve the provision of proactive and personalised health and social care for people close to home.

At the time of writing this annual report, we continue to make outstanding progress in our fight against Covid-19 through our successful vaccination programme, which has seen local clinicians returning to practice and clinicians employed in non-patient facing roles being redeployed to support the vaccination effort. We have vaccinated a million people across our city and county and continue to call forward those eligible for vaccination in line with guidance from the Joint Committee on Vaccination and Immunisation (JCVI). In delivering our vaccination programme, we have focussed on areas of lower uptake amongst some minority ethnic communities and those from marginalised or deprived groups. To date, this has included pop-up clinics in GP practices, mosques and community settings and our very own mobile vaccination bus.

During the year, it has become increasing clear that Covid-19 has had a disproportionate impact on different groups in society, many of whom already face disadvantage and discrimination. This has highlighted the need for us to increase the scale and pace of our actions to tackle health inequalities and this will be a key focus for us in the year ahead. You can read more about our work to tackle health inequalities in the *Statutory duties* section of this annual report.

Looking ahead, we will soon need to begin implementing the changes to deliver on the expectations of the Government's White Paper for health and care, the NHS Long Term Plan and the 2021/22 Planning Guidance for the NHS. We can only achieve this with by ensuring our workforce, who have worked tirelessly this year, are supported to stay well. Our wellbeing programme is constantly being reviewed and developed so we can meet the needs of our staff and support their resilience during this challenging time.

I look forward with optimism to the developments and improvements the next year will bring to the way health and care is delivered across our local area. This is the start of an important and exciting period in the further development of integrated care systems and I am looking forward to playing a part in driving forward this development, alongside system partners from the NHS, Local Authorities and Voluntary and the Community Sector.

Amanda Sullivan
Accountable Officer

About us

NHS Nottingham and Nottinghamshire CCG was formed on 1 April 2020, through the merger of the former NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham City CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG.

The CCG is a clinically-led membership organisation made up of the 126 GP Practices (as at 31 March 2021) covering Nottingham City and the boroughs/districts of Mansfield, Ashfield, Newark and Sherwood, Broxtowe, Gedling and Rushcliffe. Our member GP Practices are responsible for determining the governing arrangements for the CCG, including delegations to the CCG's Governing Body and arrangements for clinical leadership, all of which is set out in the CCG's Constitution. A list of our member GP Practices is provided within the *Members report* section of

this annual report and you can read more about our Governing Body in the *Members report* and *Governance statement* sections of this annual report.

As at 31 March 2020, the CCG employed 499 staff. Our organisational structure is divided into a number of directorates that have responsibilities in the areas of: commissioning and contracting, finance and resources, and quality and governance. Additional clinical expertise to commissioning activities is provided from GP Advisors, appointed from our member GP Practices. The CCG is of sufficient scale to employ most key functions in-house. However, the CCG has a contractual arrangement 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 also commissions IT provision and technical support through the Nottinghamshire Health Informatics Service, hosted by Sherwood Forest Hospitals NHS Foundation Trust.

Organisational purpose and activities

We are responsible for commissioning (planning and buying) health services for 1.1 million people in Nottingham and Nottinghamshire in line with our statutory responsibilities, which include:

- Most planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out of hours services, accident and emergency services, ambulance services and NHS 111 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 also have full delegated responsibility from NHS England for the commissioning of primary medical services for the people of Nottingham and Nottinghamshire.

In order to make the best decisions for our population, we have to understand the health and care needs of people living across Nottingham and Nottinghamshire. Joint Strategic Needs Assessments (JSNAs) provide the CCG with key information about the health and wellbeing of our local population. These demographics vary significantly between the City and County districts, including by age, by ethnicity, by disability, and by levels of deprivation. We use this information to commission services that will deliver the most benefit to people, with the aim of reducing health inequalities and increasing healthy life expectancy (the number of years a person

lives in ‘good health’) for our population. You can read more about the demographics and health needs of our population at https://www.nottinghaminsight.org.uk/ and https://www.nottinghamshireinsight.org.uk/.

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. Patients are at the heart of everything we do, and we actively encourage people living in Nottingham and Nottinghamshire to get involved and help us shape our plans.

We commission healthcare services from a number of providers. Our main acute (secondary care) providers are Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust. For mental health and learning disabilities, our key provider is Nottinghamshire Healthcare NHS Foundation Trust, which also provides a range of community physical health services alongside Nottingham CityCare Partnership. We also commission services from NHS organisations outside of our area and from independent and voluntary organisations.

Our objectives, strategies and plans

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.

The CCG’s strategic objectives, which are aligned to those of the Nottingham and Nottinghamshire Integrated Care System, are to improve the:

- Health and wellbeing of our population;
- Overall quality of care and life our service users, and carers, are able to have a receive; and
- Effective utilisation of our resources.

The CCG’s Commissioning Strategy 2020/22 was developed in line with a range of system strategies and plans, including the Nottingham and Nottinghamshire ICS Five Year Strategic Plan, which addresses the requirements of the NHS Long Term Plan (https://www.longtermplan.nhs.uk/). The Commissioning Strategy defines the delivery requirements for key service areas, including prevention, personalisation,

primary care, maternity, planned care, cancer, mental health, care homes, learning disabilities and autism, and urgent and emergency care, in line with the ICS Outcomes Framework (which sets out the outcomes the whole ICS will work together to achieve over the next five years).

During 2021/22, existing strategies and plans will be reviewed and refreshed in line with national and local priorities, identified to address the impact of the Covid-19 pandemic, and the anticipated move to ICSs having a statutory footing from April 2022 (subject to legislation).

More information about the Nottingham and Nottinghamshire ICS can be found at https://healthandcarenotts.co.uk.

Performance summary

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, with no patient waiting longer than 52 weeks for treatment. In addition, patients waiting for diagnostic tests should wait fewer than six weeks from referral. There are also ranges of waiting time indicators for access to cancer treatment, depending on the access route, stage of illness and the treatment needed, and for access to mental health services. For urgent and emergency care, 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. Targets for ambulance services focus on making sure the best, high quality, most appropriate response is provided for each patient first time.

However, the unprecedented impact of the Covid-19 pandemic on health and care services has meant that we have faced many challenges in meeting these standards for 2020/21. During peak periods of the Covid-19 pandemic, non-urgent treatments and operations needed to be suspended to ensure that people with Covid-19 could be treated and that critical services (such as cancer services and urgent and emergency care) could continue. Since the end of the winter wave of Covid-19, we have been working closely with partners to accelerate the delivery of non-urgent treatments and operations in order to restore all patient services to pre-pandemic levels at the earliest opportunity and to minimise potential harm. To do this, arrangements have been established to provide a system-level oversight of the waiting lists, ensuring that patients are treated in order of clinical priority and date order, and with a view to tackling health inequalities. A harm review process has also been established for higher risk patients and additional elective capacity has been secured through evening and weekend activity and from the independent sector. Despite this, capacity remains stretched, due to the ongoing social distancing requirements and increased time between patient treatment times for infection prevention and control purposes.

Our performance against most cancer standards has remained good during the year, with surgical and diagnostic capacity being protected. However, limitations in theatres and bed capacity have been experienced during the peaks of the pandemic, which now requires an increased focus on addressing the backlog of patients through the clinical prioritisation process.

The introduction of the NHS 111 First programme in December 2020 has led to a significant change in how patients' care is managed. When calling NHS 111, an increased number of patients are now being referred to an appropriate community service or being advised for self-care via virtual consultation, rather than being directed to the Accident and Emergency Department. This is starting to have a positive impact on waiting times. However, the intensity of the winter wave of Covid-19 has also placed increased pressure on our hospitals in terms of their capacity to admit patients from the Accident and Emergency Department, which has led to some breaches of the 12-hour standard for patients to be formally admitted following a decision to admit.

The below table summarises the CCG's performance in these areas for 2020/21, utilising the latest available information at the time of finalising this annual report.

Standard	Period Ended	Target	Achieved
Referral to treatment waiting times: Percentage of patients waiting less than 18 weeks between referral and treatment for Incomplete pathways (patients still waiting for treatment at the end of the reporting period)	March 2021	**>92%**	**67.07%**
Number of patients waiting over 52 weeks	March 2021	**0**	**4,960**
Diagnostic test waiting times: Percentage of patients waiting six weeks or more for a diagnostic test	March 2021	**<1%**	**35.79%**
Cancer two-week waits: All cancer two week wait	March 2021	**>93%**	**96.44%**
Two week wait for breast symptoms (where cancer was not initially suspected)	March 2021	**>93%**	**96.15%**
Cancer Faster Diagnosis Standard: Percentage of patients who are referred for the investigation of suspected cancer finding out within 28 days if they do or do not have a cancer diagnosis	March 2021	**>70%**	**83.83%**
Cancer 31 and 62 day waits: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	March 2021	**>96%**	**92.66%**
62-day wait for first treatment following an urgent GP referral	March 2021	**>85%**	**73.26%**
Improved Access to Psychological Therapy (IAPT): Percentage of population entering therapy	February 2021	**>6.25%**	**5.15%**
Percentage recovery rate	February 2021	**>50%**	**54.25%**
Percentage of people that wait six weeks or less from referral to first treatment	February 2021	**>75%**	**97.05%**
Percentage of people that wait 18 weeks or less from referral to first treatment	February 2021	**>95%**	**99.58%**
Estimated diagnosis rate for people with dementia: Dementia diagnosis rate	February 2021	**>67%**	**68.87%**
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	February 2021	**<60%**	**84.00%**
A&E waiting time: Percentage of patients who spent four hours or less in A&E	March 2021	**>95%**	**76.04%**
Ambulance clinical quality: Category 1 (life threatening illness or injury) Average Response Time	March 2021	**<00:07:00**	**00:06:34**
Category 1 (life threatening illness or injury) 90th Centile Response Time	March 2021	**<00:15:00**	**00:11:28**
Category 2 (emergency calls) Average Response Time	March 2021	**<00:18:00**	**00:20:51**
Category 2 (emergency calls) 90th Centile Response Time	March 2021	**<00:40:00**	**00:41:53**
Category 3 (urgent calls) 90th Centile Response Time	March 2021	**<02:00:00**	**02:25:00**
Category 4 (less urgent calls) 90th Centile Response Time	March 2021	**<03:00:00**	**03:21:27**

Meeting our financial duties

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, unexpected increases in demand for local health services, or projects taking longer than planned. For 2020/21, the key factor influencing our financial position was the Covid-19 pandemic.

A temporary finance regime was introduced for the first half of the year, to provide certainty of income for providers of NHS-funded services and to reduce the burden of formal contract negotiation and management arrangements, enabling staff to focus on the Covid-19 response. The financial regime ensured payments were made to organisations, based on the performance that had been delivered during 2019/20 and to reimburse specific Covid-19 costs from NHS England and NHS Improvement central funding.

For the second half of the year, the payments continued at similar level to those set nationally for the first half of the year, with some locally agreed amendments. However, from Month 7, the Covid-19 national reimbursement process was only continued for specific Hospital Discharge Programme costs. All other Covid-19 expenditure was expected to be contained within a budget allocated at a Nottingham and Nottinghamshire ICS level. The CCG worked with partner health organisations to agree how the level of Covid-19 funding would be allocated for the remaining six months. This then set a full year budget, which included Covid-19 spend, that organisations were required to stay within.

The following tables set out the CCG's financial performance for the 2020/21 year and an analysis of total expenditure. A break-down of Covid-19 specific expenditure is also provided.

Table 1: Financial performance

Duty	Target (£000)	Target (%)	Actual (£000)	Actual (%)	Achieved
Income and expenditure: Expenditure not to exceed income	Breakeven	-	22 surplus	-	✓
Cash balance: Remain below allowed cash balance	1,809	-	28	-	✓
Running costs: Remain within running cost allowance	21,137	-	20,393	-	✓
Better payment practice code: Pay NHS invoices by value within 30 days	-	95%	-	99.99%	✓
Pay NHS invoices by number within 30 days	-	95%	-	99.26%	✓
Pay non-NHS invoices by value within 30 days	-	95%	-	97.95%	✓
Pay non-NHS invoices by number within 30 days	-	95%	-	97.43%	✓
Mental health investment standard: Deliver the minimum mental health investment	175,116	-	175,250	-	✓

Table 2: Analysis of total spend

Category of expenditure	Total spend (£000)
Acute (hospital) care	884,340
Community care	150,350
Mental health care	183,320
Primary care	200,540
Prescribing	157,590
Continuing care	137,970
Other non-healthcare	84,040
Corporate running costs	20,390
Total	**1,818,540**

Table 3: Analysis of Covid-19 expenditure

Category of expenditure	Amount (£000)
Acute (hospital) care	1,865
Community care	2,890
Mental health care	59
Primary care	3,210
Hospital Discharge Programme/ Continuing care	32,976
Other non-healthcare	7,244
Corporate running costs	289
Total	**48,814**

Our financial statements for 2021/22 are set out in full in the *Annual accounts* section of this report.

Annual assessment of performance

NHS England has a legal duty to annually assess the performance of every CCG. The assessment must consider the duties of CCGs to improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. Previous approaches have involved CCG performance being assessed in key areas that covered leadership, financial management and performance in priority areas, with NHS England providing each CCG with an overall assessment rating using the CQC rating terminology of 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

For 2020/21, a simplified approach to the annual assessment of CCG performance is being taken, as a result of the differential and continued impact of the Covid-19 pandemic. This simplified approach will provide scope to take account of the different circumstances and challenges CCGs face in managing recovery across the phases of the NHS response to Covid-19 and focus on CCGs' contributions to local delivery of the overall system recovery plan. A narrative assessment, based on performance, leadership and finance, will replace the ratings system previously used.

At the time of finalising this annual report, the outcome of the annual assessment process for 2020/21 had not been published. However, once received, it will be available on our website at https://nottsccg.nhs.uk.

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 operational 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 operational risks in a consistent, systematic and co-ordinated manner. Operational risks arising from day-to-day activities are

monitored through our Corporate Risk Register and strategic risks are monitored via our Governing Body Assurance Framework.

The main risks identified by the CCG and monitored through the Corporate Risk Register during 2020/21 related to: the potential for the Covid-19 pandemic to exacerbate health inequalities and increase morbidity and mortality across the CCG's population; the potential for poor clinical outcomes, patient harm and poor patient experience at some of our main providers; the potential for non-delivery of our financial duties; the sustainability of some GP practices due to primary care workforce issues; and possible CCG workforce impacts of ongoing organisational change alongside the unplanned move to remote working (in response the Covid-19 pandemic).

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

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

Section 14R of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) requires CCGs to 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).

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.

Our Quality Strategy 2019/22 continues to reflect our ongoing commitment to ensuring a high quality health service for our local population 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 have reviewed and refreshed our Quality Strategy during 2020/21 in response to the new and unexpected challenges that have arisen as a result of the Covid-19 pandemic. The refreshed strategy now reflects our recovery and restoration priorities alongside our longer term quality objectives, with an increased system focus on reducing health inequalities and increasing collaboration.

Throughout the period of the Covid-19 pandemic, we have used a range of mechanisms to ensure that quality outcomes for our population have continued to be reviewed and delivered. This has included:

- Establishment of a system-wide 'safe today' dashboard, enabling timely information to continue to be obtained in relation to the quality of commissioned services, at a time when traditional intelligence sources and quality schedule information was suspended during the incident response.
- Establishment of an infection prevention and control outbreak dashboard to support the co-ordination of outbreak management, enabling oversight of lessons learnt processes being undertaken by provider organisations.
- Enhancement of the existing primary care quality framework, which sets out our approach to monitoring and assuring quality and improvement in primary medical services.
- Maintaining a focus on potential areas of 'unknown or hidden harm' as a direct impact of the Covid-19 pandemic, including safeguarding considerations and the unintended consequences of suspending planned care to free up inpatient and critical care capacity.

We have worked 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. We recognise that there have been services where quality standards have not been met during 2020/21 and the improvements needed have not been made. In these cases, we have worked with regulators, services and our system partners to put robust oversight and support arrangements in place.

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 and Performance Committee. You can read more about the work of this committee in the *Governance statement* section of this report.

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, in line with Section 14Z2 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). 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 who are most vulnerable and marginalised within our communities.

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 Nottingham City Council and Nottinghamshire County Council'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. This system-wide way of working has accelerated as we have worked with our partners to respond to the Covid-19 pandemic. We have worked as a system to understand the impact of Covid-19 on our communities and to reach out to different communities to support the roll out of the largest vaccination programme in the history of the NHS.

In 2020/21 we also commissioned a new patient and public engagement service from an Alliance of community and voluntary service organisations across Nottingham and Nottinghamshire. The service, led by organisations closest to our

communities, enables us to maintain a neighbourhood level engagement presence and will provide feedback from our local communities on the biggest health issues affecting them.

Our 2020/21 Annual Engagement Report, which is available on our website at https://nottsccg.nhs.uk, describes how the CCG is meeting its statutory duties in relation to patient and public engagement and provides more information on our engagement activities over the past 12 months. You can also 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 people can get involved in shaping NHS services.

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). Section 14T of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) requires CCGs 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.
- 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 the Covid-19 pandemic on health inequalities across Nottingham and Nottinghamshire and the CCG is working collaboratively with system partners as part

of the ICS to deliver against an ICS Health Inequalities Strategy and national recovery plans. Actions taken during 2020/21 include:

- Implementing and excelling on the 'eight urgent actions' to address inequalities in NHS provision and outcomes. The actions include: protecting the most vulnerable from Covid-19; restoring NHS services inclusively; developing digitally enabled care pathways; accelerating preventative programmes that proactively engage those at greatest risk of poor health; providing particular support those who suffer mental ill health; and strengthening leadership and accountability.
- Accelerating capabilities in relation to data analysis and applying a Population Health Management approach to decision-making, including for the flu and Covid-19 vaccination programmes.
- Implementing an inequalities programme for Covid-19 vaccinations that included comprehensive organic plans for groups whom additional focus needed to be given. Separate plans have been implemented for over 80s, carers, deprived communities, clinically extremely vulnerable people, people from black and minority ethnic communities, people who are homeless, people with severe and multiple disadvantage, those living in rural and isolated areas, those who are not digitally literate, people with learning difficulties and disabilities, and people with physical and mental health disabilities and mobility issues.

Health and wellbeing strategies

Section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007 requires CCGs to have regard to joint health and wellbeing strategies when exercising their functions.

In line with this duty, we are active members of the Nottingham City and Nottinghamshire County Health and Wellbeing Boards; statutory partnerships established to lead and advise on work to improve the health and wellbeing of the populations of Nottingham City and Nottinghamshire County and specifically to reduce health inequalities experienced by citizens. These Boards bring partners together to address City and County-wide issues where collaborative approaches between partners are essential. In addition to the CCG and City and County Councils, the Boards' memberships include a range of local partners, including Nottinghamshire Police, Nottinghamshire Fire and Rescue Service, Healthwatch Nottingham and Nottinghamshire, NHS England and NHS Improvement, local NHS Trusts and representatives from the voluntary sector.

The Health and Wellbeing Boards are statutorily responsible for producing joint strategic needs assessments (JSNAs) for their local populations. The JSNAs are 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 the City and County health and wellbeing strategies to address these specific factors.

The Nottingham City and Nottinghamshire County Joint Health and Wellbeing Strategies were launched in 2016 and 2018 respectively. Each strategy has four

overarching aims: Nottingham City's focus on the adoption of healthy lifestyles, maintaining positive mental health, the empowerment of citizens to manage their own health, and achieving a sustainable environment; and Nottinghamshire County's focus on giving everyone a good start in life, having healthy and sustainable places, enabling healthier decision-making, and working in partnership to improve health and care services.

During 2021/22, working arrangements between the Health and Wellbeing Boards and the evolving Nottingham and Nottinghamshire ICS will be reviewed to ensure maximum effectiveness in the context of reducing health inequalities.

Equality, diversity and inclusion

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 addition, we have to publish equality information annually; demonstrating how we have met the general aims of the public sector equality duty, and prepare and publish one or more equality objectives at least every four years.

The CCG recognises and values the diverse needs of the population we serve and we are committed to reducing health inequalities and improving the equality of health outcomes for local people. We are committed to embedding equality and diversity considerations into all aspects of our work, including policy development, commissioning processes and employment practices. 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.

We are committed to:

- Improving equality of access to health services and health outcomes for the diverse population we serve.
- Building and maintaining a diverse, culturally competent workforce, supported by an inclusive leadership team.
- Creating and maintaining an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

In practice, deliver against these commitments is achieved by embedding equality, diversity and inclusion considerations into all of our relevant business activities, including:

- ***Assessing the health needs of our population*** – We work with Local Authority Public Health colleagues to ensure that Joint Strategic Needs Assessment (JSNA) chapters consider all protected characteristic and other disadvantaged groups to accurately inform equality considerations in our commissioning intentions.
- ***Public engagement and communications*** – We engage with people from all protected characteristic and other disadvantaged groups in our population, particularly those whose voices may not be routinely heard, through a range of different mechanisms to ensure that we have the right information to commission the right health services that can be accessed by the people who need them. We also deliver targeted and tailored messaging that reaches the right people more effectively.
- ***Equality impact assessments*** – We complete equality impact assessments whenever we plan, change or remove a service, policy or function. These are completed through integrated equality and quality impact assessments (EQIAs) that also incorporate wider quality considerations (patient safety, patient experience and clinical effectiveness). EQIAs 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.
- ***Procurement and contract management*** – We include an assessment of compliance with equality legislation requirements as a routine aspect of all procurement exercises and we use the national NHS Standard Contract, which in its full-length version mandates providers of NHS services to implement the NHS Equality Delivery System, NHS Accessible Information Standard, NHS Workforce Race Equality Standard (WRES) and NHS Workforce Disability Equality Standard (WDES). A range of assurances on compliance with these requirements are incorporated within our routine quality and performance monitoring processes.
- ***Recruitment, selection and the working environment*** – We operate a fair, inclusive and transparent recruitment and selection process and maintain relevant workforce accreditations to help demonstrate that we promote equality of opportunity. We implement the NHS Workforce Race Equality Standard (WRES) and work to the requirements of the NHS Workforce Disability Equality Standard (WDES) and our working environment aims to promote the health and wellbeing of the whole workforce through a suite of human resources policies, which have been assessed from an equality perspective.
- ***Cultural competence*** – To enhance our mandatory equality and diversity and human rights training requirements, we provide relevant training and development opportunities to staff with the aim of improving their cultural competence and their understanding of the needs of our diverse population.

During 2020/21, we have established an Equality, Diversity and Inclusion Steering Group to drive the equality, diversity and inclusion agenda within the CCG and to provide a focal point for the discussion, development and implementation of ways to improve our equality performance. As a newly merged organisation, a key focus of the year has been to assess our baseline equality performance and to develop, and start to implement, our equality improvement plan. Actions taken during the year relate to our understanding of, and response to, the impact of the Covid-19

pandemic on different groups in society, improving workforce diversity at all levels within the CCG, and improving the cultural competence of our workforce.

Our Annual Equality Assurance Report for 2020/21 is available on our website at https://nottsccg.nhs.uk. This describes how we have fulfilled our statutory equality duties and the progress we have made during the year to improve our equality performance for the benefit of our local population and our staff.

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 and the NHS Act 2006 (as amended). The Civil Contingencies Act specifies that responders will be either Category 1 (primary) or Category 2 responders (supporting agencies). NHS England and NHS Improvement, acute and ambulance service providers, Public Health England and Local Authorities are Category 1 responders and CCGs are Category 2 responders.

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, representing health at any Covid-19 related Strategic Co-ordinating Group, Tactical Co-ordination Group, or system-wide meetings. These responsibilities were formally delegated to CCGs from NHS England, in accordance with the Civil Contingencies Act.

The CCG has maintained an Incident Command Centre throughout 2020/21, which has had oversight of, and co-ordinated, the response to the Covid-19 pandemic, alongside EU Exit arrangements, winter planning and extensive flooding.

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 2020/21, this was conducted with partners across the system to assess the collective response to the Covid-19 pandemic.

Accountability Report

Dr Amanda Sullivan

Accountable Officer

11 June 2021

Corporate governance report

Members report

Member practices

As at 31 March 2021, the CCG has 126 member GP practices. These are as follows:

1. Abbey Medical Centre	**43.** Hounsfield Surgery	**85.** Saxon Cross Surgery
2. Abbey Medical Group	**44.** Hucknall Road Medical Centre	**86.** Selston Surgery
3. Acorn Medical Practice	**45.** Jacksdale Medical Centre	**87.** Sherrington Park Medical Centre
4. Ashfield House	**46.** John Ryle Medical Centre	**88.** Sherwood Medical Partnership
5. Aspley Medical Centre	**47.** Jubilee Park Medical Partnership	**89.** Sherwood Rise Medical Centre
6. Bakersfield Medical Centre	**48.** King's Medical Centre	**90.** Skegby Family Medical Centre
7. Balderton Primary Care Centre	**49.** Kirkby Community Primary Care Centre	**91.** Southglade Health Centre
8. Barnby Gate Surgery	**50.** Kirkby Health Care Complex	**92.** Southwell Medical Centre
9. Beechdale Surgery	**51.** Kirkby Health Centre	**93.** Springfield Medical Centre
10. Belvoir Health Group	**52.** Leen View Surgery	**94.** St Albans Medical Centre
11. Bilborough Medical Centre	**53.** Lime Tree Surgery	**95.** St Georges Medical Practice
12. Bilborough Surgery	**54.** Linden Medical Group	**96.** St Luke's Surgery
13. Bilsthorpe Surgery	**55.** Lombard Medical Centre	**97.** St Peter's Medical Practice
14. Bramcote Surgery	**56.** Lowmoor Road Surgery	**98.** Stenhouse Medical Centre
15. Bridgeway Medical Centre	**57.** Major Oak Surgery	**99.** Sunrise Medical Centre
16. Brierley Park Medical Centre	**58.** Meadows Health Centre	**100.** The Alice Medical Centre
17. Broad Oak Medical Practice	**59.** Meden Medical Services	**101.** The Fairfields Practice
18. Calverton Practice	**60.** Melbourne Park Medical Centre	**102.** The Family Medical Centre
19. Castle Healthcare Practice	**61.** Middleton Lodge Practice	**103.** The Forest Practice

20. Chilwell Valley and Meadows Practice	**62.** Mill View Surgery	**104.** The High Green Medical Practice
21. Churchfields Medical Practice	**63.** Musters Medical Practice	**105.** The Ivy Medical Group
22. Churchside Medical Practice (Ward and Pearce)	**64.** NEMS Platform One Practice	**106.** The Manor Surgery
23. Clifton Medical Practice	**65.** Newthorpe Medical Centre	**107.** The Medical Centre
24. Collingham Medical Centre	**66.** Oakenhall Medical Practice	**108.** The Oaks Medical Centre
25. Daybrook Medical Practice	**67.** Oakwood Surgery	**109.** The Om Surgery
26. Deer Park Family Medical Practice	**68.** Orchard Medical Practice	**110.** The University of Nottingham Health Service
27. Derby Road Health Centre	**69.** Orchard Surgery	**111.** Torkard Hill Medical Centre
28. East Bridgford Medical Centre	**70.** Parkside Medical Practice	**112.** Trentside Medical Group
29. Eastwood Primary Care Centre	**71.** Peacock Healthcare	**113.** Tudor House Medical Practice
30. Elmswood Surgery	**72.** Plains View Surgery	**114.** Unity Surgery
31. Family Medical Centre	**73.** Pleasley Surgery	**115.** Victoria and Mapperley Practice
32. Forest Medical	**74.** Queens Bower Surgery	**116.** Village Health Group
33. Fountain Medical Centre	**75.** Radcliffe-on-Trent Health Centre	**117.** Welbeck Surgery
34. Gamston Medical Centre	**76.** Radford Medical Practice	**118.** Wellspring Surgery
35. Giltbrook Surgery	**77.** Rainworth Health Centre	**119.** West Bridgford Medical Centre
36. Grange Farm Medical Centre	**78.** Rise Park Surgery	**120.** West Oak Surgery
37. Greendale Primary Care Centre	**79.** Riverbank Medical Services	**121.** Westdale Lane Surgery
38. Greenfield Medical Centre	**80.** Rivergreen Medical Centre	**122.** Whyburn Medical Practice
39. Hama Medical Centre	**81.** Riverlyn Medical Centre	**123.** Willowbrook Medical Practice
40. Hickings Lane Medical Centre	**82.** Roundwood Surgery	**124.** Windmill Practice
41. Highcroft Surgery	**83.** Ruddington Medical Centre	**125.** Wollaton Park Medical Centre
42. Hill View Surgery	**84.** Sandy Lane Surgery	**126.** Woodlands Medical Practice

Composition of 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).

Dr Stephen Shortt is the CCG's Clinical Chair and Joint Clinical Leader alongside Dr James Hopkinson. The Governing Body's membership also includes the organisation's Accountable Officer, Chief Finance Officer, Chief Nurse and Chief Commissioning Officer. Membership also includes a secondary care specialist and five Non-Executive Directors, one of whom is the Deputy Chair of the Governing Body and usually presides over meetings.

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 2020 to 31 March 2021:

- Dr Stephen Shortt – Clinical Chair and Joint Clinical Leader
- Dr James Hopkinson – Lead GP for the Nottingham and Nottinghamshire Clinical Design Authority and Joint Clinical Leader
- Dr Amanda Sullivan – Accountable Officer
- Stuart Poynor – Chief Finance Officer
- Rosa Waddingham – Chief Nurse
- Lucy Dadge – Chief Commissioning Officer
- Dr Adedeji Okubadejo – Secondary Care Specialist
- Jon Towler – Non-Executive Director and Deputy Chair of the Governing Body
- Susan Sunderland – Non-Executive Director
- Susan Clague – Non-Executive Director
- Eleri De Gilbert – Non-Executive Director
- Shaun Beebe – Non-Executive Director
- Dr Hilary Lovelock – GP Representative, Mid-Nottinghamshire
- Dr Manik Arora – GP Representative, Nottingham City
- Dr Richard Stratton – GP Representative, South Nottinghamshire

Full biographies of our Governing Body members are available in 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.

Audit and Governance Committee

The following Non-Executive Directors 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)
- Eleri De Gilbert
- Jon Towler

Other committee memberships

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

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 in the '*About us*' section of our website at https://nottsccg.nhs.uk/. Further details on how we manage conflicts of interest are detailed in the *Governance statement* contained within this report.

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.

During the year, we reported one serious incident relating to unauthorised disclosure to the Information Commissioner's Office (ICO). The incident related to the publication of limited, but person-identifiable data, about a small number of staff from two primary care organisations on the Internet, as part of a procurement exercise. A full root cause analysis was undertaken and the employers of the affected staff were supported by the CCG to contact and inform the individuals affected. The full investigation and outcome was shared with the ICO who concluded no further action

was to be taken. A further ten personal data related incidents were reported during the year; however, these were not rated as serious in nature and were managed in line with our incident reporting and management procedures.

Complaints

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 maximise service development, make changes where required to systems and processes, and improve future experiences for everybody. 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. All our complaints are handled in line with the statutory NHS Complaint Handling Guidelines. Our Patient Experience Team manage the complaints process and respond to queries, resolve concerns or signpost people to appropriate services.

During 2020/21, the CCG received 102 complaints for investigation, of which three were upheld. The outcome of the complaints we upheld led to improvements to an appointment booking system, the development of a new glaucoma monitoring triage process for patients, and an improved discharge process for Covid-19 patients leaving hospital. As an organisation, we received two Ombudsman investigations this year, one of which the Ombudsman decided not to investigate and one of which remains open at the time of finalising this annual report.

Statement of Disclosure to Auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; and
- The member has taken all the steps that they ought to have taken 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. As such, the Governing Body has agreed to demonstrate its commitment to the Act and has agreed a position statement, which 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 Dr Amanda Sullivan to be the Accountable Officer of NHS Nottingham and Nottinghamshire 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)); and
- 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.

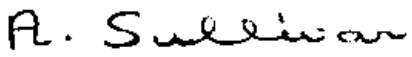
In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- 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;
- 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.



Dr Amanda Sullivan

Accountable Officer

11 June 2021

Governance statement

Introduction and context

NHS Nottingham and Nottinghamshire CCG is a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended). The CCG was formed through the merger of NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham City CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG.

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. These services include: planned hospital and rehabilitation care; maternity services; urgent and emergency care; community services; and mental health and learning disability services. The CCG also has full delegated responsibility from NHS England for commissioning primary medical services for the people of Nottingham and Nottinghamshire.

As at 1 April 2020, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The CCG is a membership organisation, comprised of all GP Practices within the CCG's geographic area, with strong clinical leadership arrangements. We work in partnership with the health and care organisations in Nottingham and Nottinghamshire as part of an Integrated Care System (ICS), with the purpose of taking collective responsibility for managing resources, delivering NHS standards and improving the health of our local population.

The primary focus of the CCG and our system partners throughout 2020/21 has been on implementing the NHS response to the Covid-19 pandemic, whilst working hard to protect and care for our population and our workforce. We have also focused on the continued wellbeing of our staff and the wider system workforce.

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.

Governance arrangements and effectiveness

The CCG observes generally accepted principles of good governance, which include ensuring that we maintain high standards of impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.

The CCG has established a Constitution, supported by a set of Standing Orders and Standing Financial Instructions, which together set out:

- The statutory framework in which the CCG operates and how it demonstrates its accountability to its member GP Practices, local people, stakeholders and NHS England.
- The role of the Governing Body, its membership and how Governing Body members will be appointed, along with details of their terms of office.
- How the CCG will conduct its business and how it will make decisions.
- The roles of statutory and mandatory committees and requirements for joint commissioning arrangements with other CCGs, local authorities and NHS England.
- How the CCG's financial affairs will be managed and the delegated limits for financial commitments on behalf of the CCG.

The CCG has also established a comprehensive Governance Handbook, which includes the terms of reference for each of the Governing Body's appointed committees and the CCG's Scheme of Reservation and Delegation, which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the CCG's Governing Body (and its committees) and employees.

The CCG has a number of policies to ensure that high standards of business conduct are maintained, particularly in relation to our decision-making arrangements. These are our Managing Conflicts of Interest Policy, Gifts, Hospitality and Sponsorship Policy, and Raising Concerns (Whistleblowing) Policy. Together, these policies set out the CCG's arrangements for managing conflicting interests and for declaring offers of gifts and hospitality. They also explain how any whistleblowing concerns, relating to the activities of the CCG, can be raised and responded to.

We maintain and publish a Register of Declared Interests for all employees and appointees of the CCG and an annual assurance exercise is completed to confirm the completeness and accuracy of the register. The CCG also maintains and publishes a Register of Procurement Decisions, which sets out how declared interests have been managed during procurement exercises, and a Gifts, Hospitality

and Sponsorship Register, which records all offers of gifts, hospitality and sponsorship, regardless of whether or not they have been accepted.

Agendas for meetings of the Governing Body and its committees also contain a standing item to ensure that members and attendees declare any interest relating specifically to the agenda items being considered and to ensure that the course of action is clearly documented within the minutes. Where appropriate, action is taken in advance of the meetings (e.g. by excluding any individual with an identified conflict of interest from that section of the meeting and ensuring that they don't receive any related papers) and Chairs are briefed on any known conflicts of interest (or potential conflicts of interest) in advance of the meeting.

The CCG has appointed two of its Non-Executive Directors in the roles of Conflicts of Interest Guardian and Freedom to Speak Up Guardian.

All of the CCG's governing documents and policies are available in the '*About us*' section of our website at https://nottsccg.nhs.uk/.

Emergency governance arrangements

Governance arrangements have needed to flex in-year to allow the CCG to operate as efficiently and effectively as possible during the period of the Covid-19 pandemic; primarily to enable rapid, robust decision-making on urgent issues directly relating to the Covid-19 outbreak and its management, but also to ensure that business-critical decisions not directly relating to the Covid-19 outbreak could continue to be made. The emergency governance arrangements included:

- All Governing Body and committees being authorised to meet on a virtual basis, with focussed agendas and streamlined papers in order to reduce the burden of meetings and release clinical and management capacity to respond to the pandemic. Agreement was also reached that there would be no sanction for technical quorum breaches as a result of illness, self-isolation or the need for clinical staff to focus on provision of care. It should be noted, however, that it did not prove necessary to utilise this agreement during the year.
- The establishment of an Incident Co-ordination Centre, supported by a number of specialist 'Cells' covering primary care, urgent care, clinical quality and safety (including care homes, home care and medicines optimisation), logistics (mainly focussed on personal protective equipment), capacity planning, business continuity and service changes. Daily Executive Management Team meeting have also been held to facilitate urgent decision-making on service change proposals to support the emergency response. These arrangements were summarised within a Covid-19 specific Scheme of Reservation and Delegation (SoRD).
- Review and amendment of delegated financial limits for the purpose of invoice and expenditure approvals and authorised signatories for payroll transactions to ensure the CCG has sufficient resilience to make payments to its suppliers and staff. A number of procurement cards were also put in place to facilitate the purchase of goods and services from suppliers who will only provide these goods and services with immediate payment.

The emergency governance arrangements have been kept under review for the entirety of 2020/21, with changes being made as required. At its 2 June 2021

meeting, the Governing Body approved a full return to ‘business as usual’ governance arrangements.

The Governing Body

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 Governing Body also has a number of responsibilities delegated to it by the CCG’s member GP Practices. These cover arrangements for discharging the CCG’s commissioning functions and statutory duties, agreeing the vision, values and strategic objectives of the CCG, approval of strategies, plans and policies, and approval of risk management arrangements.

As part of the CCG’s commitment to openness and accountability, meetings of the Governing Body are normally held in public and members of the public may ask questions in advance of each meeting, in line with the items scheduled for discussion. However, a national restriction regarding the avoidance of face-to-face meetings has been in place throughout 2020/21, as one of the ongoing measures to limit the spread of Covid-19. As such, open sessions of the Governing Body have been held virtually, utilising appropriate application software to allow access to members of the public to observe proceedings.

In accordance 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. Due to the need to prioritise the CCG’s response to the Covid-19 pandemic, there was a delay in developing the work programme for this year; however the work programme established covered a full business cycle.

The Governing Body’s membership is comprised of the CCG’s Joint Clinical Leaders, three further GP Representatives and a secondary care specialist, five Non-Executive Directors, and the CCG’s Accountable Officer, Chief Finance Officer, Chief Nurse and Chief Commissioning Officer. The Governing Body may also co-opt observers and attendees with speaking rights to attend meetings as required. The members of the Governing Body are named within the *Members Report* section of this annual report.

The Governing Body met on seven occasions during 2020/21. All meetings were quorate, in accordance with the CCG’s Standing Orders, and members achieved an average attendance of 95%. The following provides a summary of the work of the Governing Body during 2020/21:

- At its inaugural meeting in April 2020, the Governing Body received the documentation that established and would subsequently govern the new CCG. This included: receipt of the Grant of Merger and Property and Staff Transfer Schemes; adoption of the CCG's Constitution; receipt of the Delegation Agreement for Commissioning of Primary Medical Services; approval of the CCG's Governance Handbook; adoption of the CCG's organisational policies; and approval of the CCG's core values and behaviours. At the same meeting, in response to the pandemic, the Governing Body approved emergency governance arrangements to ensure that the CCG could operate efficiently and effectively during the time of the emergency response to the Covid-19 pandemic
- During the year, the Governing Body's focus remained on incident response arrangements, with regular updates being received through the Accountable Officer's Reports. This has included the establishment of incident response arrangements, the creation of surge capacity for inpatient and intensive care, maintenance of essential patient care and restoration of services, whilst tackling the planned care backlog and meeting new and emerging post-Covid care demands, and the planning and delivery of the NHS vaccination programme. There has also been a necessary focus on the availability of personal protective equipment, workforce support, outbreak management, support to the primary care and care home sectors, testing arrangements, and urgent actions required to tackle health inequalities, highlighted by the disproportionate impact that Covid-19 has had on many within our society.
- During the year, the Governing Body approved a number of investments within its delegated financial limits of responsibility, most notably, the decision making business case on the proposed development for the NHS Rehabilitation Centre at Stanford Hall.
- Reports relating to the CCG's financial position and the quality and performance of commissioned services were also considered on a routine basis.
- The Governing Body considered and approved the CCG's refreshed Quality Strategy and Equality, Diversity and Inclusion Policy.
- The organisational priorities for 2020/21 were approved; however in October, as the pandemic escalated, the Governing Body agreed a revised approach to ensure that the CCG continued to focus on essential key deliverables whilst maintaining the capacity to respond to the incident.
- The Governing Body also received regular updates in relation to the management of the CCG's strategic risks, via the Governing Body Assurance Framework and has received routine reports on the major operational risks being faced by the organisation. The CCG's Risk Management Policy was also approved, with specific consideration of the organisation's risk appetite.
- The first annual report from the Learning Disabilities Mortality Review (LeDeR) Programme was received by the Governing Body. The LeDeR Programme was established to review the deaths of people with a learning disability, identifying learning from those deaths, and to take forward the learning into service improvement initiatives.
- The Governing Body received highlight reports from each of its committees at every meeting, in order to demonstrate that delegated responsibilities were being effectively discharged. These reports summarised the key strategic discussions and approvals made by each committee, highlighting key achievements and areas of concern, as relevant.
- Updates from key strategic partnership forums were also received throughout the year, including updates from the Nottingham and Nottinghamshire Integrated Care System Partnership Board and the Nottingham City and Nottinghamshire County Health and Wellbeing Boards.
- In addition to its formal meetings, the Governing Body also held six development sessions to discuss in depth a number of key strategic commissioning projects; and to further develop

approaches to strategic and integrated commissioning and wider system working.

Committees of the Governing Body

The Governing Body has established a number of committees to assist it with the discharge of its functions. Some committees are statutory requirements, or mandated by Delegation Agreements with NHS England, whilst others are established 'by design' taking into account best practice. Together, they support the delivery of the CCG's statutory duties and enable effective oversight, scrutiny and decision-making arrangements.

The Governing Body has approved and keeps under review the terms of reference for all of its committees and each committee produced an annual work programme to ensure it is able to discharge its delegated responsibilities; albeit that these were agreed slightly later in the year than normal due to the need to prioritise the CCG's response to the Covid-19 pandemic. All committees routinely report to the Governing Body through the submission of highlight reports, ratified minutes, and other appropriate updates as necessary.

A formal review of committee effectiveness is completed on an annual basis. For 2020/21, the annual review considered whether current arrangements enable the effective discharge of delegated duties, alongside consideration of the interdependencies between committees and the suitability of current reporting and assurance mechanisms to the Governing Body. Committee business cycles and the robustness and consistency of decision-making arrangements were also examined, including whether the CCG is meeting its statutory requirements around openness and transparency. The outcome of the review was reported to the Governing Body in April 2021, which confirmed that the committees have functioned effectively over the course of year, despite the challenges the CCG has faced in relation to the Covid-19 pandemic. A small number of areas for development were identified, which will be overseen by Audit and Governance Committee on behalf of the Governing Body.

A summary of the work of each of the Governing Body's committees is set out in the sections below.

Audit and Governance Committee

The Audit and Governance Committee exists to provide 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. In June 2020, the Committee's remit was expanded to include oversight of statutory and mandatory requirements relating to health, safety, security and fire; the development, implementation and monitoring of the CCG's incident management arrangements and to review the adequacy and effectiveness of the CCG's emergency preparedness, resilience and response (EPRR) and business continuity arrangements.

The Audit and Governance Committee's membership is comprised of three Non–Executive Directors of the Governing Body; the Chair having qualifications and expertise in finance and audit matters. Members are supported by the CCG's internal auditors, external auditors and local counter fraud specialist.

The Committee met six times during 2020/21, all meetings were quorate in line with the Committee's terms of reference and its members achieved 100% attendance at meetings. The members of the Committee are named within the *Members Report* section of this annual report.

During 2020/21, 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 2021.
- Scrutinised the CCG's Register of Tender Waivers, which sets out all contracts that have been awarded without a competitive tender process.
- Received assurance reports demonstrating the arrangements in place for operational and strategic risk management (including the Executive-led reviews of the Governing Body Assurance Framework), standards of business conduct, health and safety, and information governance.
- Received updates from the CCG's Counter Fraud service on progress in achieving the NHS Counter Fraud Authority Standards for NHS Commissioners and assurance that the risks on the CCG's Fraud Risk Register were being actively managed.
- Endorsed the changes to the CCG's delegated financial limits used during the emergency response period and kept under review the CCG's use of procurement cards during this period.
- Received assurance in relation to implementation of the CCG's policy management framework.
- Scrutinised compliance with the CCG's statutory and mandatory training requirements.
- Received a comprehensive report on CCG emergency preparedness, resilience and response (EPRR) responsibilities, receiving assurance that robust structures were in place to respond to the on-going pandemic, as well as other known pressures.
- Maintained constant focus on the internal audit plan to ensure that the plan gave sufficient focus on key areas of scrutiny for to produce the end of year Head of Internal Audit Opinion, whilst recognising the pressures on CCG workload during the response to the pandemic.

- Received a report on the effectiveness of all of the Governing Body's statutory and non-statutory committees to provide assurance 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.
- Approved the six predecessor CCG Annual Reports and Accounts for 2019/20.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee exists 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.

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 Non-Executive Directors. As such, its remit excludes considerations in relation to non-executive director remuneration, fees and allowances, which are instead approved by non-conflicted members of the Governing Body.

The Remuneration and Terms of Service Committee met six times during 2020/21, with members averaging 95% attendance and all meetings achieving the quorum requirements set out in the Committee's terms of reference. The members of the Committee are named within the *Remuneration Report* section of this annual report.

During 2020/21, the Remuneration and Terms of Service Committee has:

- Made recommendations to the Governing Body for the proposed remuneration of the CCG's Very Senior Managers (VSM) and reviewed processes for their performance management.
- Kept under review the implementation of the CCG's clinical leadership structure.
- Endorsed a small number of proposed redundancies, following the restructuring exercise undertaken to align the predecessor six CCGs during the previous financial year.
- Approved a number of key human resource policies; which included policies on organisational change; sickness absence; capability; staff appraisals; recruitment and selection; and learning, development and education.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee has been established following the issuance of a formal delegation agreement from NHS England to empower the CCG to commission primary medical services for the people of Nottingham and Nottinghamshire. The Committee operates as the corporate decision-making body

for the management of the delegated functions and the exercise of the delegated powers. It exists to make collective decisions on the review, planning and procurement of primary medical services in Nottingham and Nottinghamshire, under delegated authority from NHS England. In August 2020, the Committee's remit was widened to include oversight of the development of Primary Care Networks.

The Committee is chaired by a Non-Executive Director and it has a balanced membership comprised of non-executive and clinical members, alongside the relevant managerial leads in line with the remit of the committee. Membership has been reviewed in-year to ensure its continued appropriateness in enabling the Committee to discharge its delegated responsibilities.

The Primary Care Commissioning Committee met 12 times during 2020/21 and all meetings were quorate in line with the Committee's terms of reference. The average attendance achieved by members during the year was 88%. Meetings are open to members of the public to attend, in line with the requirements of the delegation agreement. For 2020/21, this has been achieved by holding meetings virtually, utilising appropriate application software, to allow access to members of the public to observe proceedings. Members of the public may also ask questions in advance of each meeting, in line with the items scheduled for discussion.

During 2020/21, the Primary Care Commissioning Committee has:

- Considered a number of applications from GP practices; including decisions relating to the temporary closure of GP practice patient lists or to alter GP practice geographic boundaries. The Committee requested that criteria be developed to ensure all decisions made were objective and consistent and that robust EQIAs had been completed to assess the impact of all significant changes. All decisions made by the Committee continued to be informed by a wide range of views, including the views of patients, neighbouring practices and the relevant Primary Care Network (PCN).
- Scrutinised assurance reports on demand management in primary care and primary care workforce challenges in relation to additional pressures placed on GP practices during the emergency response to the pandemic. This included oversight of primary care Operational Pressures Escalation Levels (OPEL) reporting, which facilitates rapid deployment of support to practices.
- Overseen a review of Local Enhanced Services (LES) across Nottinghamshire to ensure schemes continued to meet the identified needs and priorities of the local population.
- Overseen the process for the contracting of a number of Alternative Provider Medical Services (APMS) procurements. The Committee requested improvements to future procurement processes to ensure transparency and use of best value decision making principles.
- Reviewed progress in the development of local PCNs' workforce plans, including the agreement of additional roles within PCNs, such as First Contact Physiotherapists and Pharmacy Technicians, alongside wider primary care workforce reports addressing significant risks regarding workforce.
- Received a monthly update on the position of the primary care delegated budget; oversaw assurance reports on General Practice Covid-19 additional expenses and approved priority areas of spend for primary care transformation monies.
- Following a challenging procurement process for a Nottingham City GP practice, the

Committee oversaw the implementation of a 'lessons learned' report to take into account for future procurements.

- 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.

Prioritisation and Investment Committee

The Prioritisation and Investment 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 and consultation activities, where necessary. The Committee also ensures that the CCG's procurement responsibilities are appropriately discharged, including oversight of annual procurement plans.

The Prioritisation and Investment Committee met 12 times during 2020/21 and all meetings were quorate in line with the Committee's terms of reference. The committee is chaired by a Non-Executive Director and has a balanced membership comprised of non-executive and clinical members, alongside the relevant managerial leads in line with the remit of the committee. Membership has been reviewed in-year to ensure its continued appropriateness in enabling the Committee to discharge its delegated responsibilities. The average attendance during 2020/21 was 80%.

During 2020/21, the Prioritisation and Investment Committee has:

- Regularly scrutinised the CCG's log of investments, disinvestments and contract award decisions for investments below the Committee's financial threshold (as set out in the CCG's Standing Financial Instructions) to ensure the consistency of decision-making. The Committee has also retrospectively reviewed all urgent Covid related decisions made by the Executive Team (as part of the Covid emergency response governance arrangements).
- Received, and approved, 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 scrutinised by the Committee prior to requesting formal approval by the Governing Body. For 2020/21, approval was also required to be sought from NHS England and NHS Improvement for any new investments, in line with the Covid incident response financial regime. Business cases were considered in a number of areas, including community, mental health, maternity and children and young people's services, as well as planned care.
- Scrutinised a number of service benefit reviews, which had been undertaken to review the effectiveness of existing commissioning 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. The Committee received a higher volume of requests to extend, or direct award, contracts during the year, in recognition of anticipated work to align commissioning activity across Nottingham and Nottinghamshire being paused, or delayed, due to Covid.
- Had oversight of the CCG's plans for system integration and development to support a more collaborative approach to system planning and prioritisation, including seeking assurance on

the maturity of system architecture to enable the translation of a system-led approach into action.

- Scrutinised commissioning and procurement risks from the Corporate Risk Register each month, 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.

Quality and Performance Committee

The Quality and Performance Committee exists 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. In June 2020, the Committee's remit was widened to include oversight and scrutiny of the CCG's equality performance in relation to its role as a commissioner of health services.

The Quality and Performance Committee met ten times during 2020/21 and all meetings bar one were quorate in line with the Committee's terms of reference. The February 2021 meeting of the Committee was not quorate due to exceptional circumstances; however the meeting went ahead at the decision of the Chair and those present, with agreement that any items requiring a decision would be circulated outside of the meeting for virtual approval. The committee is chaired by a Non-Executive Director and has a balanced membership comprised of non-executive and clinical members, alongside the relevant managerial leads in line with the remit of the committee. Membership has been reviewed in-year to ensure its continued appropriateness in enabling the Committee to discharge its delegated responsibilities. The average attendance was 75%.

During 2020/21, the Quality and Performance Committee has:

- Received comprehensive quality and nursing intelligence reports in relation to key quality and safety concerns across NHS commissioned services, with a specific in-year focus on quality and safety concerns arising in response to the Covid-19 pandemic. More specifically, this included presentations in relation to personal protective equipment (PPE), safeguarding 'hidden harm', Care Homes and Home Care, and the Covid vaccination programme.
- Received monthly reports which focussed on performance of CCG commissioned services and the actions being undertaken to mitigate the shortfalls in performance. During the year, the Committee requested additions to the performance report; more specifically, inclusion of performance against NHS England and NHS Improvement's Third Phase Plan restoration and recovery of services; additional metrics to oversee emergency demand and managing winter pressures; and the development of metrics to measure progress on health inequalities.
- Sought routine assurance that providers had appropriately responded to actions identified as a result of Care Quality Commission (CQC) inspections, in particular, in relation to the maternity services at Nottingham University Hospitals NHS Trust.
- Received a discussion document 'Focus on Harm – During Covid-19 and Beyond' outlining how quality intelligence and insight had been captured during the emergency response period, as a first step to longer-term work regarding learning from the pandemic.
- Commissioned a review of the CCG's quality assurance processes in response to issues

which arose in-year.

- Undertook in depth reviews of urgent care, mental health and cancer services.
- Received annual reports for assurance, relating to:
  - Community Infection Prevention and Control;
  - Disabilities Mortality Review (LeDeR);
  - Nottinghamshire Area Prescribing Committee;
  - Controlled Drugs;
  - Safeguarding;
  - Looked After Children/Children in Care;
  - Services for Children with Special Educational Needs and/or Disabilities (SEND).
- Scrutinised quality risks from the Corporate Risk Register each month, 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.

Finance and Resources Committee

The Finance and Resources 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. In June and August 2020, the Committee's remit was widened to also include oversight of the CCG's workforce, organisational development and information management and technology strategies, development and implementation of its Green Plan, and delivery the CCG's annual operational priorities. The Committee also approves awards of non-healthcare contracts.

During 2020/21, the CCG was placed under a 'temporary financial regime' that was nationally implemented by NHS England and NHS Improvement in response to the Covid-19 pandemic. This removed the CCG's allocation and consequently the Committee's usual role to oversee the development and progress of financial plans.

The Finance and Resources Committee met ten times during 2020/21 and all meetings were quorate in line with the Committee's terms of reference. The committee is chaired by a Non-Executive Director and has a balanced membership comprised of non-executive and clinical members, alongside the relevant managerial leads in line with the remit of the committee. Membership has been reviewed in-year to ensure its continued appropriateness in enabling the Committee to discharge its delegated responsibilities. The average attendance was 77%.

During 2020/21, the Finance and Resources Committee has:

- Overseen the CCGs' financial position, through the scrutiny of monthly finance reports to ensure the CCG continued its efforts to deliver best value for the population it serves.
- Overseen the CCG's QIPP Programme for those areas of spend within the CCG's span of control.
- Received monthly reports of costs associated with Covid-19 and assurance that robust control arrangements were in place to seek reimbursement of expenditure from NHS England and NHS Improvement.

- Considered Cross Provider Reports providing an overview of the financial and activity performance for NHS Nottingham and Nottinghamshire CCG with a focus on the key contracts. This included progress on mitigating actions implemented to address key areas of pressure and challenge. *It should be noted that this monthly reporting arrangement was paused in-year due to block payment agreements being put in place with the CCG's main providers, as directed by NHSE/I as part of the Covid-19 temporary financial regime.*
- Overseen the development of the CCG's 2020/21 Organisational Priorities and received updates on progress, or noted instances where actions had needed to be paused due to CCG resource being redeployed to focus on the Covid-19 incident response.
- Received workforce reports (the first of which included endorsement of proposed workforce indicators), reviewed progress against the CCG's Organisational Development Strategy and Workforce Race Equality Scheme (WRES) action plan.
- Received assurance regarding the approval, and implementation, of the CCG's future operating model (i.e. agile working model), which was considered alongside implementation of the CCG's Estate's Strategy.
- Scrutinised finance, HR and IT 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.

Patient and Public Engagement Committee

The Patient and Public Engagement Committee (PPEC) has been established as a strategic advisory group to ensure that the patient voice informs the decision-making of the CCG. As such, it does not have any delegated decision making powers.

Acting in an advisory capacity, PPEC aligns its work programme to that of the CCG's commissioning intentions and priorities and ensures that patient and public involvement is embedded across the work of the CCG. In addition, PPEC provides assurance to the Governing Body that the organisation is meeting its statutory requirements to involve the public in its commissioning activities.

PPEC meets on a monthly basis and its membership is comprised of patient, carer and voluntary and community group representatives that reflect the demographic and health needs of Nottingham and Nottinghamshire's population. The organisation's senior management team also attend meetings, as required.

Our 2020/21 Annual Engagement Report is available on the CCG's website at https://nottsccg.nhs.uk and this describes how the CCG is meeting its statutory duties in relation to patient and public engagement and the work of PPEC during the year.

Membership meetings

The CCG's member GP Practices are integral to the functioning of the CCG. The GP Practices that make up the CCG's membership are organised into Place-based groupings, based on three geographical locations:

- Mid-Nottinghamshire (which covers the boroughs/districts of Mansfield, Newark and

Sherwood, and partly covers the district of Ashfield)

- South Nottinghamshire (which covers the boroughs/districts of Broxtowe, Gedling and Rushcliffe, and partly covers the district of Ashfield)
- Nottingham City

The Governing Body is accountable to the CCG's membership. As such, meetings are held with member GP Practices on at least an annual basis to ensure that engagement, involvement and communication is effective and appropriately maintained.

As 2020/21 is the first year of the CCG's establishment, it was felt appropriate to meet with member GP Practices during November 2020 to review the past eight months, update on future plans and receive feedback. Three Member Practice meetings were held virtually; one for each of the Place-based geographical groupings. All were well attended.

The meetings discussed the response to the Covid-19 pandemic, the financial environment in which the practices operate and the future direction of primary care. Governing Body representatives also took the opportunity to put on record their thanks to all staff working in general practice for their continuing hard work and dedication to providing medical care to the CCG's population during the challenging period of pandemic response.

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 2021, and up to the date of signing this statement.

Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative 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 aspect of the CCG's governance structure is the establishment and implementation of sound risk management arrangements. Effective risk management ensures processes are in place to proactively identify, understand, monitor and address current and future risks; both operationally and strategically.

The CCG's Risk Management Policy was reviewed during early 2020/21 to ensure its continued 'fitness for purpose'. This included a high-level review of the risk appetite statement. The Policy clearly sets out the processes in place to ensure the systematic identification, assessment, evaluation and control of risks, including arrangements for the Corporate Risk Register and Governing Body Assurance Framework.

The following key elements are explicitly identified within the CCG's Risk Management Policy, which support the embedment of a risk aware culture:

- ***The Governing Body's 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 proactive and reactive risk identification within business decision making processes*** – Risks are identified through an assortment of means, such as horizon scanning, external and self-assessments (including internal and external audits), formal risk assessments and during both committee and routine team meetings. Regular meetings are held with Executive Directors and senior managers to discuss new or evolving risks within their respective portfolios/teams. How risks may impact on the public, and/or other stakeholders, is considered at the initial risk identification stage and then in more depth by relevant senior managers to ensure that the correct approach to any communication is taken.
- ***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. 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*** – 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. Incidents and near misses are captured, and reported to, the Health and Safety Steering Group or the Information Governance Steering Group and upwards to

the Audit and Governance Committee, if appropriate, to ensure action has been taken and lessons learnt.

- ***Ensuring the effectiveness of the Risk Management Policy*** – The Audit and Governance Committee has delegated responsibility for:
  - Reviewing the strategic and operational risk management processes across the CCG and satisfying itself that the overall system in place is effective.
  - Reviewing the relevance and rigour of the Governing Body Assurance Framework and Corporate Risk Register and the arrangements that surround them.
  - Providing assurance to the Governing Body in support of the Accountable Officer's Governance Statement, specifically commenting on the fitness for purpose of the Governing Body Assurance Framework and the completeness and embedment of risk management in the organisation.

The CCG's Risk Management Policy was developed in recognition that well-managed risk-taking can contribute positively to organisational performance, allowing for innovation and improvement. A fundamental aspect of the policy is the defined risk appetite, which is reviewed on an annual basis by the Governing Body and 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 and exploit opportunities; and
- ***Risk tolerance*** – which clearly sets out the boundaries of risk that the Governing Body is willing to accept.

The organisation's strategic risks are outlined within the CCG's Governing Body Assurance Framework, which provides the Governing Body with confidence that the CCG has identified its strategic risks and has robust systems, policies and processes in place that are effective and driving the delivery of its strategic objectives. All strategic risks are owned by an Executive Director of the CCG and the Governing Body receives a mid-year and year-end position updates.

Operational risks are 'live' risks the organisation is currently facing, which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives. Operational risks are captured within the CCG's Corporate Risk Register and are owned by members of the CCG's Senior Leadership Team.

A separate fraud risk register is also maintained by the CCG and reported to the Audit and Governance Committee once a year, in line with the CCG's annual fraud risk assessment. Mitigations identified in relation to the potential fraud risks largely relate to processes already in place as part of the CCG's system of internal control.

For 2020/21, the CCG has also maintained a Covid-19 risk/issues log, as risk management is deemed a 'critical function' in the organisation's emergency incident response structure. The log captures the potential risks, and issues currently being faced, specifically relating to the Covid-19 incident response.

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.

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.

Corporate Risk Reports are routinely reported to the each of the Governing Body's committees. Reports outline relevant operational risks that are in the remit of the respective committee, including any major (or red) risks, any new risks that have been identified, as well as any risks where the risk score has been mitigated to a level that can be removed from the Corporate Risk Register. Approval is sought from committee members prior to risks being archived. A Corporate Risk Report is also provided to each meeting of the CCG's Governing Body, which outlines all major (or red) risks that the organisation is currently exposed to.

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 who proactively raise awareness of the policy and provide ongoing support to committees, teams and individuals to enable them to discharge their responsibilities.

Risk assessment

The major risks identified by the CCG, and monitored through the Corporate Risk Register during 2020/21, related to:

- ***The potential for the Covid-19 pandemic to exacerbate health inequalities across the CCG's population.*** Mitigations to this risk largely relate to the restoration and recovery work that has been taken forward collectively by all system partners as part of the incident response arrangements. An ICS Health Inequalities Strategy has also been developed during 2020/21 and an implementation plan is in place. Addressing health inequalities is a key priority of the CCG for 2021/22 and will continue to be at the forefront of both Covid-recovery and 'business as usual' activity.
- ***A potential increase in morbidity and/or mortality for the CCG's population, both directly and indirectly, as a result of the Covid-19 pandemic.*** The indirect factors include, but are not limited to, changes in patient behaviours, limited access to services and longer waiting times for elective and planned care. Mitigations identified in relation to this risk largely relate to the clinical prioritisation work undertaken by the ICS Clinical Executive Group and the CCG's main providers, to ensure that planned care is being delivered based on clinical need. Use of independent sector providers has supported the management of this risk across

Nottingham and Nottinghamshire, however, capacity to address elective waiting lists continues to be a key risk area of the CCG, which will remain a priority for 2021/22.

- ***The potential for non-delivery of the CCG's financial duties for 2020/21***, due to the underlying positions of the CCG's six predecessor organisations, the impact of the Covid-19 financial regime, delays in planned service transformation and non-delivery of QIPP schemes (i.e. planned efficiencies not materialising). Financial recovery processes were 'paused' in-year due to the Covid-19 pandemic and, alongside ongoing uncertainties regarding the financial regime, mandated nationally-set block payments to providers, and increased costs of service provision (due to Covid requirements), finance risk scores remained high throughout the majority of 2020/21. In response to the CCG forecasting to meet its statutory financial duties for 2020/21, the likelihood score 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 2021/22 financial plan.
- ***The extent to which the CCG was able to spend its allocation in line with the commissioning intentions/priorities identified in the previous financial year, due to the Covid-19 financial regime.*** This, in turn, presented a risk that the health needs of the CCG's population may not be met. Limited mitigations were able to be taken in relation to this risk, as the national financial regime established in response to the Covid-19 pandemic prevented the CCG in making local investment decisions without approval from NHS England and NHS Improvement.
- The development of a 'system led' approach to prioritisation and investment in-year will support the mitigation of this risk during 2021/22.
- ***The potential for poor patient experience and patient safety concerns at Nottinghamshire Healthcare NHS Foundation Trust (NHCT).*** This risk was originally identified in October 2019, following the outcome of a Care Quality Commission (CQC) inspection being published. The CCG identified a further risk relating to lack of assurance regarding the culture and leadership at NHCT in response to the issues identified. The CCG's Quality and Performance Committee has commissioned a number of 'deep dive' reviews into the Trust. A full risk scoping exercise was also undertaken between the CCG, CQC and Regulators to determine whether appropriate actions were taken in response to the concerns identified. Governing Body and Committee level assurance requirements have been increased in-year. Monitoring and support continued throughout the Covid-19 emergency response period and the delivery of high quality services at NHCT continues to be a key priority for 2021/22.
- ***The potential for poor clinical outcomes and patient harm at maternity services provided by Nottingham University Hospitals NHS Trust (NUH)*** was identified as a risk during 2020/21, following the outcome of a Care Quality Commission (CQC) inspection being published. Monthly updates regarding NUH maternity services are provided to the CCG's Quality and Performance Committee and quality assurance processes have been strengthened. Monitoring of the quality of services continues daily and the delivery of high quality maternity services at NUH continues to be a key priority for 2021/22.
- ***The potential for workforce capacity with General Practice to significantly reduce, impacting the sustainability of some GP Practices.*** This risk has been further exacerbated by the Covid-19 pandemic, in particular, the significant support required from the primary care workforce to deliver the Covid-19 vaccination programme. There continues to be a risk that the CCG's population access needs are not met, adversely impacting patient experience and/or outcomes. GP 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. The development and embedment of Primary Care Networks (PCNs) during 2020/21 has contributed to the management of this risk, alongside implementation of the ICS Primary Care Workforce Strategy, which will

continue into 2021/22.

- ***The potential impact of an ongoing period of organisational change, alongside the unplanned move to remote working (as a result of the Covid-19 pandemic).*** This could result in:
  - Staff becoming disengaged, leading to low morale and reduced productivity.
  - Staff turnover increasing, leading to the loss of organisational memory.
  - An increase in staff experiencing musculoskeletal pain, visual fatigue and mental stress, due to incorrect Display Screen Equipment (DSE) set-up.

  The CCG's Governing Body recognised the significant impact of organisational change, and remote working, on the organisation's workforce. Significant focus has been given to the health and safety, and well-being agenda to ensure the CCG continues to address this risk. Regular (virtual) staff communication and engagement activities have been established in-year. The CCG's Staff Engagement Group has also been reinvigorated, alongside the establishment of three separate staff networks. Controls in relation to DSE and lone working assessments have been strengthened, alongside routine Covid-19 health and safety workplace risk assessments. Work is underway to take forward areas for improvement identified following the 2020/21 NHS Staff Survey.

Other sources of assurance

Internal control framework

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

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. These include the work of a range of operational steering groups and the work of the Governing Body and its committees. Of particular note is the role of the Audit and Governance Committee 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 CCG's arrangements for managing conflicts of interest have been independently reviewed by our internal auditors during 2020/21, who have provided an opinion of substantial 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 the data quality of the services we commission.

All committees of the Governing Body are also 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 personal identifiable information. The NHS Information Governance Framework is supported by a Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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 Senior Information Risk Owner (SIRO) and Caldicott Guardian 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. Staff have also been provided with an Information Governance Handbook and a series of briefings to ensure they are aware of their roles and responsibilities in relation to confidentiality, data protection and information security. We have well-established arrangements for information risk assessments, and processes in place for incident reporting and investigation of serious information incidents.

During 2020/21, much of our information governance work has been to support the processing of confidential patient information for the specific purpose of Covid-19 in line with Control of Patient Information Regulations 2002 (COPI) Notices, issued by the Secretary of State for Health and Social Care. We have also maintained a focus on the increased risk of a cyber-attack to healthcare services, as advised by the National Cyber Security Centre.

At the time of finalising this governance statement, we are in the process of confirming our 2020/21 self-assessment against all mandatory assertions and evidence requirements contained with the DSPT. Our internal auditors have independently reviewed 13 of the 37 mandatory assertions (35 of the 88 mandatory evidence items) and have provided a 'High' level of confidence in the veracity of our self-assessment, with an overall opinion of 'Substantial' assurance. The CCG will submit its self-assessment by 30 June 2021, in line with the nationally deferred timeframe in recognition of the Covid-19 national emergency. It is anticipated that this will be a successful submission, with all mandatory assertions and evidence items fully met.

We will continue to develop information governance processes and procedures in line with the requirements of the law, the DSPT 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 2020/21, the CCG has received reports relating to:

- Arden and Greater East Midlands Commissioning Support Unit (transactional payroll services)
- NHS Shared Business Services (SBS) Limited (transactional finance and accounting services)
- NHS Business Services Authority (prescription payments to pharmacists)

- NHS Digital (payments to General Practice)
- NHS Electronic Staff Records (payroll and human resources management system)

In reviewing the above reports, I have noted that, with the exception of the audit of Arden and Greater East Midlands Commissioning Support Unit, qualified opinions have been provided by the service auditors. However, consideration of the reports' findings has identified that the opinions have been qualified on the basis of a relatively small number of exceptions when testing the operation of controls. Overall, the CCG is satisfied with the management responses provided in relation to these exceptions and the actions being implemented to address them.

Control issues

There have been no significant control issues identified during 2020/21.

Review of economy, efficiency and 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.
- An ***ethical decision-making framework and service benefit review process***, which ensure robust evaluation, quality assurance, and clinical and cost effectiveness of business case proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services.
- 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 reports to every meeting of the Governing Body on financial performance, including performance against the organisation's statutory financial duties.
- 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.

Delegation of functions

The CCG is currently party to five Section 75 Partnership Agreements: three with Nottingham City Council relating to the Better Care Fund, Domestic Violence and Tier 2 Child and Adolescent Mental Health Services; and two with Nottinghamshire County Council relating to the Better Care Fund and the Integrated Community Equipment Loan Service.

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.

For all Partnership Agreements, the relevant Council is acting as host, with overall strategic oversight responsibility sitting with the Nottingham City and Nottinghamshire County Health and Wellbeing Boards.

Counter fraud arrangements

The NHS Counter Fraud Authority (NHSCFA) requires all NHS Commissioning organisations to sustain their compliance with the standards for countering fraud, bribery and corruption. 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.

During 2020/21, the CCG has not been subject to any NHSCFA quality assurance recommendations.

The NHSCFA's *Standards for NHS Commissioners: Fraud, Bribery and Corruption* were superseded in April 2021 by the *Government Functional Standard 013: Counter Fraud*. The CCG submitted its baseline assessment for 2020/21 against this new Standard on 28 May 2021, with an overall assessment rating of 'Amber'. This is not unexpected, due to the new Standard being introduced after the reporting period;

however, appropriate actions will be implementation during 2021/22 to address all areas where the new Standard has not been met.

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 concluded that:

*"I am providing an overall 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."*

During the year, internal audit issued the following audit reports:

Audit report	Audit objectives	Level of assurance
Risk Management (2021/NNCCG/01)	The objective of this review was to assess the effectiveness of the CCG's operational risk management arrangements and whether arrangements comply with the CCG's Risk Management Policy, which was also reviewed prior to its approval by the Governing Body.	Significant[2]
Conflicts of Interest (2021/NNCCG/03)	The objective of this audit was to evaluate the design of the arrangements that the CCG has in place to manage conflicts of interest and gifts and hospitality, and to ensure this complies with NHS England's guidance on managing conflicts of interest.	Substantial[2]
Delegated Primary Medical Care Functions (2021/NNCCG/04)	The objective of this audit was to examine contract oversight and management functions for Primary Medical Care Services (PMCS). This included monitoring arrangements for the quality, safety and performance of each PMCS contract and how the CCG manages underperforming practices, including sanctions, breaches and contract terminations.	Substantial[3]
Financial Management Arrangements (2021/NNCCG/06)	The objective of this review was to assess whether: • Efficient and effective processes are in place to ensure the integrity of data held on the general ledger. • Robust financial monitoring and reporting arrangements are in place. • Robust budgetary control arrangements are in place. • Controls over accounts payables are robust.	Significant[2]
Cyber Security (2021/NNCCG/07)	The objective of this audit was to assess the effectiveness of the cyber security environment maintained for the CCG by Nottinghamshire Health Informatics Service (NHIS), the information/ assurance reported to the CCG's leadership, and the actions taken to respond to any identified risk exposure. The review considered the baseline/ business as usual arrangements, but also focused, in particular, on any changes (technical and procedural) arising from the Covid-19 incident response.	Significant[2]

[2] Audit opinions provided are: **substantial**, **significant**, moderate, limited or weak assurance, in line with 360 Assurance's Internal Audit Charter.
[3] Audit opinions provided are: full, **substantial**, limited or no assurance, in line with NHS England's Internal Audit Framework for Delegated Clinical Commissioning Groups.

Audit report	Audit objectives	Level of assurance
Investment and Disinvestment Decisions (2021/NNCCG/08)	The objective of this audit was to evaluate whether investment and disinvestment decisions are being made in accordance with the CCG's Service Benefit Review Policy and that there is evidence of: • Services being reviewed on a timely basis prior to contract start and/or end dates. • Decisions being aligned to the CCG's commissioning intentions. • Quality, equality and privacy impacts having been considered in development of proposals. • Engagement with stakeholders to inform proposals, where relevant. • Recommended proposals being clearly documented to support decision making. • Authorisation of decisions, taking into account amendments to authorisation limits that were made in response to the Covid-19 pandemic to support agile decision making. The review also examined the adequacy of the CCG's processes in line with National Audit Office guidance.	Significant[2]
Governance: Committee Effectiveness Review Process (2021/NNCCG/09)	The objective of this review was to evaluate the CCG's proposed arrangements for assessing committee effectiveness and provide advice as necessary to maximise the potential gain from completing the evaluation process. This was undertaken prior to the process being applied. Subsequently, testing was undertaken of the application of the process to two sample committees. This provided an opportunity to reflect on whether there were any further lessons to learn from application of the effectiveness review process that could be applied to future years.	Significant[2]
Data Security and Protection Toolkit (2021/NNCCG/10)	The objective of this audit was to evaluate the effectiveness of the CCG's data security and protection environment, as assessed through the Data Security and Protection Toolkit. The scope of the audit was determined by NHS Digital, with 13 toolkit assertions selected for review during 2020/21. The review assessed the veracity of the CCG's self-assessed level of compliance, providing a level of confidence that the toolkit submission reflects the CCG's risk and controls.	Substantial[4]

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, executive directors, senior managers and clinical leads 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 has also been 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

[4] Audit opinions provided are: **substantial**, moderate, limited or unsatisfactory, in line with NHS Digital's DSPT Independent Assessment Guide.

broad range of internal and external assurances received by the CCG during the year as set out within the Governing Body Assurance Framework.

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 2020/21.

Remuneration and staff report

Remuneration report

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee's membership is comprised entirely of Non-Executive Directors from our Governing Body. Members of the Committee are as follows:

- Jon Towler (Chair)
- Shaun Beebe
- Sue Clague
- Eleri de Gilbert

Further details on the work of the Remuneration and Terms of Service Committee during 2020/21 are provided in the *Governance statement* contained within this report.

Policy on the remuneration of senior managers

For the purpose of this remuneration 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 CCG'. 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.

The remuneration of our executive directors and other Very Senior Managers is approved by the Governing Body on the basis of recommendations by the CCG's Remuneration and Terms of Service Committee. Remuneration levels are determined with reference to national guidance and benchmarking data. 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. The remuneration of the CCG's Non-Executive Directors is set in line with NHS Improvement's remuneration structure for NHS provider chairs and non-executive directors. The CCG does not operate any performance-related pay arrangements.

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 Clinical Leaders and Non-Executive

Directors) or is an employed position (as is the case for our Very Senior Managers). 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 three months on either side.

Remuneration of Very Senior Managers

One Very Senior Manager is paid more than £150,000 per annum pro rata. The CCG has satisfied itself that this remuneration is reasonable via the Remuneration and Terms of Service Committee, which has assured itself that the remuneration is in line with the CCG's policy on the remuneration of senior managers (see above).

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

There were no payments for loss of office made in 2020/21.

Payments to past members (subject to audit)

There were no payments to past senior managers made in 2020/21.

Pay multiples (subject to audit)

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

The banded remuneration of the highest paid Director/Member in NHS Nottingham and Nottinghamshire CCG in the financial year 2020/21 was £165,000-£170,000[5]. This was 4.01 times the median remuneration of the workforce, which was £41,723.

In 2020/21, there were no employees remunerated in excess of the highest-paid Director/Member.

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

No prior year comparative information for 2019/20 is provided as the CCG was created on the 1 April 2020 and 2020/21 is the first year of operation.

[5] In determining the highest-paid director, where non-executives (or non-executive equivalents) receive an annual remuneration for a time-commitment below the CCG's normal contractual hours, the annualised, WTE calculation reflects the different employment terms. For example, if a non-executive receives £500 remuneration for each monthly Governing Body meeting, the total annualised remuneration is £6,000, rather than being based on a daily rate of £500.

Senior manager remuneration 2020/21 (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 Manik Arora, GP Representative	60-65	0	0	0	0	60-65
Shaun Beebe, Non-Executive Director	10-15	0	0	0	0	10-15
Susan Clague, Non-Executive Director	10-15	0	0	0	0	10-15
Lucy Dadge, Chief Commissioning Officer	130-135	0	0	0	62.5-65	195-200
Eleri De Gilbert, Non-Executive Director	10-15	0	0	0	0	10-15
Dr James Hopkinson, Joint Clinical Leader	95-100	0	0	0	0	95-100
Dr Hilary Lovelock, GP Representative	60-65	0	0	0	0	60-65
Dr Adedeji Okubadejo, Secondary Care Specialist	5-10	0	0	0	0	5-10
Stuart Poynor, Chief Finance Officer	140-145	0	0	0	0	140-145
Dr Stephen Shortt, Joint Clinical Leader	95-100	0	0	0	0	95-100
Amanda Sullivan, Accountable Officer	150-155	0	0	0	0	150-155
Susan Sunderland, Non-Executive Director	10-15	0	0	0	0	10-15
Dr Richard Stratton, GP Representative	60-65	0	0	0	0	60-65
Jon Towler, Non-Executive Director	40-45	0	0	0	0	40-45
Rosa Waddingham, Chief Nurse	120-125	0	0	0	0	120-125

No prior year comparative information for 2019/20 is provided as the CCG was created on the 1 April 2020 and 2020/21 is the first year of operation.

Pension benefits (subject to audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2020 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2021 £000	(h) Employers Contribution to partnership pension £000
Lucy Dadge, Chief Commissioning Officer	2.5-5	2.5-5	30-35	65-70	550	63	641	0
Stuart Poynor, Chief Finance Officer	0	0	0	0	0	0	0	0
Amanda Sullivan, Accountable Officer	0	0	0	0	0	0	0	0
Rosa Waddingham, Chief Nurse	10-12.5	0	40-45	0	406	126	556	0

No prior year comparative information for 2019/20 is provided as the CCG was created on the 1 April 2020 and 2020/21 is the first year of operation.

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.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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).

Staff Report

Number and composition of staff

The following table provides a breakdown of our workforce by pay band and gender as at 31 March 2021:

Pay band	Female	Male	Number
Band 1	0	0	0
Band 2	3	0	3
Band 3	17	3	20
Band 4	35	7	42
Band 5	48	7	55
Band 6	52	20	72
Band 7	67	17	84
Band 8a	62	18	80
Band 8b	27	9	36
Band 8c	21	4	25
Band 8d	10	3	13
Band 9	9	7	16
Very senior managers (non-Governing Body members)	4	3	7
Any other spot salary (non-Governing Body members)	17	14	31
Governing Body members	7	8	15
Totals	**379**	**120**	**499**

Staff numbers and costs (subject to audit)

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

	Number (WTE)	Salary and wages (£'000)	Social security costs (£'000)	NHS Pension costs (£'000)	Other pensions costs (£'000)	Less: recoveries in respect of outward secondments (£'000)	Total Costs (£'000)
Permanent	423.47	20,626	2,251	3,696	122	0	26,695
Other	11.56	776	0	0	0	0	776
Total	**435.03**	**21,402**	**2,251**	**3,696**	**122**	**0**	**27,471**

Sickness absence data

The latest information on sickness absence for NHS organisations can be found on the NHS Digital website at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

Staff turnover percentage

The CCG's staff turnover rate (staff leaving the organisation) for 2020/21 was 12.29% (on a WTE basis).

Staff engagement percentages

The CCG participated in the 2020 NHS Staff Survey, alongside 51 other CCGs. We had a response rate of 76%; slightly below the average for the CCG benchmark group (80%). The survey results were largely positive, particularly in relation to health and wellbeing, support and communication from line management and senior managers, staff morale and team working. A small number of areas were highlighted where actions are required during 2021 to improve staff experiences. These include planned work to move to an agile working model, implementation of a cultural competence training programme, and the establishment of equality champion roles within the CCG.

Staff policies and other employee matters

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. This includes working to the requirements of the NHS Workforce

Race Equality Standard (WRES) and the NHS 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.

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 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 Sickness 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 are not aware of any of our employees becoming disabled during 2020/21.

In response to the Covid-19 pandemic and the move to staff working remotely from home, we have maintained a focus on the mental health and wellbeing of our staff throughout the year. This has included running ‘wellbeing weeks’ and having line manager-led wellbeing discussions. A library of information, and support, has also been made available to our staff via our Employee Assistance Programme. Our arrangements to assess the safety of staff workstations and lone working arrangements have also been strengthened. Covid-19 health and safety workplace risk assessments have been completed for all our offices spaces and individual Covid-19 risk assessments have been completed for vulnerable staff identified as having an increased risk of severe illness from coronavirus.

Trade Union Facility Time Reporting Requirements

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 acknowledge the recognised Trade Unions to support, represent and bargain for its members.

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.

Expenditure on consultancy

Expenditure on consultancy in 2020/21 totalled £198,000.

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, CCGs must publish information on their highly paid and/or senior off-payroll engagements.

Table 1: Off-payroll engagements longer than six months

Off-payroll engagements as at 31 March 2021, 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 2021	**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

Table 2: New off-payroll engagements

New off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, 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 2020 and 31 March 2021	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contacted 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

Table 3: Off-payroll Governing Body / senior official engagements

Off-payroll engagements of Governing Body members and / or senior officials with significant financial responsibility between 1 April 2020 and 31 March 2021 are shown in the table below:

	Number
Number of off-payroll engagements of Governing Body members 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.	15

Exit packages, including special (non-contractual) payments (subject to audit)

Table 1: 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 agreed departures £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	1	69,333	0	0	0	0	0	0
£100,001 - £150,000	0	0	1	122,143	0	0	0	0
£150,001 - £200,000	2	320,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	**3**	**389,333**	**1**	**122,143**	**0**	**0**	**0**	**0**

Table 2: 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	1	122,143
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	**1**	**122,143**

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Agenda for Change Terms and Conditions of Service. Exit costs in this note are accounted for in full in the year of departure. Where NHS Nottingham and Nottinghamshire CCG has agreed early retirements, the additional costs are met by NHS Nottingham and Nottinghamshire CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table. The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report. No non-contractual payments have been made to individuals.

Parliamentary accountability and audit report

NHS Nottingham and Nottinghamshire 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 the *Annual Accounts* section of this report.

Annual Accounts

Dr Amanda Sullivan

Accountable Officer

11 June 20

Entity name:	NHS Nottingham & Nottinghamshire CCG
This year	2020-21
Last year	2019-20
This year ended	31-March-2021
Last year ended	31-March-2020
This year commencing:	01-April-2020
Last year commencing:	01-April-2019

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000
Income from sale of goods and services	2	(5,739)
Other operating income	2	(936)
Total operating income		**(6,674)**
Staff costs	4	27,775
Purchase of goods and services	5	1,796,248
Depreciation and impairment charges	5	14
Provision expense	5	583
Other Operating Expenditure	5	593
Total operating expenditure		**1,825,213**
Net Operating Expenditure		**1,818,539**
Finance income		-
Finance expense		-
Net expenditure for the Year		**1,818,539**
Net (Gain)/Loss on Transfer by Absorption		68,732
Total Net Expenditure for the Financial Year		**1,887,271**
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		-
Net (gain)/loss on assets held for sale		-
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 other Financial Assets		-
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		**1,887,271**

Statement of Financial Position as at 31 March 2021

	Note	31-Mar-21 £'000	01-Apr-20 £'000
Non-current assets:			
Property, plant and equipment	13	-	14
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		-	14
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	13,757	23,533
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	13	122
Total current assets		**13,770**	23,654
Non-current assets held for sale	21	-	-
Total current assets		**13,770**	23,654
Total assets		**13,770**	23,669
Current liabilities			
Trade and other payables	23	(100,244)	(90,266)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(1,211)	(1,420)
Total current liabilities		**(101,455)**	(91,686)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(87,685)**	(68,017)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(715)	(715)
Total non-current liabilities		**(715)**	(715)
Assets less Liabilities		**(88,400)**	(68,732)
Financed by Taxpayers' Equity			
General fund		(88,400)	(68,732)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(88,400)**	(68,732)

The notes on pages 69 to 88 form part of this statement
The financial statements on pages 65 to 68 were approved by the Audit and Governance Committee on 10th June 2021 and signed on its behalf by:

A. Sullivan

Chief Accountable Officer
Amanda Sullivan

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	0	-	-	**0**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	**-**
Adjusted NHS CCG balance at 31 March 2020	**0**	-	-	**0**
Changes in CCG taxpayers' equity for 2020-21				
Net operating expenditure for the financial year	(1,818,539)			**(1,818,539)**
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets	-	-	-	**-**
Net gain/(loss) on revaluation of financial assets	-	-	-	**-**
Total revaluations against revaluation reserve	**-**	**-**		**-**
Net gain (loss) on available for sale financial assets	-	-	-	**-**
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			-	**-**
Net gain (loss) on revaluation of assets held for sale	-	-	-	**-**
Impairments and reversals	-	-	-	**-**
Net actuarial gain (loss) on pensions	-	-	-	**-**
Movements in other reserves	-	-	-	**-**
Transfers between reserves	-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	**-**
Transfers by absorption to (from) other bodies	(68,732)	-	-	**(68,732)**
Reserves eliminated on dissolution	-	-	-	**-**
Net Recognised CCG Expenditure for the Financial year	**(1,887,271)**	**-**	**-**	**(1,887,271)**
Net funding	1,798,871	-	-	**1,798,871**
Balance at 31 March 2021	**(88,400)**	**-**	**-**	**(88,400)**

The notes on pages 69 to 88 form part of this statement

Statement of Cash Flows for the year ended
31 March 2021

	Note	2020-21 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(1,818,539)
Depreciation and amortisation	5	14
Impairments and reversals	5	-
Non-cash movements arising on application of new accounting standards		-
Movement due to transfer by Modified Absorption		-
Other gains (losses) on foreign exchange		-
Donated assets received credited to revenue but non-cash		-
Government granted assets received credited to revenue but non-cash		-
Interest paid		-
Release of PFI deferred credit		-
Other Gains & Losses		-
Finance Costs		-
Unwinding of Discounts		-
(Increase)/decrease in inventories		-
(Increase)/decrease in trade & other receivables	17	9,775
(Increase)/decrease in other current assets		-
Increase/(decrease) in trade & other payables	23	9,977
Increase/(decrease) in other current liabilities		-
Provisions utilised	30	(791)
Increase/(decrease) in provisions	30	583
Net Cash Inflow (Outflow) from Operating Activities		**(1,798,980)**
Cash Flows from Investing Activities		
Interest received		-
(Payments) for property, plant and equipment		-
(Payments) for intangible assets		-
(Payments) for investments with the Department of Health		-
(Payments) for other financial assets		-
(Payments) for financial assets (LIFT)		-
Proceeds from disposal of assets held for sale: property, plant and equipment		-
Proceeds from disposal of assets held for sale: intangible assets		-
Proceeds from disposal of investments with the Department of Health		-
Proceeds from disposal of other financial assets		-
Proceeds from disposal of financial assets (LIFT)		-
Non-cash movements arising on application of new accounting standards		-
Loans made in respect of LIFT		-
Loans repaid in respect of LIFT		-
Rental revenue		-
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(1,798,980)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		1,798,871
Other loans received		-
Other loans repaid		-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-
Capital grants and other capital receipts		-
Capital receipts surrendered		-
Non-cash movements arising on application of new accounting standards		-
Net Cash Inflow (Outflow) from Financing Activities		**1,798,871**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(109)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**122**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**13**

The notes on pages 69 to 88 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England/Improvement 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 2020-21 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 CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

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 CCG has entered into a pooled budget arrangement under section 75 of the NHS Act 2006, the CCG 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 CCG is in a jointly controlled operation, the CCG recognises:

· The assets the CCG controls;
· The liabilities the CCG incurs;
· The expenses the CCG incurs; and,
· The CCG's share of the income from the pooled budget activities.
· If the CCG is involved in a jointly controlled assets arrangement, in addition to the above, the clinical commissioning group recognises:
· The CCG's share of the jointly controlled assets (classified according to the nature of the assets);
· The CCG's share of any liabilities incurred jointly: and,
· The CCG'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 CCG.

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 CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The CCG 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 CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

1.7 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.

Notes to the financial statements

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 CCG's 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 CCG commits itself to the retirement, regardless of the method of payment.

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

1.8 Payments to NHS Provider Organisations

In 2020/21 the NHS system was subject to a temporary financial framework, created by NHS England Improvement, in response to the COVID-19 global pandemic. Fixed payments were made to NHS provider organisations under that framework, under instruction of NHS England and Improvement. Those payments are included in Note 5 of the accounts.

1.9 Other Expenses

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

1.1 Grants Payable

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

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

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

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

1.11.2 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.

1.11.3 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.

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG'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 CCG;
· 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.

Notes to the financial statements

1.12.2 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.

1.12.3 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 CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the CCG 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.

1.13 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.

1.13.1 The CCG 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 CCG'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.

1.13.2 The CCG as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the CCG'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 CCG'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.

1.14 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 CCG's cash management.

1.15 Provisions

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG 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 -0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 0.18% (2019-20: 0.55%) 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% (2019-20: 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% (2019-20: 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 CCG 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.

1.16 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the CCG 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 CCG.

1.17 Non-clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG 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.

Notes to the financial statements

1.18 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 CCG, 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 CCG. 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.

1.19 Financial Assets

Financial assets are recognised when the CCG 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.

1.19.1 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 asset.

1.19.2 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.

1.19.3 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.

1.19.4 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 CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG 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 CCG 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 CCG 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.

1.2 Financial Liabilities

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

1.20.1 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.

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 CCG's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.20.3 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.

1.21 Value Added Tax

Most of the activities of the CCG 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.

1.22 Foreign Currencies

The CCG'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.

1.23 Third Party Assets

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

Notes to the financial statements

1.24 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

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 CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.25 Critical accounting judgements and key sources of estimation uncertainty

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

1.25.1 Critical accounting judgements in applying accounting policies

The CCG has previously exercised its accounting judgement in respect of costs associated with the maternity pathway; some of which have been treated as a prepayment. However, due to the temporary financial framework in response to the COVID-19 Global pandemic, these arangements have been suspended, so there are no prepayments relating to this in the 20/21 Accounts.

1.25.2 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 - In previous years, the CCG included estimations for partially completed spells which span the end of the financial year. However, due to the temporary financial framework in response to the COVID-19 Global pandemic, these arangements have been suspended, so there are no estimates for Partially Completed Spells in the 20/21 Accounts.

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

1.26 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.

1.27 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 2020-21. 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.

2 Other Operating Revenue

	2020-21 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	**-**
Non-patient care services to other bodies	**1,261**
Patient transport services	**-**
Prescription fees and charges	**2,960**
Dental fees and charges	**-**
Income generation	**-**
Other Contract income	**1,518**
Recoveries in respect of employee benefits	**-**
Total Income from sale of goods and services	**5,739**
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	**936**
Total Other operating income	**936**
Total Operating Income	**6,674**

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	-	411	-	-	-	-	1,235	-
Non NHS	-	850	-	2,960	-	-	283	-
Total	**-**	**1,261**	**-**	**2,960**	**-**	**-**	**1,518**	**-**

	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	-	1,261	-	2,960	-	-	1,518	-
Total	**-**	**1,261**	**-**	**2,960**	**-**	**-**	**1,518**	**-**

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

	2020-21 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies	2019-20 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s	£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

	Admin			Programme			Total		2020-21
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	10,327	199	**10,526**	10,299	491	**10,790**	20,626	690	**21,316**
Social security costs	1,163	-	**1,163**	1,088	-	**1,088**	2,251	-	**2,251**
Employer contributions to the NHS Pension Scheme	2,478	-	**2,478**	1,219	-	**1,219**	3,696	-	**3,696**
Other pension costs	122	-	**122**	-	-	**-**	122	-	**122**
Apprenticeship Levy	-	-	**-**	-	-	**-**	-	-	**-**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	160	-	**160**	229	-	**229**	389	-	**389**
Gross employee benefits expenditure	**14,250**	**199**	**14,449**	**12,835**	**491**	**13,326**	**27,084**	**690**	**27,775**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**14,250**	**199**	**14,449**	**12,835**	**491**	**13,326**	**27,084**	**690**	**27,775**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**14,250**	**199**	**14,449**	**12,835**	**491**	**13,326**	**27,084**	**690**	**27,775**

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees	Other	2020-21 Total
	£'000	£'000	£'000
Employee Benefits - Revenue			
Salaries and wages	**-**	**-**	**-**
Social security costs	**-**	**-**	**-**
Employer contributions to the NHS Pension Scheme	**-**	**-**	**-**
Other pension costs	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Total recoveries in respect of employee benefits	-	-	-

4.2 Average number of people employed

	2020-21 Permanently employed	Other	Total
	Number	Number	Number
Total	**423.47**	**11.56**	**435.03**
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	69,333	-	-	1	69,333
£100,001 to £150,000	-	-	1	122,143	1	122,143
£150,001 to £200,000	2	320,000	-	-	2	320,000
Over £200,001	-	-	-	-	-	-
Total	**3**	**389,333**	**1**	**122,143**	**4**	**511,476**

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 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	**-**	**-**	**-**	**-**	**-**	**-**

	2020-21 Departures where special payments have been made	
	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

	2020-21 Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	1	122,143
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	**1**	**122,143**

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

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

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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 employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

5. Operating expenses

	2020-21 Admin £'000	2020-21 Programme £'000	2020-21 Total £'000
Purchase of goods and services			
Services from other CCGs and NHS England	626	197	822
Services from foundation trusts	135	497,505	497,639
Services from other NHS trusts	-	606,993	606,993
Provider Sustainability Fund	-	-	-
Services from Other WGA bodies	-	-	-
Purchase of healthcare from non-NHS bodies	-	313,327	313,327
Purchase of social care	-	-	-
General Dental services and personal dental services	-	-	-
Prescribing costs	-	159,313	159,313
Pharmaceutical services	-	-	-
General Ophthalmic services	-	-	-
GPMS/APMS and PCTMS	-	166,421	166,421
Supplies and services – clinical	-	1,605	1,605
Supplies and services – general	285	18,310	18,595
Consultancy services	191	6	198
Establishment	511	1,582	2,093
Transport	11	7,132	7,143
Premises	3,239	17,978	21,217
Audit fees	192	-	192
Other non statutory audit expenditure			
· Internal audit services	-	-	-
· Other services	-	-	-
Other professional fees	100	24	124
Legal fees	255	6	262
Education, training and conferences	135	169	303
Funding to group bodies	-	-	-
CHC Risk Pool contributions	-	-	-
Non cash apprenticeship training grants	-	-	-
Total Purchase of goods and services	**5,680**	**1,790,567**	**1,796,248**
Depreciation and impairment charges			
Depreciation	-	14	14
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	**-**	**14**	**14**
Provision expense			
Change in discount rate	-	-	-
Provisions	-	583	583
Total Provision expense	**-**	**583**	**583**
Other Operating Expenditure			
Chair and Non Executive Members	538	5	542
Grants to Other bodies	-	71	71
Clinical negligence	-	-	-
Research and development (excluding staff costs)	-	(23)	(23)
Expected credit loss on receivables	-	(14)	(14)
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-	-
Inventories written down	-	-	-
Inventories consumed	-	-	-
Other expenditure	15	1	16
Total Other Operating Expenditure	**553**	**40**	**593**
Total operating expenditure	**6,233**	**1,791,205**	**1,797,438**

6.1 Better Payment Practice Code

Measure of compliance	2020-21 Number	2020-21 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	39,936	485,140
Total Non-NHS Trade Invoices paid within target	38,910	475,190
Percentage of Non-NHS Trade invoices paid within target	**97.43%**	**97.95%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	4,070	1,117,219
Total NHS Trade Invoices Paid within target	4,040	1,117,084
Percentage of NHS Trade Invoices paid within target	**99.26%**	**99.99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2020-21 £'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 (19/20: £nil)

8. Investment revenue

There was no Investment Income during the year (19/20: £nil)

9. Other gains and losses

There were no Other Gains and Losses during the year (19/20: £nil)

10. Finance costs

There were no Finance Costs during the year (19/20: £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.

On 1 April 2020, the Clinical Commissioing Groups of NHS Mansfield & Ashfield, NHS Newark & Sherwood, NHS Nottingham City, NHS Nottingam North & East, NHS Nottingham West, and NHS Rushcliffe ceased to exist, and NHS Nottingham and Nottinghamshire CCG was established.

The figures shown below, are disclosed after adjusting for inter-trading balances between the six Clinical Commissioning Groups.

	NHS Mansfield & Ashfield CCG	NHS Newark & Sherwood CCG	NHS Nottingham City CCG	NHS Nottingham North & East CCG	NHS Nottingham West CCG	NHS Rushcliffe CCG	TOTAL
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Transfer of property plant and equipment	14	-	-	-	-	-	14
Transfer of intangibles	-	-	-	-	-	-	-
Transfer of cash and cash equivalents	18	36	20	8	24	16	122
Transfer of receivables	1,625	1,453	5,907	1,300	5,312	2,903	18,500
Transfer of payables	(19,544)	(8,824)	(26,800)	(10,517)	(4,752)	(14,797)	(85,234)
Transfer of provisions	(323)	(199)	(963)	(273)	(172)	(204)	(2,134)
Net loss on transfers by absorption	**(18,210)**	**(7,534)**	**(21,836)**	**(9,482)**	**412**	**(12,082)**	**(68,732)**

As NHS Nottingham & Nottinghamshire CCG is the recipient in the transfer of a function, it has recognised the assets and liabilities received as as the date of transfer. These balances are disclosed within the Statement of Financial Position and accompanying notes as at 1 April 2020. The corresonding net debit reflecting the loss is recognised within the income and expenses disclosed within the Statement of Comprehensive Net Expenditure, but outside of operating activities.

12. Operating Leases

12.1 As lessee

Where the CCG is a lessee, include a general description of significant leasing arrangements, including:

(a) *basis on which contingent rent is determined*

(b) *terms of renewal, purchase options or escalation clauses and*

(c) *restrictions imposed by lease arrangements]*

12.1.1 Payments recognised as an Expense

	Land	Buildings	Other	2020-21 Total
	£'000	£'000	£'000	£'000
Payments recognised as an expense				
Minimum lease payments	-	4,184	6	**4,189**
Contingent rents	-	-	-	**-**
Sub-lease payments	-	-	-	**-**
Total	**-**	**4,184**	**6**	**4,189**

12.1.2 Future minimum lease payments

	Land	Buildings	Other	2020-21 Total
	£'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

	2020-21
	£'000
Recognised as income	
Rent	-
Contingent rents	-
Total	**-**

[A general description of leasing arrangements]

12.2.2 Future minimum rental value

	2020-21	2020-21	2020-21
	£'000	£'000	£'000
	NHSE Bodies	Other DHSC 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

The CCG has no property, plant and equipment assets at the year end (19/20: £nil)

14 Intangible non-current assets

The CCG has no Intangible non-current assets at the year end (19/20: £nil)

15 Investment property

The CCG has no Investment Property at the year end (19/20: £nil)

16 Inventories

The CCG has no Inventories at the year end (19/20: £nil)

17.1 Trade and other receivables	**Current 31-Mar-21 £'000**	**Non-current 31-Mar-21 £'000**	Current 01-Apr-20 £'000	Non-current 01-Apr-20 £'000
NHS receivables: Revenue	5,903	-	8,025	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	1,129	-	6,681	-
NHS accrued income	1,073	-	2,929	-
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	1,130	-	464	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	2,120	-	2,178	-
Non-NHS and Other WGA accrued income	1,751	-	3,045	-
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	(33)	-	(47)	-
VAT	664	-	237	-
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	20	-	21	-
Total Trade & other receivables	**13,757**	**-**	**23,533**	**-**
Total current and non current	**13,757**		**23,533**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	31-Mar-21 DHSC Group Bodies £'000	**31-Mar-21 Non DHSC Group Bodies £'000**	**01-Apr-20 DHSC Group Bodies £'000**	**01-Apr-20 Non DHSC Group Bodies £'000**
By up to three months	12	41	2	3
By three to six months	78	134	28	54
By more than six months	-	83	-	66
Total	**90**	**258**	**30**	**123**

17.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies**	**Other financial assets**	**Total**
	£'000	**£'000**	**£'000**
Balance at 01 April 2020	(47)	-	**(47)**
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	-	-	**-**
Financial assets that have been derecognised	14	-	**14**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(33)**	**-**	**(33)**

18 Other financial assets
The CCG has no Other Financial Assets at the year end

19 Other current assets
The CCG has no Other Current Assets at the year end

20 Cash and cash equivalents

	2020-21 £'000
Balance at 01 April 2020	-
Net change in year	13
Balance at 31 March 2021	**13**
Made up of:	
Cash with the Government Banking Service	13
Cash with Commercial banks	-
Cash in hand	-
Current investments	-
Cash and cash equivalents as in statement of financial position	**13**
Bank overdraft: Government Banking Service	-
Bank overdraft: Commercial banks	-
Total bank overdrafts	**-**
Balance at 31 March 2021	**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

22 Analysis of impairments and reversals
The CCG has no Impairments or Reversals at the year end

23 Trade and other payables	**Current 31-Mar-21 £'000**	**Non-current 31-Mar-21 £'000**	Current 01-Apr-20 £'000	Non-current 01-Apr-20 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	4,440	-	13,172	-
NHS payables: Capital	-	-	-	-
NHS accruals	1,941	-	16,069	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	37,454	-	27,726	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	40,270	-	20,189	-
Non-NHS and Other WGA deferred income	-	-	27	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	237	-	304	-
VAT	-	-	-	-
Tax	260	-	253	-
Payments received on account	-	-	-	-
Other payables and accruals	15,642	-	12,527	-
Total Trade & Other Payables	**100,244**	**-**	**90,266**	**-**
Total current and non-current	**100,244**		**90,266**	

Other payables include £1,495,000 outstanding pension contributions at 31 March 2021

24 Other financial liabilities
The CCG has no Other Financial Liabilities at the year end

25 Other liabilities
The CCG has no Other Liabilities at the year end

26 Borrowings
The CCG has no Borrowings at the year end

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

28 Finance lease obligations
The CCG has no Finance Lease Obligations at the year end

29 Finance lease receivables
The CCG has no Finance Lease Receivables at the year end

30 Provisions

	Current 2020-21 £'000	Non-current 2020-21 £'000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	-	-
Redundancy	-	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	0	-
Continuing care	1,256	-
Other	(45)	715
Total	**1,211**	**715**
Total current and non-current	**1,926**	

	Pensions Relating to Former Directors	Pensions Relating to Other Staff	Legal Claims	Continuing Care	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2020	**-**	**-**	**201**	**1,256**	**678**	**2,135**
Arising during the year	-	-	684	-	-	**684**
Utilised during the year	-	-	(791)	-	-	**(791)**
Reversed unused	-	-	(93)	-	(8)	**(101)**
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 2021	**-**	**-**	**-**	**1,256**	**671**	**1,926**
Expected timing of cash flows:						
Within one year	-	-	-	1,256	(45)	**1,211**
Between one and five years	-	-	-	-	715	**715**
After five years	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**-**	**1,256**	**671**	**1,926**

31 Contingencies

The CCG has no Contingencies at the year end

32 Commitments

32.1 Capital commitments

	2020-21 £'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:

	2020-21 £'000
In not more than one year	23,465
In more than one year but not more than five years	-
In more than five years	-
Total	**23,465**

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	Equity Instruments designated at FVOCI	Total
	2020-21 £'000	2020-21 £'000	2020-21 £'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	3,023		3,023
Trade and other receivables with other DHSC group bodies	5,621		5,621
Trade and other receivables with external bodies	1,232		1,232
Other financial assets	-		-
Cash and cash equivalents	13		13
Total at 31 March 2021	**9,890**	**-**	**9,890**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost	Other	Total
	2020-21 £'000	2020-21 £'000	2020-21 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	164		**164**
Trade and other payables with other DHSC group bodies	29,301		**29,301**
Trade and other payables with external bodies	70,282		**70,282**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2021	**99,747**	**-**	**99,747**

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.

	2020/21 £'000
Balance at 1 April	**991**
Income	
Nottinghamshire County Council ASCH&PP	1,354
Nottinghamshire County Council CFCS	400
Nottinghamshire City Council ASCH & CYP	1,133
Bassetlaw CCG	821
NHS Nottingham & Nottinghamshire CCG	5,531
Continuing Health care funding	0
Other income	7
TOTAL INCOME	**10,237**
Expenditure	
Partnership Management & Administration costs	815
Contract delivery and collection costs	1,327
ICES Equipment	6,389
Continuing Healthcare Specialist Equipment	0
Minor Adaptations	66
Direct Payments	2
TOTAL EXPENDITURE	**8,599**
Balance at 31 March	**1,638**
Carry Forward by Partner	
Nottinghamshire City Council ASCH	465
Notts County Council - ASCH	1,022
Notts County Council - CYPS	69
ICELS Staffing reserves	50
Bassetlaw CCG	32
Balance at 31 March	**1,638**

The second pooled budget is 'The Better Care Fund (BCF)' and is hosted by Nottingham City Council, and jointly commissions services to achieve national and local objectives to integrate health and social care services in Nottingham City.
It is between the CCG and Nottingham City Council, and its aims are to improve the quality & efficiency of services.
Memorandum Account for Nottingham City Better Care Fund

	2020/21 £'000
Funding	
NHS Nottingham & Nottinghamshire CCG	24,734
Nottingham City Council (Capital)	2,768
Nottingham City Council	-
Nottingham City Council (Improved Better Care Fund)	16,115
	43,617
Expenditure	
Access & Navigation	1,980
Assistive Technology	468
Carers	714
Co-ordinated Care	16,115
Capital Grants	2,768
Independence Pathway	0
Programme Costs	27
Integrated Care	16,333
Primary Care	2,554
Facilitating Discharge	2,577
Housing Related Schemes	81
Total Expenditure	43,617
Balance Carried forward for all partners	0

NHS Nottingham & Nottinghamshire CCG's shares of the Income & expenditure handled by the pooled budget in the financial year were:

	2020/21 £'000
Income	9,731
Expenditure	-9,731
	0

36 NHS Lift investments
The CCG has no LIFT investments at the year end

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
East Leake Medical Group	2,536	-	26	-
Belvoir Health Group	3,312	-	207	-
The Calverton Practice	1,344	-	18	-
Rivergreen Medical Centre	996	-	18	-
Huthwaite Medical Practice	1,193	-	-	-
NHS England	1,217	419	164	3,031
NHS Trusts	608,170	286	293	3,810
Foundation Trusts	498,967	441	5,925	1,264
Health Education England	0	665	-	-
Special Health Authorities	95	-	26	-
Other Group Bodies	10,605	-	1,559	-

38 Events after the end of the reporting period
There were no Events after the end of the reporting period.

39 Third party assets
The CCG has no Third Party Assets

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:

	2020-21 Target	2020-21 Performance
Expenditure not to exceed income	1,825,256	1,825,213
Capital resource use does not exceed the amount specified in Directions	-	-
Revenue resource use does not exceed the amount specified in Directions	1,818,582	1,818,539
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	20,395	20,393

41 Analysis of charitable reserves
The CCG has no Charitable Reserves at the year end

42 Losses and special payments

Losses
The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases	Total Value of Cases
	2020-21 Number	2020-21 £'000
Administrative write-offs		
Fruitless payments	-	-
Store losses	-	-
Book Keeping Losses	-	-
	-	-
Constructive loss	-	-
Cash losses	-	-
Claims abandoned	-	-
Total	**-**	**-**

Special payments

	Total Number of Cases	Total Value of Cases
	2020-21 Number	2020-21 £'000
Compensation payments	-	-
Compensation payments Treasury Approved	-	-
Extra Contractual Payments	-	-
Extra Contractual Payments Treasury Approved	-	-
Ex Gratia Payments	-	-
Ex Gratia Payments Treasury Approved	-	-
Extra Statutory Extra Regulatory Payments	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-
Special Severance Payments Treasury Approved	-	-
Total	**-**	**-**

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Nottingham and Nottinghamshire Clinical Commissioning Group ("the CCG") for the year ended 31 March 2021 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 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England 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 2020/21.

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.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks to the CCG's operating model and analysed how those risks might affect the CCG's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition. We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected cash postings, journals made by unexpected users and seldom used accounts.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Inspecting transactions in the period following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under the NHS Act 2006, as amended by paragraph 223I1 (3) of Section 27 of the Health and Social Care Act 2012, the CCG must ensure that its revenue resource allocation in any financial year does not exceed the amount specified by NHS England. Expenditure in excess of the amount specified is unlawful.

We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

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; and
- 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 has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 25, 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 CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless 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 if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure 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 25, 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 CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. 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 and NHS England 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.

We have nothing to report in this respect.

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, 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 Nottingham and Nottinghamshire CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Sarah Brown
for and on behalf of KPMG LLP,
Chartered Accountants
1 Snow Hill Queensway
Birmingham
B4 6GH

14 June 2021