Nottingham and Nottinghamshire
Clinical Commissioning Group

Annual Report and Accounts

2021/22

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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Organisational Changes

The Health and Care Act 2022 received Royal Assent on 28 April 2022 and as such, NHS Nottingham and Nottinghamshire CCG will be disestablished on 30 June 2022 and NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) will be established on 1 July 2022 as a new statutory NHS body. Where this annual report refers to additional documents that can be accessed from the CCG's website, or information that can be provided on request, these will still be available via the ICB's website or by contacting the ICB at the details shown above.

About this report

This annual report and accounts for the year ending 31 March 2022 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 structure of this report therefore follows that outlined in the guidance and includes:

- The ***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 a more detailed performance analysis, which provides a further information about how we have performed this year and how the CCG has met its statutory duties across several key areas.
- The ***Accountability Report*** – This describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations. It comprises three sections:
  - The ***Corporate Governance Report***;
  - The ***Remuneration and Staff Report***; and
  - The ***Parliamentary Accountability and Audit Report***.
- The ***Annual Accounts*** – This section presents the CCG's financial statements for the year 2021/22.

The following acronyms are used frequently throughout this report:

CCG	Clinical Commissioning Group
ICB	Integrated Care Board
ICS	Integrated Care System
NHSE/I	NHS England and NHS Improvement
NUH	Nottingham University Hospitals NHS Trust
SFHT	Sherwood Forest Hospitals NHS Foundation Trust
NHCT	Nottinghamshire Healthcare NHS Foundation Trust

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

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Performance Report

Signed by:

Dr Amanda Sullivan
Accountable Officer

16 June 2022

Performance overview

Introduction

Welcome to the 2021/22 annual report for NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG). This section of the annual report provides an overview of our organisation, describing who we are, what we do and how we have performed during the financial year ended 31 March 2022.

Accountable Officer's Statement

I am delighted to present our annual report and accounts for 2021/22. This year has been our organisation's second year of operation, following the successful merger of our six predecessor CCGs on 1 April 2020 and the subsequent establishment of the Nottingham and Nottinghamshire Clinical Commissioning Group ("the CCG").

This annual report comes following another challenging year, requiring the CCG's continued response to the COVID-19 pandemic and a large proportion of the year spent at a high level of national NHS emergency preparedness and response. The NHS continues to face unprecedented challenges in dealing with the COVID-19 pandemic and there remains considerable pressure on frontline staff. We continue to adapt to, and learn from, new ways of working and to absorb the additional workload that the response to the pandemic has necessitated. Once again, we have seen the unceasing dedication and resilience of our workforce and I am proud of the way in which our partner organisations across the local health and care system continue to work together to protect our local communities.

In particular, I would like to acknowledge and thank the staff and volunteers who, together, have made the local COVID-19 Vaccination Programme such a success. The steep rise in the prevalence of the Omicron COVID-19 variant at the end of 2021 necessitated the swift mobilisation of additional resource to offer booster vaccinations. Many temporary new vaccination sites were opened, including at GP surgeries, in community settings, and at community pharmacies. We also made use of a mobile facility to ensure maximum access to the vaccine throughout the Nottingham and Nottinghamshire area. We retained our focus on areas of lower uptake amongst some minority ethnic communities and those from marginalised or deprived groups. At the time of writing, 85% of our patient population have received two doses of the vaccine and the programme will continue to focus on working in areas of lower uptake to boost vaccination rates.

Whilst front line staff in GP surgeries and in secondary care have continued to work tirelessly in maintaining services for emergency admissions, cancer treatment and other clinically urgent care, the pandemic has inevitably resulted in significantly increased waiting times for elective diagnostics, treatments, and surgeries. A focus for our CCG this year has therefore been to accelerate the restoration and recovery of elective care for our population,

and we have utilised national funds to develop and implement innovative ways to increase the number of elective operations, tests, and scans. You can read more about our work to address these challenges in the *Performance summary* section of this annual report.

The response to the pandemic has demonstrated that we cannot build a strong and resilient healthcare system for the future without a fundamental change in the way all health and social care partners work together. Work to develop integrated healthcare systems commenced before the onset of the pandemic, but the pandemic has both accelerated this work and demonstrated just what can be achieved through partnership working. Through the Government's Health and Care Act 2022, there is now a legislative framework to support and further build on this collaboration. As part of this change, all CCGs will be abolished on 30 June 2022 and their statutory functions will transfer to Integrated Care Boards (ICBs).

Primarily, the key to improving the health and wellbeing of all our local populations will be taking concerted action to tackle health inequalities. As an ICB, we will be able to address this significant challenge more effectively. We know that COVID-19 has exacerbated the stark inequalities already faced by our local populations and substantially increased them in both the short and long term. You can read more about our work to tackle health inequalities in the *Statutory duties* section of this annual report.

Throughout 2021/22, we have been working towards the establishment of the ICB for Nottingham and Nottinghamshire. This period of preparation has included working closely with our colleagues at NHS Bassetlaw CCG, following the decision to move the area of Bassetlaw into the Nottingham and Nottinghamshire Integrated Care System (ICS).

As this is the last annual report for the Nottingham and Nottinghamshire CCG, I would like to take the opportunity to thank those colleagues on the CCG's Governing Body who will come to the end of their terms of office when the CCG is disestablished. Their support, commitment, and dedication to the organisation over the past years has been instrumental in our development and success and I wish them the very best for the future.

I look forward with optimism to the developments 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, and I am looking forward to playing a part in driving this forward, alongside system partners from the NHS, Local Authorities and the Voluntary and Community Sector.

Dr 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 124 GP Practices (as at 31 March 2022) 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 2022, the CCG employed 514 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 1,270,500 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. You can read more about our approach to public and patient involvement in the *Statutory duties* section of this annual report.

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 (ICS), 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.
- 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).

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

Performance Summary

Whilst we have maintained a robust and consistent focus on our performance this year, through the mechanisms detailed in the Performance Analysis section of this annual report, 2021/22 has proved to be a challenging year for us in delivering against our national targets. Urgent care and planned care have been impacted throughout the year by staffing capacity issues, unprecedented demand, issues with patient flow and the ongoing impact following the required national response to the COVID-19 pandemic. We continue to work closely with our partners across the health and social care community to improve performance in these areas through implementation of robust recovery plans and this will continue to be a focus for the new ICB in the coming year.

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

The CCG achieved all of its statutory financial duties for the 2021/22 year, and you can read more about these and other key statutory duties in the *Performance Analysis* section of this annual report. For full details of our accounts please see the *Annual Accounts* section of this annual report.

Our Principal Risks

We have a clear and integrated approach to risk management, combined with defined ownership of risk at all levels within the organisation. Identifying and assessing risks at both strategic and 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 2021/22 related to: the potential for health inequalities to be exacerbated if healthcare services were not promptly restored and recovered; the potential for poor clinical outcomes, patient harm and poor patient experience at some of our main healthcare providers, with specific reference to local maternity services; the potential for non-delivery of our financial duties, including over-reliance on non-recurrent mitigations; and the sustainability of some GP practices due to primary care workforce issues and the impact of the COVID-19 pandemic.

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

Performance Analysis

Introduction

This section of the report describes our performance measures in more detail and illustrates the level of delivery in 2021/22.

Monitoring Performance

We are required to report on key national health targets and performance standards, many of which are drawn from the NHS Constitution or are derived from national priorities. However, as the pandemic continued throughout 2021/22, various established targets remained paused by NHS England and NHS Improvement (NHSE/I) to enable the wider NHS to directly respond to the impact of COVID-19.

During the last year, a key priority has been to recover elective care services which were paused during the initial phase of COVID-19 during 2020/21. These are delivered through the service contracts that we hold with local health organisations providing NHS services.

In order to respond collectively as a local health system to the challenges of the pandemic, a number of system wide forums have been established to review the achievement of national and jointly agreed local measures. These conversations have enabled a focused discussion to ensure services perform well during the continuing challenges of the pandemic and meet the health needs of our patients and citizens.

The responsibility for performance management ultimately sits with the Governing Body; however, this duty has been delegated to our Quality and Performance Committee to ensure consistent scrutiny, with issues escalated to the Governing Body as necessary.

Areas that are under performing receive additional focus by the Quality and Performance Committee, which includes reviewing the underlying causal factors and remedial actions in place, the potential impact of underperformance on the quality of services and delivery of recovery plans through system collaboration.

The Integrated Performance Reports to our Governing Body set out the CCG's performance against all required standards and are available on our website at https://nottsccg.nhs.uk/. These governance arrangements are underpinned by the CCG's Performance Management Framework, which recognises that securing high quality services for patients requires the robust assessment of key performance and outcome indicators.

NHS England has a statutory duty to conduct performance assessments of CCGs to assess their capability, ensure that they are complying with statutory responsibilities and are also performing in a way that is delivering improvements in care to patients. This is performed through the NHS System Oversight Framework, an aligned approach developed by NHSE/I

which places an emphasis on system performance across ICSs and in ensuring consistent expectations of their constituent organisations.

Working with Partners

As part of our approach to system working, we are required to develop annual operational plans in line with national requirements; working together with our NHS partners in the Nottingham and Nottinghamshire ICS to ensure triangulation of activity, workforce and money in the planning process. Our Operational Plan for 2021/22 reflects the 2021/22 Operational Planning Guidance and sets out our priority areas as follows:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Continuing to meet the needs of patients with COVID-19.
- Maximising elective activity, taking full advantage of the opportunities to transform the delivery of service.
- Restoring full operation of all cancer services.
- Expanding and improving mental health services.
- Expanding and improving services for people with a learning disability and/or autism.
- Delivering improvements in maternity care, including responding to the recommendations of the Ockenden review.
- Restoring and increasing access to primary care services.
- Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities.
- Transforming community services and improving discharge.
- Ensuring the use of NHS 111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments.

We work collaboratively with system partners to deliver on these priorities. Delivery of the plan is oversighted at a system level; with updates on individual priorities provided monthly and performance against the overall plan reported quarterly.

Urgent and Emergency Care

Historically, the most challenging performance targets for the CCG have been the NHS Constitution targets for urgent and emergency care, and with the increased demand through the pandemic the challenge has been exacerbated. The vast majority of residents use the Accident and Emergency Department at Nottingham University Hospitals NHS Trust (NUH) or Sherwood Forest Hospitals NHS Foundation Trust (SFHT) when they need to access urgent and emergency care. However, some of these services are also delivered at the Urgent Care Centre within Nottingham City and at Newark Hospital. The national standard required that 95% of attending patients have a maximum 4-hour wait in the Accident and Emergency Department from arrival to admission, transfer or discharge,

however this was paused during 2021/22 due to the additional infection control measures required to be put in place at the 'front door' of the NHS.

The focus for the period of the pandemic has been on minimising the number of patients waiting over 12 hours following a decision to admit into the hospital setting, as well as aiming to receive patients into hospital from ambulances as quickly as possible, to support ambulances being available for other patients. There have been several instances where patients have been waiting longer for services than is considered acceptable. The system undertakes a full incident review in each case to assess for any potential harm and works collectively to address these delays as a whole urgent care pathway to ensure patients reach the right services at the right time wherever possible.

Since 2020 the Accident and Emergency Local Delivery Board has been combined to now cover both Nottinghamshire providers as a collaborative system forum. This Board has responsibility for oversight of the urgent and emergency care pathway, with a clear aim of improving performance against the national Accident and Emergency waiting time standard, as well as being responsive to the changing pressures upon the system as the pandemic waves moved through the area. The Board has been established in line with national guidance and its membership includes senior leaders from across the health and social care community. The Board is currently chaired by the CCG's Accountable Officer.

It is expected that moving forward there will be new standards for urgent and emergency care, following national trials being conducted pre-pandemic of which NUH were part; however, these have yet to be confirmed.

East Midlands Ambulance Services NHS Trust (EMAS) provides all ambulance services within Nottingham and Nottinghamshire and has been significantly impacted by the scale of demand for services for the duration of the pandemic. Since 2017 data reporting enables focus on how the service has responded to different levels of need: Category 1 calls are those for people with life-threatening illnesses or injuries; category 2 relates to emergency calls; category 3 relates to urgent calls; and category 4 relates to less urgent calls.

Below is a table summarising the CCG's annual performance in these areas for 2021/22. Where relevant, recovery actions are in place, which are being continually reviewed and updated to improve performance.

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

National Indicator	Target	2021/22	Commentary
A&E waiting time			
Percentage of patients who spent four hours or less in A&E	**>95%**	**68.53%**	*The figure reported is annualised for April 2021 to March 2022 and reflects the performance against this standard at CCG level.*
Number of A&E waits for admission from decision to admit to admission over 12 hours	**0**	**658**	*The figure reported is at Trust level and is for March 2022*
Ambulance clinical quality			
Ambulance Handover Times Over 60 Minutes	**0**	**365**	*The figure reported is at Trust level and is for March 2022*
Category 1 Average Response Time	**<00:07:00**	**00:08:27**	

National Indicator	Target	2021/22	Commentary
Category 1 90th Centile Response Time	<00:15:00	00:14:26	*The figures reported are for the end of period at March 2022.*
Category 2 Average Response Time	<00:18:00	00:49:21	
Category 2 90th Centile Response Time	<00:40:00	01:46:09	
Category 3 90th Centile Response Time	<02:00:00	09:25:01	
Category 4 90th Centile Response Time	<03:00:00	08:23:26	

This winter followed an unprecedented 18 months. The COVID-19 pandemic increased workforce pressures across the local system exponentially, leading to concerns across both health and social care partners around staff wellbeing, stress and burnout. As part of our collective planning process for winter, we listened to voices from the frontline to fully understand the reality for care providers and undertook a listening event with staff from across the system to frame and focus on planning for winter, elective activity and the financial position. Further work was then undertaken with our partner organisations to identify the key issues and goals and develop a system plan, part of which was looking at different ways of working to be able to deliver a sustainable response to local pressures. The response encompassed the following:

- **Identification of risks, thresholds and triggers** – ensuring a focus on proactive planning and working through key system priorities at pace. This included the development of a 'System Escalation Framework' to support understanding of pressures beyond urgent care.
- **Admissions** – focussing on managing demand through innovation and provider collaboration; providing support to primary care initiatives linking to the right place care model.
- **Discharges** – focussing on discharge and flow and creating additional capacity through a collective approach over winter.
- **Workforce** – developing shared staffing models and approaches both to maintain and attract people collaboratively and establishing a 'staff bureau' to enable the sharing of risks and resources across the system.

Planned Care – Access to Treatment

During the initial phase of the pandemic response in 2020/21, all non-urgent planned care services were paused to enable the hospitals to have the capacity to treat covid patients and to enable additional infection control measures to be put in place, which included increased distancing between patients, enhanced cleaning between patient treatments and zoning of hospital areas for covid and non-covid patients. This led to a significantly reduced number of patients being treated and as such patients have been waiting longer for services and an increased number of patients have been waiting than we would have considered acceptable prior to the pandemic. The patients waiting longest are reviewed for any potential harm and are routinely contacted by the Trusts.

During 2021/22 the focus has been on recovering planned care services to pre-pandemic levels and treating those patients with greatest clinical need as priority, including those waiting for cancer treatments. In addition, the financial regime adopted during 2021/22 by NHSE/I sought to ensure that a focus on delivering increasing volumes of planned care services was supported by financial incentives.

NUH and SFHT are our main providers of acute services, however for 2021/22 the system has collectively sought to utilise all available capacity including independent sector providers to ensure patients with highest clinical need were treated first.

Below is a table summarising the CCG's annual performance in 2021/22 for key NHS Constitution Standards and recovery priorities for planned care relating to waiting times for diagnostic tests and planned treatment. Performance is measured at CCG level.

National Indicator	Target	2021/22	Commentary
Referral to treatment pathways			
Percentage incomplete patients <18 weeks	**>92%**	**68.36%**	*The figure reported is the end of period position as at March 2022.*
Waiting list (increase since March 2020)	**28,548**	**32,182**	The figure reported is the end of period position as at March 2022.
104 Week Waits	**46**	**262**	The figure reported is the end of period position as at March 2022.
RTT Activity level v 2019/20	**100%**	**110.2%**	*This figure relates to the difference between March 2022 and March 2020.*
Percentage of patients waiting six weeks or more for a diagnostic test	**<1%**	**36.75%**	*The figure reported is the end of period position as at March 2022.*
Cancelled operations			
Number of cancelled operations rebooked beyond 28 days	**0**	**31**	*The figure reported is for Quarter 3 2021/22 and is at Trust level. Reporting against this indicator was suspended nationally in response to the COVID-19 pandemic and restarted for Quarter 3 2021-22*

Cancer Care – Access to Treatment

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

Cancer diagnostics and treatment is primarily provided by NUH however services are also delivered through SFHT, as well as increased utilisation of independent sector for less complex cases during 2021/22. NUH is a regional cancer centre offering specialist cancer diagnostic and treatment services, and as such, it receives a relatively high number of tertiary referrals from surrounding areas, which can in some instances impact on the Trust's performance. During 2021/22 referrals into Nottinghamshire cancer services have been at around 120% of pre-pandemic levels indicating that a significant volume of patients who did not come forward during 2020/21 national lockdown, have since entered the system. However, with these increased levels of referrals and the continued impact of the pandemic on staff absence and service capacity, this has impacted upon the ability to provide timely care in all instances, across diagnostics, treatment and surgery. The system conducts weekly cancer prioritisation discussions to identify patients with greatest clinical need, and the system's providers conduct routine communication and support to patients who are waiting longer than expected.

Below is a table summarising the CCG's annual performance against the key indicators for 2021/22. Performance against all of these indicators is measured at CCG level. Where relevant, recovery actions are in place, which are being continually reviewed and updated to improve performance.

National Indicator	Target	2021/22	Commentary
Cancer two week waits			
All cancer two week wait	>93%	79.09%	*The figures reported are for March 2022.*
Two week wait for breast symptoms (where cancer was not initially suspected)	>93%	57.89%	
No. 1st OP (referrals) v 19/20	>100%	162.2%	*This figure relates to the difference between March 2022 and March 2020*
No. 1st treatment v 19/20	>100%	87.0%	*This figure relates to the difference between March 2022 and March 2020*
Cancer waits			
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	>96%	75.56%	*The figures reported are for March 2022.*
62-day wait for first treatment following an urgent GP referral	>85%	66.03%	
28 day faster diagnosis	>70%	79.01%	

Other national priorities

Targets to improve mental health services and services for children and young people are set nationally. During Q1 2021/22, a number of targets had been paused including children's wheelchairs, which restarted from Q2 2021/22. To deliver these targets we work closely with our providers, primary care networks and member GP practices. Below is a table summarising the CCG's performance in a range of these areas for 2021/22. Performance against all of these indicators is measured at CCG level. Where relevant, recovery action plans are in place. These are continually reviewed and updated to ensure an improvement in performance.

National Indicator	Target	2021/22	Commentary
Estimated diagnosis rate for people with dementia			
Dementia diagnosis rate	>67%	68.81%	*The figure reported is the end of period position as at March 2022.*
Improved Access to Psychological Therapy (IAPT)			
Percentage of population entering therapy	>7,675	6,800	*Performance is measured on a rolling three-month basis and the figure shown is as at February 2022.*
Percentage recovery rate	>50%	49.10%	*Performance is measured on a rolling three-month basis and the figure shown is as at February 2022.*
Percentage of people that wait six weeks or less from referral to first treatment	>75%	80.39%	*The figure reported is the end of period position as at February 2022.*
Percentage of people that wait 18 weeks or less from referral to first treatment	>95%	99.67%	*The figure reported is the end of period position as at February 2022.*
CYP Access			
Children & Young People Increasing Access	11,709	15,535	*The figure reported is the end of period position as at February 2021.*
Out of Area Placements			
Out of Area Occupied Bed Days	460	274	*The figure reported is the end of period position as at Q3 2021-22.*
Perinatal Mental Health Services			
Percentage of women with moderate/complex to severe Perinatal Mental Health difficulties that access care and support in the community	8.6%	7.02%	*The figure reported is the end of period position as at March 2022.*
Early Intervention in Psychosis Waiting Times			
Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	>60%	83.0%	*The figure reported is the end of period position as at February 2022.*
Children waiting less than 18 weeks for a wheelchair			

National Indicator	Target	2021/22	Commentary
Percentage of children that received equipment in less than 18 weeks of being referred to the wheelchair service.	**>92%**	**73.0%**	*Performance is measured on a quarterly basis and the figure shown is as at Q3 2021/22. Reporting against this indicator was suspended nationally in response to the COVID-19 pandemic and restarted for Quarter 2 2021-22*
Continuing Care			
% of full NHS Continuing Healthcare assessments taking place in acute hospital setting	**<15%**	**3.1%**	*Performance is measured on a quarterly basis and the figure shown is as at Q4 2021/22.*
% of full NHS Continuing Healthcare eligibility decisions made by the CCG within 28 days	**>85%**	**80.5%**	*Performance is measured on a quarterly basis and the figure shown is as at Q4 2021/22.*

Performance against 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 2021/22, the key factor influencing our financial position continued to be the COVID-19 pandemic.

A temporary finance regime was introduced initially in the previous financial year 2020/21, 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. This temporary financial regime has continued during the entire financial year 2021/22.

The financial regime ensured payments were made to organisations, based on the performance that had been delivered during 2019/20 (uplifted for inflation and growth) and to reimburse specific COVID-19 costs from NHS England and NHS Improvement central funding.

The CCG has delivered against its key financial targets despite the challenges faced during this second year of the pandemic. We have also worked closely with our system partners and minimised the overall financial impact which arose during the system's response to the pandemic.

The following tables set out the CCG's financial performance for the 2021/22 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	-	16 surplus	-	✓
Cash balance: Remain below allowed cash balance	2,075	-	39	-	✓

Duty	Target (£000)	Target (%)	Actual (£000)	Actual (%)	Achieved
Running costs: Remain within running cost allowance	20,934	-	18,944	-	✓
Better payment practice code: Pay NHS invoices by value within 30 days	-	95%	-	99.98%	✓
Pay NHS invoices by number within 30 days	-	95%	-	98.42%	✓
Pay non-NHS invoices by value within 30 days	-	95%	-	98.32%	✓
Pay non-NHS invoices by number within 30 days	-	95%	-	97.09%	✓
Mental health investment standard: Deliver the minimum mental health investment	160,821	-	161,076	-	✓

Table 2: Analysis of total spend

Category of expenditure	Total spend (£000)
Acute (hospital) care	1,091,410
Community care	178,237
Mental health care	203,346
Primary care	210,086
Prescribing	159,604
Continuing care	127,275
Other non-healthcare	96,020
Corporate running costs	18,944
Total	**2,084,922**

Table 3: Analysis of COVID-19 expenditure

Category of expenditure	Amount (£000)
Acute (hospital) care	179
Community care	1,850
Mental health care	-22
Primary care	2,248
Hospital Discharge Programme/ Continuing care	13,193
Other non-healthcare	936
Corporate running costs	331
Total	**18,715**

Our financial statements for 2021/22 are set out in full in the *Annual accounts* section of this 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 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 information and data in relation to serious incidents, patient and staff feedback, infection prevention and control, safeguarding processes and clinical outcomes. These mechanisms are strengthened further by wider intelligence gathering through established system relationships. This includes regular attendance at the internal quality oversight and assurance meetings of system partners to be able to understand internal conversations and assurance processes. This approach utilises both qualitative and quantitative intelligence which supports quality oversight, assurance and planning, as well as highlighting early any emerging concerns that may be identified on either a theme, provider or system basis.

Our Quality Strategy continues to reflect our ongoing commitment to ensuring a high-quality health service for our local population and the need to work closely with our system partners to fully deliver the requirements of the NHS Long Term Plan and ensure consistent, equitable quality of care. During the year, the CCG has updated its Quality Strategy Delivery Plan to reflect local changes, the refreshed national vision for quality and the required response to the pandemic.

Our collaboration with system partners as part of the Nottingham and Nottinghamshire ICS will continue to be strengthened with the establishment of the ICB in July 2022. This year has seen a particular focus on the evolution of system architecture with regard to quality and we have actively worked with partners to develop and deliver against a core set of principles to address three core components: quality planning, quality improvement, and quality control. A system-wide quality strategy is currently being developed which will reflect these components, whilst encompassing the CCG's current delivery plan which remains focused on the recovery and restoration of services, reducing health inequalities and increasing engagement.

The impact of the COVID-19 pandemic has continued into 2021/22 and we have continued to ensure there are systems in place to ensure quality outcomes for our population. These mechanisms have included:

- **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.
- **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.
- **A Primary Care Assurance and Support Framework for General Practice**, a joint initiative across the CCG to analyse local intelligence and information. The output acts as an early warning system in identifying primary care providers that may benefit from support/intervention to ensure high quality care is offered.

- **Maintaining a focus on potential areas of 'unknown or hidden harm' as a direct impact of the COVID-19 pandemic**. This has included a comprehensive focus on provider waiting list trajectories and recovery plans and monitoring their delivery.

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 the year 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.

A particular focus during this year has been placed on Nottingham University Hospitals NHS Trust (NUH) following a number of concerns relating to organisational culture, patient safety, patient experience and leadership. Scrutiny has focused on maternity services alongside wider organisation issues following a CQC report rating the Trust as inadequate in the domain 'well led'. The CCG continues to offer support and challenge to NUH and continues to work closely with NHSE/I and regulators.

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. During the year we have commissioned two independent assurance reviews of our operational and governance arrangements from Grant Thornton. The first of these was a retrospective review of one of the predecessor CCG's oversight and assurance arrangements on the quality and safety of NUH's maternity services. The review concluded that the Governing Body at the time should have applied a higher level of enquiry and scrutiny to the information it received.

The second report reviewed our current quality assurance processes and assessed their fitness for the future. The report commended the CCG and its committees in terms of its proactive approach to governance, both now and moving towards governance as part of a system-focussed approach. The report included twelve recommendations which related to our operational procedures as opposed to our governance systems.

You can read more about the work of the Quality and Performance Committee (and our other committees) in the *Governance Statement* section of this report.

Engaging People and Communities

The NHS belongs to all of us, and in line with our statutory duties we welcome the active participation of patients, carers, community representatives and groups and the public in planning, delivering and evaluating services that we commission. The CCG recognises that to improve local health services we need to involve local people in the work that we do; ensuring 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 approach to communications and engagement is underpinned by the following principles for involving local people in our commissioning activities:

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

The CCG has established a Patient and Public Engagement Committee (PPEC) to act as an advisory group to the Governing Body, ensuring that patient and public engagement remains at the heart of our decision-making. The PPEC meets on a monthly basis and is comprised of Non-Executive Director acting as Chair and representatives from Healthwatch Nottingham and Nottinghamshire; and local community and voluntary sector organisations on behalf of underrepresented communities such the Nottingham and Nottinghamshire Refugee Forum, Improving Lives, and the African Institute. The membership also includes a further independent member and health and social care champions. Meeting of the PPEC are supported by CCG officers with relevant expertise in the areas being discussed.

As part of the Nottingham and Nottinghamshire ICS, we continue to work closely with our health and social care partners and the community and voluntary sector. During 2021/22, this collaboration has helped us to further understand the impact of COVID-19 on our populations and to reach out to different communities to support the roll out of the largest vaccination programme in the history of the NHS.

Our contract with our alliance of community and voluntary organisations has continued to evolve this year, ensuring that feedback mechanisms are in place to maintain an engagement presence at place and neighbourhood level. This allows us to continuously hear from our local communities on the biggest health and social care issues affecting them.

As new statutory arrangements come into effect from 1 July 2022, patient and citizens will continue to be a crucial part of our work. We have secured funding from NHSE/I to establish a voluntary, community, and social enterprise organisations (VCSE) alliance and we are also working towards a citizens' panel and an engagement practitioners network. PPEC has also progressed the development of a citizen's intelligence advisory group and going forwards, this forum will help us to ensure that the patient voice is heard at all levels of the ICB.

Our 2021/22 Annual Engagement Report is available on our website at https://nottsccg.nhs.uk. This describes in full as to 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 considered 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.

As part of the Nottingham and Nottinghamshire ICS, the CCG continues to work collaboratively with system partners to address the key challenges faced by our populations, such as more people living longer in ill health, inequity of access to services, and increasing vacancies in the health and care workforce. These challenges can be grouped into three categories that have a reinforcing effect on each other: the health and wellbeing of the population, the provision of services and the effective utilisation of health and care system resources.

In response to these challenges, the leaders of our local health and care system have come together to develop a five-year strategic plan that sets out a shared vision to 'both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age'. The full ICS Health Inequalities Strategy 2020-24 can be found here at the Nottingham and Nottinghamshire ICS website.

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 joint health and wellbeing strategies for both Nottingham City and Nottinghamshire County have recently been refreshed, setting out the ambitions and priority areas for the next several years. The CCG has played an active part in supporting the refresh of these strategies, which can be found on the council's websites, at www.nottinghamshire.gov.uk and www.nottinghamcity.gov.uk.

Through well-established system working arrangements, the Chairs of the Health and Wellbeing Boards have been actively engaged in relation to the CCG's contribution to the joint health and wellbeing strategies.

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 PSED 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. We are committed to reducing health inequalities and improving the equality of health outcomes for

local people, which means 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, delivery against these commitments is achieved by ensuring the following actions are undertaken across our business activities:

- **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.

The CCG has established an Equality, Diversity and Inclusion (EDI) Steering Group to drive the equality, diversity and inclusion agenda within the organisation and to provide a focal point for the discussion, development and implementation of ways to improve our equality performance. The work of the Group focusses on the CCG's three equality objectives:

Objective 1 - Improve access and outcomes for patients and communities who experience disadvantage and inequalities

Objective 2 - Improve workforce diversity at all levels within the CCG to be reflective of the population we serve, with a specific focus on ethnicity, disability and sexual orientation

Objective 3 - Improve the cultural competence of our workforce and empower our staff to support us in improving equality, acceptance and inclusion in our organisation.

An Equality Improvement Action Plan has been developed to achieve these objectives, encompassing equality improvement initiatives already agreed through our patient and public engagement work, the annual staff survey and measuring the CCG's performance against the NHS Workforce Race Equality Standard. In particular, the Plan recognises the urgent need to understand and address the health inequalities experience by different groups who have suffered disproportionately as a result of the COVID-19 pandemic. We continue to work with our partner organisations in the health and care system to address these issues and to listen and learn from our diverse communities and our staff networks.

In terms of monitoring our performance, the EDI Steering Group has developed an 'Equality Performance Assessment Framework' which enables an assessment of equality performance against our key business activities. The framework has been developed utilising the NHS Equality Delivery System (EDS), ensuring that these activities have been mapped appropriately to the existing EDS goals and outcomes.

Our Annual Equality Assurance Report is available on our website at https://nottsccg.nhs.uk.

Emergency Preparedness, Resilience and Response (EPRR)

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could cause large numbers of casualties and affect the health of the community or the delivery of patient care. The Civil Contingencies Act (2004) (CCA) and the NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Framework requires NHS organisations and providers of NHS-funded care to have plans and arrangements in place to respond to such incidents while maintaining services to patients.

Under the CCA, the CCG is defined as a Category 2 Responder. This means that there is a statutory duty to co-operate with Category 1 Responders, which includes NHSE/I, acute trusts and the emergency services. In addition to meeting our legal requirements, we are also required to comply with national guidance issued by NHSE/I and the ISO standards for business continuity.

The continuing response to COVID-19 remained the main EPRR area of work during 2021/22. Throughout the COVID-19 pandemic, the CCG has fulfilled the role of local system leaders for health within the Local Resilience Forum, representing health at any COVID-19 related meetings within the Nottingham and Nottinghamshire ICS. These responsibilities were formally delegated to CCGs from NHS England, in accordance with the CCA.

In addition to the COVID-19 response, the CCG has maintained its ability to response to incidents and other EPRR related challenges. The CCG operates a two tier on-call system which provides 24/7 response and local health leadership to emergencies and issues affecting Nottingham and Nottinghamshire's urgent care system. In 2021/22 the CCG liaised with partners in responding to fuel shortages, Storms Arwen, Barra, Dudley and Eunice; and industrial fire.

The CCG completes an annual EPRR self-assessment, which provides assurance that NHS organisations are working to meet the NHSE/I EPRR Core Standards. For 2021/22 the CCG was assessed as substantially compliant with the Core Standards and actions were agreed with NHSE/I to address a small number of areas requiring improvement.

Sustainable Development

For the NHS, sustainable development has been recognised at a national level as an integral part of healthcare; climate change is not only a major threat to our planet, but to our health as well. The CCG is committed to contributing to the NHSE/I aim for the NHS to be the world's first 'net zero' national health service and in doing all we can to reduce our impact on the environment. This involves taking action around our NHS Carbon Footprint (emissions we control directly) and our NHS Carbon Footprint Plus (emissions we can influence).

As part of the Nottingham and Nottinghamshire ICS, the CCG forms part our system's overall Green Plan. This describes the specific actions and priority interventions we need to take to achieve carbon net zero and lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services. This work has involved extensive collaboration across all of our system partners, building on individual commitments already made to support this agenda to define the necessary actions to help meet the carbon emission reductions as defined by the NHS Carbon Footprint Plus for our local area. The plan also commits to an annual 'Sustainability Summit', where our staff, stakeholders and the public can review our progress and contribute as to what more can be done going forward.

In line with England, the Midlands region has committed to an 80% reduction in our Carbon Footprint (from the 1990 baseline) by 2028-2032, requiring a further carbon reduction of 554 ktCO2e. As the 1990 baseline data is not available at an ICS level, the 80% reduction target uses the 2019/20 baseline equating to Nottingham and Nottinghamshire reducing carbon emissions by 132 ktCO2e by 2028-2032 and a total 165 ktCO2e reduction by 2040 to achieve net zero for our ICS, as summarised in Figure 1.

Figure 1 NHS Carbon Footprint:

	NHS Carbon Footprint * (ktCO$_2$e)		**Reductions required from current levels (ktCO$_2$e)**	
Area	**1990**	**Current (2019/20)**	**By 2028-2032**	**By 2040**
Midlands	3,127	1,179	-554	-1,179
Nottingham and Nottinghamshire ICS	Unavailable at ICS level	165	-132	-165

In line with England, the Midlands region has committed by 2036-2039 to reduce their *carbon footprint plus* by 80% (from the 1990 baseline), requiring a further carbon emissions reduction of 3,380 ktCO2e. Similarly, to the carbon footprint, the carbon footprint plus 80% reduction by 2036-39 uses the 2019/20 data as the ICS baseline, therefore requiring the Nottingham and Nottinghamshire ICS to reduce carbon emissions by a further 442 ktCO2e and a total of 553 ktCO2e reduction by 2040 to achieve net zero.

Figure 2 NHS Carbon Footprint Plus:

	NHS Carbon Footprint Plus ** (ktCO$_2$e)		**Reductions required from current levels (ktCO$_2$e)**	
Area	**1990**	**Current (2019/20)**	**By 2036-2039**	**By 2045**
Midlands	6,255	4,631	-3,380	-4,631
Nottingham and Nottinghamshire ICS	Unavailable at ICS level	553	-442	-553

An ICS system delivery group has been established to progress implementation of the plan, with oversight and scrutiny arrangements currently being designed as part of the ICB governance arrangements.

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Signed by:

Dr Amanda Sullivan
Accountable Officer

16 June 2022

Corporate Governance Report

Members Report

Member practices

As at 31 March 2022, the CCG has 124 member GP practices. These are as follows:

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

20. Churchside Medical Practice (Ward and Pearce)
21. Clifton Medical Practice
22. Collingham Medical Centre
23. Daybrook Medical Practice
24. Deer Park Family Medical Practice
25. Derby Road Health Centre
26. East Bridgford Medical Centre
27. Eastwood Primary Care Centre
28. Elmswood Surgery
29. Family Medical Centre
30. Forest Medical
31. Fountain Medical Centre
32. Gamston Medical Centre
33. Giltbrook Surgery
34. Grange Farm Medical Centre
35. Greendale Primary Care Centre
36. Greenfield Medical Centre
37. Hama Medical Centre
38. Hickings Lane Medical Centre
39. Highcroft Surgery
40. Hill View Surgery
41. Hounsfield Surgery

62. Musters Medical Practice
63. Newthorpe Medical Centre
64. Oakenhall Medical Practice
65. Oakwood Surgery
66. Orchard Medical Practice
67. Orchard Surgery
68. Parkside Medical Practice
69. Peacock Healthcare
70. Plains View Surgery
71. Pleasley Surgery
72. Radcliffe-on-Trent Health Centre
73. Radford Medical Practice
74. Rainworth Health Centre
75. Rise Park Surgery
76. Riverbank Medical Services
77. Rivergreen Medical Centre
78. Riverlyn Medical Centre
79. Roundwood Surgery
80. Ruddington Medical Centre
81. Sandy Lane Surgery
82. Saxon Cross Surgery
83. Selston Surgery

104. Springfield Medical Centre
105. The Medical Centre
106. The Oaks Medical Centre
107. The Om Surgery
108. The University of Nottingham Health Service
109. Torkard Hill Medical Centre
110. Trentside Medical Group
111. Tudor House Medical Practice
112. Unity Surgery
113. Victoria and Mapperley Practice
114. Village Health Group
115. Welbeck Surgery
116. Wellspring Surgery
117. West Bridgford Medical Centre
118. West Oak Surgery
119. Westdale Lane Surgery
120. Whyburn Medical Practice
121. Willowbrook Medical Practice
122. Windmill Practice
123. Wollaton Park Medical Centre
124. 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 following shows people who were members of the CCG Governing Body from 1 April 2021 to 31 March 2022:

- 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 (to 24 September 2021)

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.

Register of Interests

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 publicly 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.

There were no serious incidents requiring external reporting as described within the national DSPT Guidance: "Guide to the Notification of Data Security and Protection Incidents" during 2021/22.

There were eleven personal data related incidents reported during the year however, these were not rated as serious in nature and were managed in line with the CCG's 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 2021/22, the CCG received 260 complaints about local NHS services, of which, 40 were eligible for investigation about a CCG issue and 100 of each were about ongoing treatment and were responded to by the services directly. As an organisation, we received one Ombudsman investigation this year, which the Ombudsman decided not to pursue. One Ombudsman investigation remains open from 2020/21 which is attributed to the backlog caused by the COVID-19 pandemic.

Statement of Disclosure to Auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report.
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

Whilst the CCG does not meet the requirements for producing an annual Slavery and Human Trafficking Statement (as set out in the Modern Slavery Act 2015), the Governing Body fully supports the Government's objectives to eradicate modern slavery and human trafficking. 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)).
- 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.
- 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

16 June 2022

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 2021, 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.

In line with the Health and Care Act 2022, Integrated Care Boards (ICB) will be established on 1 July 2022 and as such, the CCG will be disestablished on 30 June 2022. Key focuses for this last full year of the CCG's operation have been the continued work with our system partners on the local NHS response to the COVID-19 pandemic and establishing robust arrangements to oversee the transition into the new statutory arrangements.

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

During the second year of the national COVID-19 pandemic, governance arrangements have again needed to flex in-year to allow the CCG to operate as efficiently and effectively as possible.

At the start of the year, it was announced that the national incident level for the NHS COVID-19 response was to be reduced from level 4 to level 3, with the incident response focus remaining on monitoring, coordinating and responding to the impacts of the easing of lockdown and any subsequent surges, whilst delivering planning for recovery. However, during December 2021, NHS England and NHS Improvement (NHSE/I) declared a move back to a level 4 national incident in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in COVID-19 cases (both Delta and Omicron variants). In May 2022 NHS England announced a stepping down from a level 4 national to a level 3 regional incident in recognition of community cases and hospital inpatient numbers showing a sustained decline.

In line with national guidance aimed at supporting NHS organisations to release staff capacity and enable rapid and robust decision-making on urgent issues, the CCG's Governing Body agreed the following emergency governance arrangements during the course of this period:

- All Governing Body and committee meetings received focussed agendas (on business-critical items) and streamlined papers in order to reduce the burden of meetings and release clinical and management capacity to respond to the pandemic. For business-critical decisions urgently required outside of the scheduled Governing Body or committee meetings, it was agreed that the existing emergency decision-making powers, as set out in the CCG's Standing Orders or committee terms of reference, could be utilised.
- The CCG's Executive and Clinical Leadership Team was delegated authority to make urgent decisions relating directly to the management of the COVID-19 pandemic. This function was supported by the CCG's Service Change Group; a non-decision making forum comprised of commissioning, finance, procurement, quality and governance leads which ensured that requests had been scrutinised in advance by colleagues with the appropriate skills and knowledge to do so.

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 during 2021/22, 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. The Governing Body's work programme established during 2020/21 continued to operate and was reviewed and updated for quarter two onwards in line with transition plans.

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 six occasions during 2021/22. All meetings were quorate, in accordance with the CCG's Standing Orders, and members achieved an average annual attendance of 92%.

During the year, the Governing Body:

- Continued to keep under review emergency governance arrangements, stepping the arrangements back up in January 2022 following the national increase to a level 4 incident for the NHS COVID-19 response.
- Approved a number of investments within its delegated financial limits of responsibility and oversaw the development of planning for the 'Tomorrow's NUH Programme'. This included the approval of public engagement exercises to inform the development of the pre-consultation business plan to transform the hospital services run by Nottingham University Hospitals NHS Trust and in doing so, re-shape health services in Nottingham and Nottinghamshire.

- Routinely received reports relating to the CCG's financial position and the quality and performance of commissioned services.
- Received the CCG's Annual Equality Assurance Report, describing how the CCG is meeting the Public Sector Equality Duty of the Equality Act 2010.
- Received regular updates in relation to the management of the CCG's strategic risks, via the Governing Body Assurance Framework and received routine reports on the major operational risks being faced by the organisation.
- Received highlight reports from each of its committees at every meeting for assurance 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.
- Received updates from key strategic partnership forums throughout the year, including updates from the Nottingham and Nottinghamshire Integrated Care System (ICS) 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; these were to further develop approaches to strategic and integrated commissioning and wider system working in preparation for the anticipated transition to new statutory arrangements.

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. All committees routinely report to the Governing Body through the submission of highlight reports, ratified minutes, and other appropriate updates as necessary.

The organisation has not conducted a formal review of committee effectiveness during 2021/22 as a key output of this year-end exercise is to inform the following year. However, each committee has developed an annual report to summarise its work over the year and ensure it can demonstrate its discharge of delegated duties. These will be utilised as part of the 'handover' process to the new ICB, to ensure that any key themes, risks, issues, learning and areas of good practice identified over the year will be retained as part of the organisation's corporate memory.

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, health and safety, emergency preparedness and monitoring progress against the CCG's overarching policy work programme.

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 2021/22, all meetings were quorate in line with the Committee's terms of reference and its members achieved 94% attendance at meetings. The members of the Committee are named within the *Members Report* section of this annual report.

During the year, the Audit and Governance Committee:

- Approved the CCG Annual Reports and Accounts for 2020/21.
- Scrutinised reports from the CCG's internal and external auditors, which culminated in the receipt of year-end opinions and conclusions in June 2022.
- Scrutinised the CCG's Register of Tender Waivers to receive assurance that all contracts awarded without a competitive tender process have been awarded in line with procurement regulations.
- Received assurance reports demonstrating the arrangements in place for operational and strategic risk management, standards of business conduct, health and safety, statutory and mandatory training 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.
- Received assurance in relation to implementation of the CCG's policy management framework.
- Received robust assurances on the CCG's probity arrangements, which included a comprehensive self-assessment of the organisation's whistleblowing arrangements against national best practice.

- 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.
- Oversaw the progression of a due diligence plan, developed to ensure that a comprehensive exercise was performed as part of the CCG's closure and the ICB's pending establishment. This work was required to ensure the safe transfer of staff and property to the new organisation, in addition to preserving corporate memory. Since January 2022, the CCG has met 'in common' with the Audit Committee of NHS Bassetlaw CCG to ensure a joined-up approach to the due diligence requirements.

Auditor Panel

In line with the Local Accountability and Audit Act 2014, the Governing Body agreed to establish an Auditor Panel during February 2022 to advise on the appointment of the CCG's external audit service. This was required following the deferral of the CCG's closedown, whereby a short-term appointment became necessary to oversee the CCG's annual report and accounts process for 2021/22.

The membership and duties of the CCG's Auditor Panel is aligned to the national guidance, which includes the Chair of the Audit and Governance Committee acting as Chair to the Panel and a further two Non-Executive members of the Governing Body appointed as members.

The Panel met once in March 2022 to review a proposal to appoint the CCG's existing external audit service for the three month period. Members were assured that the correct procurement approach was being followed and agreed that engaging the existing provider would ensure continuity of service during the period of transition.

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.

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 2021/22, with an annual average of 63% member attendance. All meetings achieved 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 the year, the Remuneration and Terms of Service Committee:

- Made recommendations to the Governing Body for the proposed remuneration of the ICB's Chief Executive and Executive Directors whilst appointed in designate capacity.
- Endorsed two proposed redundancies; one as a result of the restructuring exercise undertaken to align the predecessor six CCGs during the previous financial year; and one in response to a team restructuring exercise.
- Received the CCG's first Gender Pay Gap Report, which is a nationally mandated annual return.

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. The Committee's remit also includes oversight of the development of our local 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 effectiveness.

The Primary Care Commissioning Committee met 12 times during the year and all meetings were quorate in line with the Committee's terms of reference. The average annual attendance achieved by members during the year was 91%. Meetings are open to members of the public to attend, in line with the requirements of the delegation agreement. For 2021/22, 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 the year, the Primary Care Commissioning Committee:

- Considered a number of applications from member GP practices, including decisions relating to the temporary closure of GP practice patient lists, altering GP practice geographic boundaries, changes to practice opening times or practice merger requests. Robust Equality and Quality Impact Assessments have been completed to assess the impact of all significant changes. All decisions made by the Committee continue to be informed by a wide range of views, including the views of patients, stakeholders and the relevant Primary Care Network (PCN).
- Scrutinised assurance reports on access and workforce challenges in relation to additional pressures placed on GP practices during the emergency response to the pandemic. This includes monthly oversight of primary care Operational Pressures Escalation Levels (OPEL) reports, which facilitate rapid deployment of support to practices in need and feed into wider system resilience discussions. The report evolved during the Winter to include data on primary care staff absence levels as this became a key issue for primary care as a result of the Omicron wave of the COVID-19 pandemic.

- Developed and implemented a ‘Primary Care Support and Assurance process’; a framework that consolidates hard and soft intelligence from a multitude of sources and teams and acts as an early warning system by rating practices red, amber or green. It enables practices requiring support or intervention to be identified proactively. Since implementation, two quarterly reports have been received and the process has become a key source of assurance. In addition to the quarterly assurance dashboard the Committee receives a regular briefing on quality issues related to primary care, this also includes information about Care Quality Commission (CQC) inspections and ratings.
- Received the annual patient survey report. The CCG response rate was 36%. The CCG surpassed the national average against ‘Overall experience of the GP Practice’. In order to improve patient experience further, a focus on telephony and online bookings/services was agreed.
- Approved the addition of two Local Enhanced Services (LES) across Nottinghamshire (long Covid and weight management) to meet the needs and priorities of the local population.
- Received a six-monthly report related to primary care estates, which included plans and priorities to address estate issues and developments. Work has commenced in 2022 to develop an ICB primary care estates strategy.
- Oversaw the process for contracting the Interpreter and Translation Services and a Special Allocation Scheme for Nottingham and Nottinghamshire. The Interpreter and Translation Service procurement remains a work in progress. Both contracts are considered key to addressing population health inequalities.
- Reviewed, on a quarterly basis, the progression and development of PCNs and the achievement of plans for additional roles within these. PCNs are two years into a five-year programme of development and performing well against national and regional expectations. The focus for PCNs as they move to year three is to develop their role and accountabilities within the ICB.
- Received a monthly update on the position of the primary care delegated budget and received assurance reports on General Practice COVID-19 additional expenses. The Committee also approved priority areas of spend for primary care transformation monies, for example the winter access fund. The winter access fund is a specific funding stream from NHSE/I available between November 2021 to March 2022 to improve access in primary care. This fund has provided an opportunity for innovative solutions to address access issues to be implemented on a trial basis. Several of the CCG’s initiatives have been commended regionally and work is underway to evaluate the impact of the funding and to capture the learning in the ICB Primary Care Strategy which will determine the future direction for primary medical services.
- Scrutinised primary care risks from the Corporate Risk Register monthly, with a particular focus on major risks, new risks, and escalating risks. This includes reviewing the effectiveness and progress of mitigating actions. The risk profile over the year reflects increasing demand on the primary care workforce as a result of greater demand for primary care services and the ongoing pressures related to the COVID-19 pandemic.
- Received monthly reports related to the transition of primary care to the ICB. A key feature of this being the development of the Primary Care Strategy, governance arrangements and planning for the delegation of primary podiatry, optometry and dentistry services from April 2023.

Prioritisation and Investment Committee

The Prioritisation and Investment Committee exists to oversee the development of the CCG’s commissioning strategies and plans to reduce health inequalities, improve health outcomes, and improve quality of care. The Committee also sets the CCG’s ethical decision-making framework and prioritisation methodology and process, and evaluates, scrutinises and quality assures the clinical and cost effectiveness of business case

proposals for new investments, recurrent funding allocations and decommissioning and disinvestment of services. The Committee also ensures that the CCG's procurement responsibilities are appropriately discharged.

The Prioritisation and Investment Committee meetings are scheduled monthly. The Committee will meet, as a minimum, on a bi-monthly basis. Its membership is comprised of non-executive, clinical and managerial members. The Committee met thirteen times during the year; twelve regularly scheduled meetings and one extra ordinary meeting convened to consider an urgent item. On a further two occasions, the Committee utilised its urgent decision-making powers to consider urgent requests via email. Quorate decisions were reached on both occasions and these were reported back at the following formal meetings. The average annual attendance of members at meetings during 2021/22 was 80%.

During the year, the Prioritisation and Investment Committee:

- 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.
- Oversaw 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.
- Regularly considered opportunities to promote system working and collaborative commissioning arrangements with local authorities and system partners. In particular, these discussions focussed on whether effective steps were being taken to tackle health inequalities.
- Endorsed the CCG's Evaluation Framework and approved this as a best practice guide on how to evaluate commissioned services and inform future commissioning decisions. The Committee fed back proposed methods of ensuring successful implementation of the framework throughout the organisation, to maximise its effectiveness.
- Endorsed the strategic direction of travel proposed by NHS Derby and Derbyshire CCG (the co-ordinating commissioner) with regards to the regional contracts for the NHS 111 Service.
- Endorsed the Mental Health and Investment Plan for 2021-22. The proposal was in line with the Mental Health Long Term Plan and the ICS financial plans for mental health services. The Committee also discussed required improvements to communications and engagement relating to mental health services, in order to spread awareness of the services available amongst the public.
- Received, and approved several requests for uplifts to existing contracts. These requests were made in light of activity increases as well as rising costs, where uplifts had not been made for some time. The Committee considered these requests with the CCG's future financial position in mind, ensuring continued awareness that efficiencies must be made where recurrent funding is not available.
- Regularly received updates on the overnight closure of Newark Hospital Urgent Treatment Centre, which remains ongoing at the time of writing this statement. The Committee discussed the possibility of a permanent closure and the decision-making process around this, for future consideration.
- Considered a proposal to change the commissioning model for adult homecare for continuing healthcare, bringing the contracts for Nottingham and Nottinghamshire under one model, where these have previously been separated.
- Scrutinised the CCGs performance and delivery of the 2021/22 Better Care Fund (BCF) national conditions. The Committee noted that future governance arrangements needed to include oversight and accountability for the delivery of this work, to ensure alignment with future plans for joint commissioning for integrated care.

- Considered and approved several contract variations surrounding community care beds, with an associated non recurrent budget provision.
- Considered an urgent request relating to the children's and young people's neurodevelopmental service after it transpired that the provider was unable to deliver a recovery trajectory for a significant backlog of patients. The Committee approved action to allow the existing contract to expire and approved investment to enable a new provider to deliver the service.
- Received regular updates on the pressures faced within key provider organisations, considering ways to provide support.
- Received regular updates surrounding the ongoing Community Transformation Programme and its desired outcome.
- Endorsed the establishment of a Mental Health and Learning Disability Specialist Treatment Funding Panel for the management of funding requests for mental health/learning disability treatments or packages of care that are outside the scope of locally commissioned services, noting that the appropriate advice had been sought from governance leads and the CCG's solicitors.
- Scrutinised extracts from the CCG Corporate Risk Register on a monthly basis. Risks often described cost and or staffing pressures and the negative impact these would have on services, as well as the COVID-19 pandemic and its impact on operations. Other key areas of concern related to ensuring appropriate commissioning was undertaken in line with CCG priorities to ensure the health needs of the population are met.
- Scrutinised monthly Service Change Reports which described actions being taken to manage CCG contracts nearing expiry. In addition, the Committee also routinely received the CCG's log of investment, disinvestment, and contract award decisions agreed via the Accountable Officer and Chief Finance Officer (as set out in the CCG's Standing Financial Instructions) to ensure appropriate oversight of decision-making.

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. The Committee's remit also includes 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 eleven times during 2021/22 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 annual attendance by members at Committee meetings was 89%.

During the year, the Quality and Performance Committee:

- 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 as a result of the COVID-19 pandemic.
- 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 to describe system pressures in more detail. As such, the recovery trajectory for elective and cancer care and performance against this trajectory are routinely included.

- Alternated the focus of meetings between a deep dive on specific providers/services and the scrutiny of routine quality and performance reports. This has enabled the Committee to give the necessary attention to performance and quality issues arising across the CCG area whilst ensuring it fulfils the duties described in its terms of reference.
- Undertaken deep dives in relation to NUH performance and NUH maternity services, Nottinghamshire Healthcare NHS Foundation Trust (NHFT), community services recovery, restoration and transformation, care homes and the home care sector, 104 week waits and cancer services.
- Maintained a high level of vigilance in respect of performance at NUH following a number of concerns relating to organisational culture, patient safety, patient experience and leadership. Scrutiny has focused on maternity services alongside wider organisation issues following a CQC report rating the Trust as inadequate in the domain 'well led'. The CCG continues to offer support and challenge to NUH and continues to work closely with NHSE/I and regulators.
- Sought routine assurance that providers had appropriately responded to actions identified as a result of CQC inspections.
- Received two external assurance reports; both commissioned from Grant Thornton. The first review was a retrospective review of the former CCGs' oversight arrangements to provide assurance of the quality and safety of NUH's maternity services. The review covered the period 2016 to 2020 and concluded that the Governing Body of one of the former CCGs should have applied a higher level of enquiry and scrutiny to the information it received. The second report reviewed current quality assurance processes and assessed their fitness for the future. The report commended the CCG and its committees in terms of its proactive approach to governance, both now and moving towards governance in the system space. The report included twelve recommendations which related to working practices as opposed to governance systems.
- Received reports and commented on the design for quality in the ICB to ensure there is shared accountability for quality assurance and improvement. This included a specific focus on the shared commitment and vision to address health inequalities across the health and care system.
- Received regular updates on citizen engagement including plans for engagement in the ICB.
- Approved the CCG statement on modern slavery which is published on the CCG website.
- Received a number of annual reports across a range of its responsibilities, including
  - Complaints and patient experience
  - Serious incidents and never events
  - Equality, diversity and inclusion
  - Infection prevention and control
  - Disabilities Mortality Review (LeDeR)
  - Nottinghamshire Area Prescribing Committee
  - Medicine Safety Officers report
  - Safe Management of Controlled Drugs; and
  - Safeguarding
- 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 Quality, Innovation, Productivity and Prevention (QIPP) targets. The Committee's remit also includes 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.

The Finance and Resources Committee met eleven times during 2021/22 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 annual attendance of members at Committee meetings was 90%.

During the year, the Finance and Resources Committee:

- Scrutinised monthly finance reports which outline the CCG's financial position as well as performance against efficiency targets. The Committee particularly focused on performance against Elective Recovery Fund (ERF) targets and the subsequent impact on the CCG's financial position.
- Received updates on the performance against the CCG's savings plan.
- Received updates on the system financial position on a monthly basis, which included COVID-19 expenditure.
- Monitored progress of the COVID-19 Vaccination Programme. The costs associated with this programme provided context for discussions surrounding the wider system financial position.
- Reviewed 2021/22 financial budgets and plans at the beginning of the financial year, prior to seeking Governing Body approval.
- Received updates on the progress made against the CCG's Organisational Development (OD) strategy/plan for 2019/21. Members were assured by the increased use of the Apprenticeship Levy uptake for leadership workshops within the CCG during 2021/22. Focussed discussions were held regarding the cultural change associated with the transition to the ICB, and potential actions required to manage this.
- Received a plan for the CCG to move towards an agile working model, inclusive of estates plans and actions taken to make offices secure. The Committee monitored the impact of various lockdowns throughout 2021/22. The model changed to meet national guidance and rules around social distancing and office working on numerous occasions.
- Scrutinised an action plan which was produced following a review of the annual staff survey results. Progress against this plan was also reported back to the Committee throughout the year. The Committee was assured that the plan had been endorsed by various staff groups.
- Received extracts from the Corporate Risk Register, highlighting risks relating to the Committee's responsibilities, at each meeting.
- Received an update outlining activity and financial modelling for the Tomorrows NUH Programme. The Committee was assured that a comprehensive planning approach had been applied to the financial aspects of the programme, whilst enabling any flexibility needed in order to respond to changing activity pressures.

- Received a regular 'Cross Provider Report', enabling scrutiny of the finance and activity performance of the CCG each month, paying particular focus to the actions taken to manage major acute contracts.
- Received regular updates on matters which impact the capacity, capability and morale of the CCG workforce. The Committee scrutinised performance against targets for staff turnover, completion of staff appraisals and sickness absence. The Committee noted the fluctuating levels of COVID-19 throughout the year and the impact this had on key performance indicators.
- Oversaw the development and submission of the 2021 Workforce Race Equality Standard (WRES) action plan. The final plan was submitted for approval to the Governing Body.
- Received a comprehensive Annual Equality Assurance Report in relation to the CCG's role as an employer and the actions taken to ensure equality, diversity and inclusion is embedded into policy development and employment practices.

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 2021/22 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.

CCG Closedown and ICB Establishment

Following the announcement that a revised target date of 1 July 2022 had been set for the establishment of Integrated Care Boards (replacing the previously stated target date of 1 April 2022), the Governing Body agreed to a number of proposals to ensure the CCG remained legally constituted and able to operate effectively during its extended period of existence. The actions implemented were:

- The continuation in post of the existing GP Representative roles and Non-Executive Director roles on the Governing Body for the extended period of CCG operation.
- Additional Governing Body and Committee meetings being scheduled, with the final meeting of the Governing Body being held in June 2022 and the final meetings of committees held in May 2022 (with

the exception of the Audit and Governance Committee, which was scheduled to meet in June in line with the national Annual Report and Accounts timeline).

- Updating the terms of reference for any 'decision-making' committees to include the ability to make decisions virtually, should this be required following the last scheduled meeting.
- Ensuring ICB designate leaders have been fully involved in any CCG decision-making that will impact on the ICB.

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 2022, 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 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.

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 they 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 2021/22, 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; overseen by the Planned Care Transformation Board and its supporting governance structure. An ICS Health Inequalities Strategy is also in place, supported by an ICS Health Inequalities Plan that has been developed during 2021/22. Addressing health inequalities will continue to be a key priority for the CCG until such time as the new ICB is established.
- **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 healthcare 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 continued to support the management of this risk across Nottingham and Nottinghamshire, however, capacity to address elective recovery targets continues to be a key risk area of the CCG for 2022/23, and subsequently the ICB when established.
- **The potential for non-delivery of the CCG's financial duties for 2021/22**, due to deterioration in underlying position of the CCG, the depletion of non-recurrent funds available, delays in planned service transformation (i.e. planned efficiencies not materialising) and non-achievement of elective recovery activity (i.e. additional elective recovery fund monies were not received). Financial recovery processes were 'paused' in-year due to the COVID-19 pandemic. This, alongside ongoing uncertainties regarding the financial regime, mandated nationally set block payments to providers, and increased levels of activity costs of service provision (due to COVID requirements), meant that finance risk scores remained high throughout the majority of 2021/22. In response to the CCG forecasting to meet its statutory financial duties for 2021/22, 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 2022/23 financial plan.
- **The transition to system-led financial accountability was also recognised as a potential risk to the delivery of the CCG's financial position**. This risk has been managed via the development of an ICS Finance Framework and the establishment of system finance governance arrangements. This will be a significant area of focus for 2022/23.
- **The potential for poor patient experience and patient safety concerns at Nottinghamshire Healthcare NHS Foundation Trust**. This risk was originally identified following the outcome of a CQC inspection being published. The CCG identified a further risk relating to lack of assurance regarding the culture and leadership at the Trust in response to the issues identified. The CCG's Quality and Performance Committee has commissioned a number of 'deep dive' reviews into the Trust; both in relation to service quality and wider governance. Governing Body and Committee level assurance requirements have been increased in-year. Monitoring and support continued throughout 2021/22 and the delivery of high-quality services at the Trust continues to be a key priority for 2022/23.
- **The potential for poor patient experience, clinical outcomes and patient safety concerns at Nottingham University Hospitals NHS Trust; specifically, in relation to the Trust's maternity services** continued to be a significant risk area during 2021/22. Concerns were initially identified following the outcome of a CQC inspection; with further concerns being raised through local and regional reviews. Routine updates regarding the Trust and its maternity services, are provided to the CCG's Quality and Performance Committee and both CCG and system-led quality assurance

processes have been strengthened. Monitoring of the quality of services continues daily and the delivery of high-quality maternity services at the Trust continues to be a key priority for 2022/23.

- **The potential for workforce capacity with General Practice to significantly reduce, impacting the sustainability of some GP Practices**. This has been further exacerbated by sustained levels of significant pressure of primary care as a result of the COVID-19 pandemic, in particular, delivery of the booster 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 Primary Care Commissioning Committee has received routine assurance updates in relation to primary care workforce; and supported the development of the CCG's Primary Care Support and Assurance Framework. The development and embedment of PCNs during 2021/22 has also contributed to the management of this risk.
- **The potential impact of loss of public confidence in local primary and secondary health services, as a result of national and local media/reports and known quality issues**, was recognised as a key risk for the CCG during 2021/22. This may impact the extent to which citizens interface with health services, resulting in increased pressure on urgent and emergency care services, as services will not be accessed until a point of crisis. Mitigations to this risk largely relate to the planning and recovery governance structures, primary care transformation, as well as targeted work being undertaken by the CCG's Communication Team.

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 2021/22, 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 into the specific committee terms of reference as necessary. This includes review of the timeliness, accuracy, validity, reliability, relevance and completeness of data.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular person-identifiable information. 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 its own Information Governance Management Framework, which is underpinned by a comprehensive suite of information governance policies. These 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 also has a designated Data Protection Officer (DPO) 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 are issued 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 and processes for information risk management and incident reporting and investigation of serious information incidents.

Over 2021/22 information governance activity continued to support the CCG's work addressing the COVID-19 response, helping to ensure that data that was needed was available, reliable, kept secure and was used lawfully in line with data protection law and Control of Patient Information (COPI) Regulations 2002 and COPI Notices.

Cyber security assurance has remained a high priority and significant resource has been focused on addressing threats such as Log4j and ensuring and maintaining strong resilience across the IT network. We continue to work closely with NHS Digital and the National Cyber Security Centre and follow the national advice.

At the time of finalising this governance statement, we are in the process of confirming our 2021/22 self-assessment against all mandatory assertions and evidence requirements contained with the DSPT. NHS Digital announced CCGs were not required to have an annual internal audit of its DSPT for 2021/22 due to the formation of ICBs. However, an internal audit has been carried out for the CCG on a small selection of assertions examining 11 evidence items to support the Head of Internal Audit Opinion. The audit outcome was confirmed as 'Significant Assurance'. The CCG will submit its self-assessment by 30 June 2022 and it is anticipated that this will be a successful submission, with all mandatory assertions and evidence items fully met.

Information governance plays a valuable and essential role in supporting the development and improvement of safe and effective patient services and will continue to evolve and progress to meet the needs of those services into the future.

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 2021/22, 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 and employment 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 payroll services report, qualified opinions have been provided by the service auditors. These opinions have been qualified on the basis of a small number of exceptions identified in the testing of controls. Overall, we are satisfied with the management responses in relation to these exceptions and the actions being taken to address them.

Control issues

There have been no significant control issues identified during 2021/22.

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

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.

The CCG is currently party to a number of Section 75 Partnership Agreements: four with Nottingham City Council relating to the Better Care Fund, Domestic Violence, Tier 2 Child and Adolescent Mental Health Services and Infection Prevention and Control (IPC); and two with Nottinghamshire County Council relating to the Better Care Fund and the Integrated Community Equipment Loan Service.

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.

The NHSCFA's *Standards for NHS Commissioners: Fraud, Bribery and Corruption* were superseded in April 2021 by the *Government Functional Standard 013: Counter Fraud* and the requirement to complete the *Counter Fraud Functional Standard Return*. This covers 13 key components of Counter Fraud work that all NHS funded organisations should be compliant with.

The 2021/22 self-assessment has recently been completed and shows an overall compliance rating of 'Green'

Head of Internal Audit Opinion

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

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

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

Audit report	Audit objectives	Level of assurance
Conflicts of Interest (2022/NNCCG/01)	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[1]
Continuing Healthcare (2122/NNCCG/03)	The aim of this review was to determine whether the CCG's Continuing Healthcare Policy had been correctly and consistently applied during the decision-making process and that communication with patients and their families was undertaken in a manner which supports the personalisation of healthcare being provided.	Significant[2]
ICS Transition Arrangements (2122/NNCCG/05)	The purpose of this review was to provide an independent assurance in respect of transition workstream delivery and the operation of the ICS Risk and Transition Committee.	Significant[1]
Multi Agency Safeguarding Hub (2122/NNCCG/06)	The objective of this review was to support the further development of Multi Agency Safeguarding Hub (MASH) arrangements. This included the examination of a number of areas in place for the MASH; these included its purpose, its policies and operating procedures and its staffing structures.	Limited[1] *(see section below table for further information)*
Integrity of the General Ledger and Key Financial Systems (2122/NNCCG/07)	The purpose of this review was to assess the adequacy of controls over the CCG's general ledger and its financial reporting arrangements. It also sought to determine as to whether a robust, efficient and effective control environment was in place in relation to the pay expenditure, accounts receivable and treasury management systems.	Significant[1]
Data Protection Security Standards (2122/NNCCG/09)	As CCGs were not required by NHS Digital to obtain an independent assurance of their completion of the Data Security and Protection Toolkit for 2021/22, this review was undertaken to examine the CCG's compliance with a sample of the assertions contained within the standards.	Significant[1]
Safeguarding (2122/NNCCG/10)	This review was focussed on the arrangements for safeguarding adults, reflecting on system level arrangements and safeguarding during the COVID-19 pandemic.	N/A[3]
Patient and Public Engagement (2122/NNCCG/12)	The purpose of this review was to evaluate the arrangements that are being developed to ensure that the ICB complies with guidance that has been issued as part of the establishment process relating to engaging with patients.	N/A[2]

[1] Audit opinions provided are: substantial, significant, moderate, limited or weak assurance, in line with 360 Assurance's Internal Audit Charter.

[2] Audit opinions provided are substantial, significant, moderate, limited or weak assurance (in line with 360 Assurance's Internal Audit Charter).

[3] N/A refers to advisory audit reports where no formal opinion is provided.

Audit report	Audit objectives	Level of assurance
ICS Operational Planning (2122/NNICS/01)	The overall objective of this review was to evaluate governance arrangements implemented by the ICS to ensure that all relevant partners were appropriately involved in the preparation of the H1 2021/22 Operational Plan and that activity, finance and workforce data used to support the production of the Plan was accurate and consistent.	N/A[2]

Multi Agency Safeguarding Hub Review

The Multi Agency Safeguarding Hub (MASH) is comprised of local authority, police and health. The health component is funded by the CCG, with contributions from local NHS partners.

The MASH review was undertaken at the request of the CCG as part of the preparation for ICB establishment and the development of a safeguarding model for the future for the local system. This work was intended to provide an independent view to help inform this work and to ensure that the CCG was able to contribute fully to a much wider partnership review of the MASH arrangements being performed to determine a service that was 'fit for purpose' and robust for the future.

The conclusion of an audit opinion of 'limited' assurance is attributed across a number of the controls examined as part of the review. This included the current service specification having not been reviewed since 2015, the absence of established performance monitoring mechanisms for the expectations set out in the specification and the current staffing model no longer aligning to these expectations due to the increase in activity since first agreed. The review also highlighted the need to ensure that staff were adequately supervised and supported; to review records management arrangements and to ensure that existing MASH guidance documentation was reviewed to identify any gaps in formal policies or procedures.

The audit report has subsequently been reviewed by the CCG's Quality and Performance Committee, which was assured that robust safeguarding arrangements were in place and that the risks in the report were identified against the MASH's own objectives. The Committee was also informed of the actions taken to swiftly address the four 'high' rated risks detailed within the report; and were advised of the actions in place to address the remaining three 'medium' rated risks. It was noted by the Committee that all of these actions were expected to be executed ahead of the report's stated implementation date.

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 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 2021/22.

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 2021/22 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 (VSM) 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 2021/22

Payments to past members (subject to audit)

There were no payments to past senior managers made in 2021/22.

Fair pay disclosure: percentage change in remuneration of highest paid director (subject to audit)

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	6.6%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-2.8%	-

The above information for employees should be interpreted in the context of the merger of six Nottinghamshire CCGs into one organisation on 1 April 2020. The CCG at that point was able to rationalise some of the duplication of staffing at a higher level than had previously arisen from managing six separate entities. As a result, there were higher salary costs in the first months of 2020/21 together with some redundancy costs in that year, which did not recur in 2021/22.

Pay ratio information (subject to audit)

As of 31 March 2022, remuneration ranged from £3,250 to £190,000 (no change and an increase of 14.6% respectively against 2020/21: £3,250 to £165,830) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). 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.

Remuneration of NHS Nottingham and Nottinghamshire CCG's staff in 2021/22 is shown in the table below:

	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£31,534	£42,121	£53,219
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£31,534	£42,121	£53,219

The ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director, is illustrated in the table below.

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2021/22	6.10	4.57	3.62
2020/21	5.47	4.01	3.15

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director in the CCG in the financial year 2021/22 was £190,000 - £195,000 (2020/21, £165,000 - £170,000). The relationship to the remuneration of the organisation's workforce is disclosed in the tables below. During 2021/22, no employees received remuneration in excess of that of the highest paid director (2020/21, none).

2021/22	25th percentile total remuneration	25th percentile salary	Median total remuneration	Median salary	75th percentile total remuneration	75th percentile salary
Band of highest paid[1] director's total remuneration/ salary (£000)	£190 - £195	£190 - £195	£190 - £195	£190 - £195	£190 - £195	£190 - £195
Total remuneration/ salary[1,2] of the workforce (£)	31,534	31,534	42,121	42,121	53,219	53,219
Ratio	6.10	6.10	4.57	4.57	3.62	3.62

2020/21	25th percentile total remuneration	25th percentile salary	Median total remuneration	Median salary	75th percentile total remuneration	75th percentile salary
Band of highest paid[1] director's total remuneration/ salary (£000)	£165 - £170	£165 - £170	£165 - £170	£165 - £170	£165 - £170	£165 - £170
Total remuneration/ salary[1,2] of the workforce (£)	31,534	31,534	42,121	42,121	53,168	53,168
Ratio	5.47	5.47	4.01	4.01	3.15	3.15

[1] Calculated from annualised amounts as of 31 March 2022. The amounts therefore reflect the annualised value of in-year pay awards, and the values disclosed may as a result differ from amounts shown elsewhere in this report, which disclose the totals paid in-year

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

Senior manager remuneration, including salary and pension entitlements (subject to audit)

2021/22

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100[i]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£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	35-37.5	165-170
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 [ii]	135-140	0	0	0	0	135-140
Dr Stephen Shortt - Chair/Joint Clinical Leader	95-100	0	0	0	0	95-100
Amanda Sullivan - Accountable Officer	160-165	0	0	0	0	160-165
Susan Sunderland - Non-Executive Director	10-15	0	0	0	0	10-15
Dr Richard Stratton - GP Representative	25-30	0	0	0	0	25-30
Jon Towler - Non-Executive Director	40-45	0	0	0	0	40-45
Rosa Waddingham - Chief Nurse	120-125	0	0	0	30-32.5	150-155

2020/21

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100[i]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£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 - Chair	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

[i] Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

[ii] It was agreed that Nottingham & Nottinghamshire CCG's Chief Finance Officer, Mr Poynor, would also fulfil this role for Bassetlaw CCG from 15/02/22. The values shown above for Mr. Poynor represent Nottingham & Nottinghamshire CCG's share of his salary and allowances with Bassetlaw CCG reporting the remaining share. Mr. Poynor's total salary is in the range £140,000 to £145,000.

Name and Title	2020/21 (a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100[i]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Dr Stephen Shortt - Chair	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	197.5-200	320-325

Pension benefits as of 31 March 2022 (subject to audit)

Name and Title	2021/22 (a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2021	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2021	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Amanda Sullivan, Accountable Officer	0	0	0	0	0	0	0	0
Stuart Poynor, Chief Finance Officer	0	0	0	0	0	0	0	0
Rosa Waddingham, Chief Nurse	2.5-5	0	45-50	0	556	22	601	0
Lucy Dadge, Chief Commissioning Officer	2.5-5	0-2.5	30-35	65-70	641	39	701	0

Name and Title	2020/21 (a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2020	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2021	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Amanda Sullivan, Accountable Officer	0	0	0	0	0	0	0	0
Stuart Poynor, Chief Finance Officer	0	0	0	0	0	0	0	0
Rosa Waddingham, Chief Nurse	10-12.5	0	40-45	0	406	126	556	0
Lucy Dadge, Chief Commissioning Officer	2.5-5	2.5-5	30-35	65-70	550	63	641	0

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

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 2022:

Pay band	Female	Male	Number
Band 1	0	0	0
Band 2	1	1	2
Band 3	24	3	27
Band 4	30	4	34
Band 5	51	6	57
Band 6	52	22	74
Band 7	72	23	95
Band 8a	68	15	83
Band 8b	33	10	43
Band 8c	17	5	22
Band 8d	10	2	12
Band 9	9	7	16
Very senior managers (non-Governing Body members)	1	2	3
Any other spot salary (non-Governing Body members)	16	16	32
Governing Body members	7	7	14
Totals	**391**	**123**	**514**

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	429.74	20,359	2,294	3,843	0	0	26,496
Other	7.67	821	0	0	0	0	821
Total	**437.41**	**21,180**	**2,293**	**3,843**	**0**	**0**	**27,317**

Sickness absence data

Sickness absence data for 2021/22 has been calculated in accordance with guidance from the Department of Health and Social Care (DH).

Sickness absence data 2021/22	
Total days lost per year (WTE)	4431.60
Total days available per year (WTE)	156272.62
Average working days lost due to sickness absence (per WTE)	**6.4**

Staff turnover percentage

The CCG's rolling twelve-month staff turnover rate (staff leaving the organisation) for 2021/22 was 14.19% (on a WTE basis).

Staff engagement percentages

The CCG participated in the 2021 NHS Staff Survey, alongside 39 other CCGs. We had a response rate of 84%; above the average for the CCG benchmark group (79%). The survey results remained largely positive, building on the progress made in the previous year's survey in relation to health and wellbeing, support and communication from line management and senior managers. A small number of areas were highlighted where actions are required during 2022 to improve staff experiences. Working in partnership with our staff networks, the CCG is developing an action plan aligned to the NHS People Promise to help address this.

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.

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 2021/22.

We have developed an overarching Equality Improvement Plan which includes two specific equality objectives for our organisation:

- To improve workforce diversity at all levels within the CCG to be reflective of the population we serve, with a specific focus on ethnicity, disability and sexual orientation; and
- To improve the cultural competence of our workforce and empower our staff to support us in improving equality acceptance and inclusion in our organisation.

These objectives are being supported through use of the NHS Employers 'Measuring Up' Tool to help us understand where we have underrepresentation in our workforce when compared to our population demographics; and the utilisation of our Staff Survey results

and feedback from our staff groups. As part of the plan, we have identified a number of actions that are needed to help achieve these objectives and defined the desired outcome for each.

Responsibility for monitoring the CCG's equality performance in relation to its role as an employer sits with our Finance and Resources Committee. This includes monitoring the delivery of plan in relation to recruitment, training and development, cultural competence and staff experience. Our Equality Improvement Plan can be found on our website at https://nottsccg.nhs.uk.

Three Staff Networks have also been established: a BAME Staff Network, a LGBTQ+ Staff Network and a Staff Disability and Wellbeing Network (DAWN), each with an Executive sponsor. These networks are staff-led, and they shape their own agendas, with support from the Human Resources Team. They provide a safe space for staff to discuss their lived experiences, or those of their family, friends or wider communities and networks, with the aim of ensuring an inclusive and diverse working environment for all staff; with no fear of discrimination or disrespect. The Staff Networks are seen as key advisory forums to support the work of the CCG as an employer, but also as a commissioner of health services, through the provision of shared insights, constructive challenge to existing ways of working, and through the co-production of equality initiatives and improvement plans.

There will be a continued focus as we transition into a new organisation to ensure that the insights, ideas and concerns from the Staff Networks are systematically and meaningfully considered and responded to. As part of our preparatory work for the new ICB, we have also performed a comprehensive review of our arrangements for 'Freedom to Speak Up' (FTSU) this year; engaging with the National Guardian's Office and FTSU leads from NHSE/I to ensure that our mechanisms for enabling the system's workforce to speak up will be as robust as possible.

We have maintained a focus on the mental health and wellbeing of our staff as the response to the COVID-19 pandemic and remote working has continued, although we are now in the process of implementing an 'Agile Working Policy' to take into account the changed national guidance on working from home.

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.

We have continued to run our '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. In addition, our ICS has established a Staff Support Hub, where staff can access rapid assessments into Mental Health Services to support their mental health and wellbeing. The ICS has also launched the 'Thrive' app to provide 24-hour support to all employees of systems partners.

As a system, we are committed to the national vision of 'one workforce' and working with our partners to deliver the priorities set out in the NHS People Plan. As part of the Nottingham and Nottinghamshire ICS Operational Plan 2021/22 (as described in the *Performance Analysis* section of this annual report), we have co-produced plans to address key system issues around staff health and wellbeing, addressing inequalities, recruitment and retention, and capability and capacity.

Going into the next year, the arrangements introduced by the Health and Care Act 2022 will further strengthen this collaboration; enabling more effective leadership and oversight of this important agenda and ensuring our system continues to develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.

Expenditure on consultancy

Expenditure on consultancy in 2021/22 totalled £456,000.

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: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2022, for more than £245[1] per day and that last longer than six months, are shown in the table below.

	Number
Number of existing engagements as of 31 March 2022	**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: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245[2] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	10
Of which:	
No. not subject to off-payroll legislation[3]	1
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	9
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
The number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: No. of engagements that saw a change to IR35 status following the consistency review	0

[1] *The £245 threshold is set to approximate the minimum point of the pay scale for a senior civil servant*

[2] *The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant*

[3] *A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.*

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

Any off-payroll engagements of Governing Body members and / or senior officials with significant financial responsibility between 1 April 2021 and 31 March 2022 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	1	5,857	0	0	1	5,857	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	1	160,000	0	0	1	160,000	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	**2**	**165,857**	**0**	**0**	**2**	**165,857**	**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	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**0**	**0**

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 the 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.

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4.4 which will be the number of individuals. No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary. The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit report

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 Financial Statements of this report at page 76-79. An audit certificate and report is also included in this Annual Report at pages 102.

Annual Accounts 2021/22

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

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(11,322)	(5,739)
Other operating income	2	(1,114)	(936)
Total operating income		**(12,436)**	**(6,674)**
Staff costs	4	27,444	27,775
Purchase of goods and services	5	2,065,008	1,796,248
Depreciation and impairment charges	5	-	14
Provision expense	5	(1,095)	583
Other Operating Expenditure	5	6,000	593
Total operating expenditure		**2,097,357**	**1,825,213**
Net Operating Expenditure		**2,084,921**	**1,818,539**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**2,084,921**	**1,818,539**
Net (Gain)/Loss on Transfer by Absorption		-	68,732
Total Net Expenditure for the Financial Year		**2,084,921**	**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		**2,084,921**	**1,887,271**

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	13	-	-
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		**-**	**-**
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	7,477	13,757
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	53	13
Total current assets		**7,530**	13,770
Non-current assets held for sale	21	-	-
Total current assets		**7,530**	**13,770**
Total assets		**7,530**	**13,770**
Current liabilities			
Trade and other payables	23	(96,648)	(100,244)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(831)	(1,211)
Total current liabilities		**(97,480)**	**(101,455)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(89,949)**	**(87,685)**
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	(715)
Total non-current liabilities		**-**	**(715)**
Assets less Liabilities		**(89,949)**	**(88,400)**
Financed by Taxpayers' Equity			
General fund		(89,949)	(88,400)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(89,949)**	**(88,400)**

The notes on pages 80 to 101 form part of this statement

The financial statements on pages 76 to 79 were approved by the Audit and Governance Committee on 16th June 2022 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 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(88,400)	0	0	**(88,400)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(88,400)**	**0**	**0**	**(88,400)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating expenditure for the financial year	(2,084,922)			**(2,084,922)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	0	**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(2,084,922)**	**0**	**0**	**(2,084,922)**
Net funding	2,083,373	0	0	**2,083,373**
Balance at 31 March 2022	**(89,949)**	**0**	**0**	**(89,949)**

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

The notes on pages 80 to 101 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(2,084,922)	(1,818,539)
Depreciation and amortisation	5	0	14
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	6,280	9,775
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(3,595)	9,977
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	(791)
Increase/(decrease) in provisions	30	(1,095)	583
Net Cash Inflow (Outflow) from Operating Activities		**(2,083,332)**	**(1,798,980)**
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	**0**
Net Cash Inflow (Outflow) before Financing		**(2,083,332)**	**(1,798,980)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,083,373	1,798,871
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**2,083,373**	**1,798,871**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**40**	**(109)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**13**	122
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**53**	**13**

The notes on pages 80 to 101 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England/ has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 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 clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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 Clinical Commissioning Group is a going concern and the financial statements are prepared on the going concern basis.

As explained more fully on page 27 following the approval of the Health and Care Bill on 28th April 2022, NHS Nottingham & Nottinghamshire CCG (the CCG) will be dissolved on 30 June 2022. Whilst the CCG as an entity will cease to exist on that date, the activities undertaken by the CCG will continue to be undertaken by NHS Nottingham & Nottinghamshire Integrated Care Board. In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG should be prepared on a going concern basis

1.2 Accounting Convention

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

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

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

commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. If the Clinical Commissioning Group is in a jointly controlled operation, the Clinical Commissioning Group recognises:

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

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

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

1.5 Operating Segments

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

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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 clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 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 clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 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 clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,

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 clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

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

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

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

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

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

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

1.13 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 Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group’s surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.13.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group’s net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group’s net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 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 clinical commissioning group’s cash management.

1.15 Provisions

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation (except where immaterial), its carrying amount is the present value of those cash flows using HM Treasury’s discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.70% (2020-21: 0.18%) 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 0.95% (2020-21 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 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.16 Clinical Negligence Costs

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

1.17 Non-clinical Risk Pooling

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

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 clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.19 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.19.1 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 clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

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

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

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

1.2 Financial Liabilities

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

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

1.22 Foreign Currencies

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

1.23 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group 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 handled.

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

1.25 Critical accounting judgements and key sources of estimation uncertainty

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

1.25.1 Critical accounting judgements in applying accounting policies

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 21/22 Accounts (and as with 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:

Prescribing Costs - the clinical commissioning group 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 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

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

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

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

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

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	-
Non-patient care services to other bodies	5,795	1,261
Patient transport services	-	-
Prescription fees and charges	3,667	2,960
Dental fees and charges	-	-
Income generation	-	-
Other Contract income	1,860	1,518
Recoveries in respect of employee benefits	-	-
Total Income from sale of goods and services	**11,322**	**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	1,114	936
Total Other operating income	**1,114**	**936**
Total Operating Income	**12,436**	**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	-	1,602	-	-	-	-	1,017	-
Non NHS	-	4,193	-	3,667	-	-	843	-
Total	**-**	**5,795**	**-**	**3,667**	**-**	**-**	**1,860**	**-**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	-	-	-	-	-	-	-
Over time	-	5,795	-	3,667	-	-	1,860	-
Total	**-**	**5,795**	**-**	**3,667**	**-**	**-**	**1,860**	**-**

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		2021-22
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits									
Salaries and wages	10,407	197	**10,604**	9,952	624	**10,576**	20,359	821	**21,180**
Social security costs	1,191	-	**1,191**	1,103	-	**1,103**	2,293	-	**2,293**
Employer contributions to the NHS Pension Scheme	2,580	-	**2,580**	1,264	-	**1,264**	3,843	-	**3,843**
Other pension costs	0	-	**0**	0	-	**0**	0	-	**0**
Apprenticeship Levy	(39)	-	**(39)**	-	-	**-**	(39)	-	**(39)**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	160	-	**160**	6	-	**6**	166	-	**166**
Gross employee benefits expenditure	**14,299**	**197**	**14,496**	**12,325**	**624**	**12,948**	**26,623**	**821**	**27,444**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**14,299**	**197**	**14,496**	**12,325**	**624**	**12,948**	**26,623**	**821**	**27,444**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**14,299**	**197**	**14,496**	**12,325**	**624**	**12,948**	**26,623**	**821**	**27,444**

4.1.1 Employee benefits

	Admin			Programme			Total		2020-21
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'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**

4.2 Average number of people employed

	2021-22 Permanently employed Number	2021-22 Other Number	2021-22 Total Number	2020-21 Permanently employed Number	2020-21 Other Number	2020-21 Total Number
Total	**429.74**	**7.67**	**437.41**	**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

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	5,857	-	-	1	5,857
£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	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**165,857**	**-**	**-**	**2**	**165,857**

	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	1	1	1
£150,001 to £200,000	2	320,000	-	-	2	320,000
Over £200,001	-	-	-	-	-	-
Total	**3**	**389,333**	**1**	**1**	**4**	**389,334**

	2021-22 Departures where special payments have been made		2020-21 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2021-22 Other agreed departures		2020-21 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	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:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

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

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,308	822
Services from foundation trusts	588,426	497,639
Services from other NHS trusts	735,369	606,993
Provider Sustainability Fund	-	-
Services from Other WGA bodies	1	0
Purchase of healthcare from non-NHS bodies	346,953	313,327
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	161,571	159,313
Pharmaceutical services	-	-
General Ophthalmic services	-	-
GPMS/APMS and PCTMS	177,328	166,421
Supplies and services – clinical	1,644	1,605
Supplies and services – general	21,730	18,595
Consultancy services	456	198
Establishment	1,914	2,093
Transport	8,085	7,143
Premises	19,017	21,217
Audit fees	200	192
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees	163	124
Legal fees	350	262
Education, training and conferences	492	303
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**2,065,008**	**1,796,248**
Depreciation and impairment charges		
Depreciation	-	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**
Provision expense		
Change in discount rate	-	-
Provisions	(1,095)	583
Total Provision expense	**(1,095)**	**583**
Other Operating Expenditure		
Chair and Non Executive Members	501	542
Grants to Other bodies	4,546	71
Clinical negligence	-	-
Research and development (excluding staff costs)	(54)	(23)
Expected credit loss on receivables	182	(14)
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	825	16
Total Other Operating Expenditure	**6,000**	**593**
Total operating expenditure	**2,069,913**	**1,797,438**

6.1 Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**	**2020-21 Number**	**2020-21 £'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	39,463	555,593	39,936	485,140
Total Non-NHS Trade Invoices paid within target	38,316	546,263	38,910	475,190
Percentage of Non-NHS Trade invoices paid within target	**97.09%**	**98.32%**	**97.43%**	**97.95%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,012	1,331,001	4,070	1,117,219
Total NHS Trade Invoices Paid within target	996	1,330,687	4,040	1,117,084
Percentage of NHS Trade Invoices paid within target	**98.42%**	**99.98%**	**99.26%**	**99.99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2021-22 £'000**	**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 (20/21: £nil)

8. Investment revenue

There was no Investment Income during the year (20/21: £nil)

9. Other gains and losses

There were no Other Gains and Losses during the year (20/21: £nil)

10. Finance costs

There were no Finance Costs during the year (20/21: £nil)

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

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

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense	**Land £'000**	**Buildings £'000**	**Other £'000**	**2021-22 Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**2020-21 Total £'000**
Payments recognised as an expense								
Minimum lease payments	-	1,245	-	**1,245**	-	4,184	6	**4,189**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**1,245**	**-**	**1,245**	**-**	**4,184**	**6**	**4,189**

12.1.2 Future minimum lease payments	**Land £'000**	**Buildings £'000**	**Other £'000**	**2021-22 Total £'000**	Land £'000	Buildings £'000	Other £'000	**2020-21** Total £'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	**2021-22 £'000**	**2020-21** £'000
Recognised as income		
Rent	-	-
Contingent rents	-	-
Total	**-**	**-**

12.2.2 Future minimum rental value	**2021-22 £'000 NHSE Bodies**	**2021-22 £'000 Other DHSC Group Bodies**	**2021-22 £'000 Non DH Group Bodies**	**2020-21 £'000 NHSE Bodies**	**2020-21 £'000 Other DHSC Group Bodies**	**2020-21 £'000 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 (20/21: £nil)

14 Intangible non-current assets

The CCG has no Intangible non-current assets at the year end (20/21: £nil)

15 Investment property

The CCG has no Investment Property at the year end (20/21: £nil)

16 Inventories

The CCG has no Inventories at the year end (20/21: £nil)

17.1 Trade and other receivables

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	1,757	-	5,903	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	1,129	-
NHS accrued income	6	-	1,073	-
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	1,108	-	1,130	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,656	-	2,120	-
Non-NHS and Other WGA accrued income	2,480	-	1,751	-
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	(215)	-	(33)	-
VAT	672	-	664	-
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	14	-	20	-
Total Trade & other receivables	**7,477**	**-**	**13,757**	**-**
Total current and non current	**7,477**		**13,757**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	-	9	12	41
By three to six months	-	166	78	134
By more than six months	24	181	-	83
Total	**24**	**356**	**90**	**258**

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2020	(33)	-	**(33)**
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	(182)	-	**(182)**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(215)**	**-**	**(215)**

18 Other financial assets
The CCG has no Other Financial Assets at the year end (20/21: £nil)

19 Other current assets
The CCG has no Other Current Assets at the year end (20/21: £nil)

20 Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	-	-
Net change in year	-	-
Balance at 31 March 2022	**-**	**-**
Made up of:		
Cash with the Government Banking Service	-	-
Cash with Commercial banks	53	13
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**53**	**13**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2022	**53**	**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 (20/21:£nil)

22 Analysis of impairments and reversals
The CCG has no Impairments or Reversals at the year end (20/21: £nil)

23 Trade and other payables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**
Interest payable	-	-	-	-
NHS payables: Revenue	4,765	-	4,440	-
NHS payables: Capital	-	-	-	-
NHS accruals	949	-	1,941	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	29,541	-	37,454	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	36,849	-	40,270	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	117	-	237	-
VAT	-	-	-	-
Tax	273	-	260	-
Payments received on account	-	-	-	-
Other payables and accruals	24,153	-	15,642	-
Total Trade & Other Payables	**96,648**	**-**	**100,244**	**-**
Total current and non-current	**96,648**		**100,244**	

Other payables include £1,380k outstanding pension contributions at 31 March 2022. (20/21:£1,495k)

24 Other financial liabilities
The CCG has no Other Financial Liabilities at the year end (20/21: £nil)

25 Other liabilities
The CCG has no Other Liabilities at the year end (20/21: £nil)

26 Borrowings
The CCG has no Borrowings at the year end (20/21: £nil)

27 Private finance initiative, LIFT and other service concession arrangements
The CCG has no Private Finance Initiatives, LIFT or other Service Concession Arrangements at the year end (20/21: £nil)

28 Finance lease obligations
The CCG has no Finance Lease Obligations at the year end (20/21: £nil)

29 Finance lease receivables
The CCG has no Finance Lease Receivables at the year end (20/21: £nil)

30 Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	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	831	-	1,256	-
Other	-	-	(45)	715
Total	**831**	**-**	**1,211**	**715**
Total current and non-current	**831**		**1,926**	

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Agenda for Change £'000	Equal Pay £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2021	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,256**	**671**	**1,926**
Arising during the year	-	-	-	-	-	-	-	89	-	**89**
Utilised during the year	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	-	-	-	-	-	(514)	(671)	**(1,184)**
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 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**831**	**-**	**831**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	831	-	**831**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**831**	**-**	**831**

31 Contingencies

The CCG has no Contingencies at the year end (20/21: £nil)

32 Commitments

32.1 Capital commitments

	2021-22 £'000	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:

	2021-22 £'000	2020-21 £'000
In not more than one year	62,153	23,465
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	**62,153**	**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 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'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	1,454		1,454
Trade and other receivables with other DHSC group bodies	2,477		2,477
Trade and other receivables with external bodies	1,433		1,433
Other financial assets	-		-
Cash and cash equivalents	53		53
Total at 31 March 2022	**5,417**	**-**	**5,417**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	313		**313**
Trade and other payables with other DHSC group bodies	20,776		**20,776**
Trade and other payables with external bodies	75,169		**75,169**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2022	**96,258**	**-**	**96,258**

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.

	2021/22 £'000	2020/21 £'000
Balance at 1 April	**1644**	**991**
Income		
Nottinghamshire County Council ASCH&PP	1,393	1,354
Nottinghamshire County Council CFCS	410	400
Nottinghamshire City Council ASCH & CYP	786	1,133
Bassetlaw CCG	782	821
NHS Nottingham & Nottinghamshire CCG	5,772	5,531
Continuing Health care funding	0	0
Other income	6	7
TOTAL INCOME	**10,793**	**10,237**
Expenditure		
Partnership Management & Administration costs	933	815
Contract delivery and collection costs	1,451	1,327
ICES Equipment	6,436	6,389
Continuing Healthcare Specialist Equipment	0	0
Minor Adaptations	93	66
Direct Payments	6	2
TOTAL EXPENDITURE	**8,919**	**8,599**
Balance at 31 March	**1,874**	**1,638**
Carry Forward by Partner		
Nottinghamshire City Council ASCH	583	465
Notts County Council - ASCH	1,222	1,016
Notts County Council - CYPS	27	75
ICELS Staffing reserves	22	50
Bassetlaw CCG	19	32
Balance at 31 March	**1,873**	**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 NHS Nottingham City CCG and Nottingham City Council, and its aims are to improve the quality & efficiency of services.

Memorandum Account for Nottingham City Better Care Fund

	2021/22 £'000	2020/21 £'000
Funding		
NHS Nottingham & Nottinghamshire CCG	26,057	24,734
Nottingham City Council (Capital)	2,768	2,768
Nottingham City Council		-
Nottingham City Council (Improved Better Care Fund)	16,115	16,115
Total Funding	**44,940**	**43,617**
Expenditure		
Access & Navigation	2,106	1,980
Assistive Technology	469	468
Carers	714	714
Co-ordinated Care	16,115	16,115
Capital Grants	2,768	2,768
Independence Pathway		0
Programme Costs	28	27
Integrated Care	17,307	16,333
Primary Care	2,690	2,554
Facilitating Discharge	2,657	2,577
Housing Related Schemes	86	81
Total Expenditure	**44,940**	**43,617**
Balance Carried forward for all partners	**0**	**0**

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

	2021/22 £'000	2020/21 £'000
Income	10,283	9,731
Expenditure	-10,283	-9,731
	0	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 £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
East Leake Medical Group	3,566	-	-	-
Belvoir Health Group	3,658	-	62	-
The Calverton Practice	1,360	-	37	-
Rivergreen Medical Centre	1,037	-	7	-
Huthwaite Medical Practice	1,292	-	16	-
NHS England	1,487	1,718	313	1,454
NHS Trusts	736,006	126	3,882	1
Foundation Trusts	593,181	834	1,519	308
Health Education England	-	370	-	-
Special Health Authorities	7	-	45	-
Other Group Bodies	12,676	-	1,941	-

38 Events after the end of the reporting period
On 28th of April 2022, the Health and Care Bill was approved by Parliament. The Health and Care Bill approves the formation of Integrated Care Boards and for them to take over the functions of Clinical Commissioning Groups. As a result NHS Nottingham & Nottinghamshire CCG will be dissolved on 30 June 2022, and NHS Nottingham & Notinghamshire Integrated Care Board] will be formed from the following day. In line with the provisions of the Group Accounting Manual the assets and liabilities of the CCG will transfer to the newly formed Integrated Care Board at book value. Further details are provided in the accounting policies on page 80.

39 Third party assets
The CCG has no Third Party Assets (20/21: £nil)

40 Financial performance targets

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

	2021-22		2020-21	
	Target	Performance	Target	Performance
Expenditure not to exceed income	2,097,374	2,097,357	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	2,084,938	2,084,922	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	20,934	18,944	20,395	20,393

41 Analysis of charitable reserves
The CCG has no Charitable Reserves at the year end (20/21: £nil)

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 2021-22 Number	Total Value of Cases 2021-22 £'000	Total Number of Cases 2020-21 Number	Total Value of Cases 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 2021-22 Number	Total Value of Cases 2021-22 £'000	Total Number of Cases 2020-21 Number	Total Value of Cases 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	-	-	-	-
Special Severance Payments	-	-	-	-
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 2022 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 2022 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 2021/22.

Basis for opinion

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

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 July 2022, NHS Nottingham and Nottinghamshire CCG will be dissolved and its services transferred to NHS Nottingham and Nottinghamshire Integrated Care Board. Under the continuation of service principle, the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

Going concern basis of preparation

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; and
- 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 above conclusions are 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 procedure 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 unusual 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.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of CCG-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries that were considered outside of the normal course of business and other unusual journal characteristics.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the completeness of recorded accruals through testing of expenditure after the year end.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement related 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 from inspection of the CCG's regulatory and legal correspondence 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 the National Health Service Act 2006 and financial reporting legislation. 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;
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements; and
- in our opinion the other information has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22.

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 2021/22. 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 2021/22.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 34, 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 34, 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 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Richard Walton
for and on behalf of KPMG LLP
Chartered Accountants
St Nicholas House
31 Park Row
Nottingham
NG1 6FQ

21 June 2022