NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Annual Report and Accounts

1 April – 30 June 2022

This document can be made available in large print and in other languages by request to the organisation at:

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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 was disestablished on 30 June 2022 and its functions transferred to a new statutory NHS body, NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), which was established on 1 July 2022. Where this annual report refers to additional documents that can be accessed from the CCG's website at the National Archives. Alternatively, information can be provided on request by contacting the ICB's Corporate Governance Team at the contact details above.

About this report

This annual report and accounts for the period 1 April – 30 June 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). 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 period 1 April – 30 June 2022

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Performance Report

Signed by:

Dr Amanda Sullivan
Accountable Officer

28 June 2023

Performance Overview

Introduction

Welcome to the annual report for NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) covering the period 1 April – 30 June 2022. 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 reporting period.

Accountable Officer's Statement

Welcome to our annual report and accounts for the organisation's final three months of operation before our transition to the new statutory body, NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), on 1 July 2022. This is an exciting development for Nottingham and Nottinghamshire, building on existing arrangements already established through the Nottingham and Nottinghamshire Integrated Care System (ICS), and enabling us to achieve more for our local populations through effective partnership working.

I am delighted to say that I have been appointed as the Chief Executive of the new organisation and I look forward to playing a part in driving this forward, alongside system partners from the NHS, Local Authorities and the Voluntary and Community Sector.

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.

A key focus for this reporting period has therefore been in finalising work started during to 2021/22 to ensure the effective closedown of the CCG and the safe transfer of functions to the new organisation. This has meant working with our colleagues at NHS Bassetlaw CCG (BCCG), following the decision to move the area of Bassetlaw into the Nottingham and Nottinghamshire ICS. In particular, I have worked closely with the accountable officer of BCCG, Idris Griffiths, to ensure our 'handover' to the ICB puts it in the best possible starting position from day one.

Whilst this report covers a fairly small amount of time, there has continued to be a large amount of activity undertaken with regards to fulfilling the CCG's responsibilities. Key priorities for the CCG during this period have been tackling the ongoing challenges brought by the Covid-19 pandemic, such as the recovery of elective care services, the resilience of the urgent and emergency care system, addressing organisational and system financial challenges and working with our system partners on the delivery of actions needed to achieve high quality care for our local populations.

As this is the last annual report for NHS Nottingham and Nottinghamshire CCG, I would like to take the opportunity to thank those colleagues on our Governing Body who came to the end of their terms of office when the CCG was 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 provides the opportunity to make real positive changes to enable each and every citizen to enjoy their best possible health and wellbeing.

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 123 GP Practices (as at 30 June 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 30 June 2022, the CCG employed 509 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, through the mechanisms detailed in the *Performance Analysis* section of this annual report, this reporting period has continued to be a challenging time for us in delivering against our

national targets. Urgent care and planned care have been impacted 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 for the rest of the year.

The CCG has a responsibility to manage its 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 reporting period, 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 the reporting period related to: the potential for health inequalities to be exacerbated across our populations should robust processes not be implemented for the recovery of healthcare services; the potential consequences of safety concerns highlighted at two of our provider organisations following the outcome of Care Quality Commission (CQC) reviews and the possible impact on primary care staff due to sustained pressures in GP practices. We have also continued to monitor key finance risks, namely, the potential for non-delivery of the CCG's financial duties during the reporting period and the achievement of a collective break-even financial position with system partners by year-end

Further information on the risks described above and how we manage risk within the CCG is included in 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 and for quarter 1 of 2022/23.

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 and into 2022/23, various established targets remained paused by NHS England and NHS Improvement to enable the wider NHS to directly respond to the impact of Covid.

As was the case in 2021/22, the recovery of elective care services, which were paused during the initial phase of covid during 2020/21, has continued to be a key priority. These services are delivered through the 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 wider 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 oversight and scrutiny and any issues are 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 duty is enacted through the NHS System Oversight Framework (SOF), an approach which

recognises and supports system working and places a greater emphasis on system performance.

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 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 (NUHT) or Sherwood Forest Hospitals 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 has been paused since 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 the hospital from ambulances as quickly as possible, to support ambulances being available for other patients. The 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 NUHT 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 the service has been significantly impacted by the scale of demand for services for the duration of the pandemic. 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 and Quarter 1 of 2022/23. 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	2021/22		Q1 2022/23		
	Target	Actual	Target	Actual	Commentary
A&E waiting time					
Percentage of patients who spent four hours or less in A&E	>95%	68.53%	>95%	79.70%	*The figure reported for 2021/22 is annualised for April 2021 to March 2022 and reflects the performance against this standard at CCG level. The Q1 position reflects performance over the three month period.*
Number of A&E waits for admission from decision to admit to admission over 12 hours	0	658	0	668	*The figures reported are at Trust level and are for March 2022 and June 2022*
Ambulance clinical quality					
Ambulance Handover Times Over 60 Minutes	0	365	0	389	*The figures reported are at Trust level and are for March 2022 and June 2022*
Category 1 Average Response Time	<00:07:00	00:08:27	<00:07:00	00:08:49	*The figures reported are for the end of period at March 2022 and end of June 2022*
Category 1 90th Centile Response Time	<00:15:00	00:14:26	<00:15:00	00:14:57	
Category 2 Average Response Time	<00:18:00	00:49:21	<00:18:00	00:52:32	
Category 2 90th Centile Response Time	<00:40:00	01:46:09	<00:40:00	01:53:04	
Category 3 90th Centile Response Time	<02:00:00	09:25:01	<02:00:00	09:08:23	
Category 4 90th Centile Response Time	<03:00:00	08:23:26	<03:00:00	08:14:38	

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 / 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.

Since 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 NHS England and NHS Improvement sought to ensure that a focus on delivering increasing volumes of planned care services was support by financial incentives.

NUHT and SFHT are our main providers of acute services, however for 2021/22 and quarter 1 of 2022/23 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 and quarter 1 of 2022/23 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.

NHS Constitution Standard	2021/22		Q1 2022/23		Commentary
	Target	Actual	Target	Actual	
Referral to treatment pathways					
Percentage incomplete patients <18 weeks	>92%	68.36%	>92%	66.78%	*These figures illustrate the difference between March 2022 and March 2020. The position at June 2022 is compared to June 2020.*
Waiting list (increase since March 2020 and June 2020)	28548	32182	-	46184	
104 waits	46	262	0	67	
RTT Activity level v 2019/20	100%	110%	100%	158%	
Diagnostic Test Waiting Times					
Percentage of patients waiting six weeks or more for a diagnostic test	<1%	36.75%	<1%	39.80%	*This figure relates to the difference between March 2022 and March 2020. The position at June 2022 is compared to June 2020.*
Cancelled operations					
Number of cancelled operations rebooked beyond 28 days	0	31	0	51	*The figure reported is for Quarter 3 2021/22 and Quarter 1 22/23 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 Nottingham University Hospitals NHS Trust (NUH) however services are also delivered through Sherwood Forest Hospitals (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 and quarter 1 of 2022/23 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 services 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 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 and quarter 1 of 2022/23. Performance against these indicators is measured at

CCG level. Where relevant, recovery actions are in place, which are being continually reviewed and updated to improve performance. The volume of referrals and treatments were suppressed during quarter 1 of 2020/21 due to the impact of the pandemic, which influences the referral and treatment volumes metrics below.

NHS Constitution Standard	2021/22		Q1 2022/23		Commentary
	Target	Actual	Target	Actual	
Cancer two week waits					
All cancer two week wait	>93%	79.09%	>93%	70.16%	*Figures reported are for March 2022 and for June 2022*
Two week wait for breast symptoms (where cancer was not initially suspected)	>93%	57.89%	>93%	59.62%	
No. 1st OP (referrals) v 19/20	>100%	162.20%	>100%	125.00%	*This figure relates to the difference between March 2022 and March 2020. The end of Q1 position is June 2022 compared to June 2020*
No 1st treatment (v19/20)	>100%	87.00%	>100%	146.00%	*This figure relates to the difference between March 2022 and March 2020. The end of Q1 position is June 2022 compared to June 2020*
Cancer Waits					
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	>96%	75.56%	>96%	82.28%	*Figures reported are for March 2022 and for June 2022*
62-day wait for first treatment following an urgent GP referral	>85%	66.03%	>85%	47.90%	
Faster diagnosis 28 day	>70%	79.01%	>70%	76.43%	

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 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 and quarter 1 of 2022/23. Performance against 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	2021/22 Target	2021/22 Actual	Q1 2022/23 Target	Q1 2022/23 2021/22	Commentary
Estimated diagnosis rate for people with dementia					
Dementia diagnosis rate	**>67%**	**68.81%**		**68.90%**	*The figure reported is the end of period position as at March 2022 and end of June 2022.*
Improved Access to Psychological Therapy (IAPT)					
Number patients entering therapy (IAPT)	**>7,675**	**7,575**	**>8984**	**8,110**	*Performance is measured on a rolling three-month basis and the figure shown is as at March 2022 and June 2022.*
Percentage recovery rate (IAPT)	**>50%**	**52.30%**	**>50%**	**51.70%**	*Performance is measured on a rolling three-month basis and the figure shown is as at March 2022 and June 2022.*
Percentage of people that wait six weeks or less from referral to first treatment (IAPT)	**>75%**	**76.90%**	**>75%**	**77.00%**	*The figure reported is the end of period position as at March 2022 and end of June 2022.*
Percentage of people that wait 18 weeks or less from referral to first treatment (IAPT)	**>95%**	**99.70%**	**>95%**	**100.00%**	*The figure reported is the end of period position as at March 2022 and end of June 2022.*
CYP Access					
Children & Young People Increasing Access (1+ Contact)	**11,709**	**16,620**	**13,300**	**17,880**	*The figure reported is the end of period position as at March 2022 and end of June 2022.*
Out of Area Placements					
Out of Area Occupied Bed Days	**180**	**215**	**0**	**1360**	*The figure reported is position for quarter 4 2021/22 and quarter 1 of 2022/23*
Perinatal Mental Health Services					
Percentage of women with moderate/complex to severe Perinatal Mental Health difficulties that access care and support in the community	**8.60%**	**7.02%**	**9.30%**	**7.10%**	*The figure reported is the end of period position as at March 2022 and end of June 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%**	**76.00%**	**>60%**	**70.00%**	*The figure reported is the end of period position as at March 2022 and end of June 2022.*
Children waiting less than 18 weeks for a wheelchair					
Percentage of children that received equipment in less than 18 weeks of being referred to the wheelchair service.	**>92%**	**73.00%**		**68.89%**	*Performance is measured on a quarterly basis and the figure shown is as at Q4 2021/22 and Q1 2022/23. 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%**	**3.10%**		**2.90%**	*Performance is measured on a quarterly basis and the figure shown is as at Q4 2021/22 and Q1 2022/23.*
% of full NHS Continuing Healthcare eligibility decisions made by the CCG within 28 days	**>85%**	**80.50%**		**82.90%**	*Performance is measured on a quarterly basis and the figure shown is as at Q4 2021/22 and Q1 2022/23.*

Performance against financial duties

Due to the disestablishment of CCGs on 30 June 2022 and establishment of ICBs on 1 July 2022, NHS England changed the way that funding allocations were made in 2022/23. Initial allocations of a proportion of the funding available for the financial year were made to CCGs based on planned expenditure for the period to 30 June 2022 with the balance due to be allocated to ICBs. Allocation adjustments were then made to generate a balanced position for each CCG by moving funding to or from the ICB allocation for the remainder of the financial year.

The CCG's financial position is reported at each Governing Body meeting with narrative identifying key risks through the year. The accompanying set of accounts details our finances for the period 1 April to 30 June 2022.

CCGs receive two allocations from NHS England, one to utilise to commission healthcare for our registered population (the 'programme' allocation) and one to utilise on the costs of commissioning that healthcare (the 'running costs' allocation). In the period April to June 2022, the former totalled £519.7 million and the latter £4.7 million giving total resources of £524.4 million.

Since 2017/18, NHS Nottingham and Nottinghamshire CCG has taken responsibility, delegated from NHS England, for commissioning general medical services. Funding of £41.1 million allocated to the CCG for these purposes in April to June 2022 is included within the 'programme' allocation above.

Whilst allocations are granted on an annual basis, the utilisation of the cumulative surplus is guided by NHS England. In April to June 2022, NHS England did not permit the CCG to utilise any of its historic surplus. This therefore remained at £11.9 million and is not included in the allocation figures above.

Overall, therefore, our expenditure (net of income) during April to June 2022 was £524.4 million which was spent as per Table 2 below.

Table 1: Financial performance

Duty	Target £000	Target (%)	Actual £000	Actual (%)	Achieved
Income and expenditure: Expenditure not to exceed income	Breakeven	-	Breakeven	-	✓
Cash balance: Remain below allowed cash balance	2,196	-	146	-	✓
Running costs: Remain within running cost allowance	5,269	-	4,696	-	✓
Better payment practice code: Pay NHS invoices by value within 30 days	-	95%	-	99.94%	✓
Pay NHS invoices by number within 30 days	-	95%	-	96.28%	✓

Duty	Target £000	Target (%)	Actual £000	Actual (%)	Achieved
Pay non-NHS invoices by value within 30 days	-	95%	-	98.88%	✓
Pay non-NHS invoices by number within 30 days	-	95%	-	99.79%	✓
Mental health investment standard: Deliver the minimum mental health investment		-	42,446	-	✓

Table 2: Analysis of total spend

Category of expenditure	Total spend (£000)
Acute (hospital) care	281,724
Community care	42,919
Mental health care	50,556
Primary care	48,634
Prescribing	40,632
Continuing care	32,541
Other non-healthcare	22,724
Corporate running costs	4,696
Total	**524,426**

Table 3: Analysis of Covid-19 expenditure

Category of expenditure	Amount (£000)
Acute (hospital) care	65
Community care	-154
Mental health care	
Primary care	7
Hospital Discharge Programme/ Continuing care	497
Other non-healthcare	250
Corporate running costs	0
Total	**665**

Looking ahead, as the CCG's responsibilities transfer into the NHS Nottingham and Nottinghamshire ICB, the financial challenges faced will remain largely in line with those experienced previously by the CCG. These include: the ongoing impact of, and recovery from, the COVID-19 pandemic; inflationary increases; an increasing and ageing population; improved drugs and technologies; and increasing patient expectations

We remain firmly committed to achieving recurrent financial balance and to building our partnership working to deliver sustainable local health services within the available resources as part of the ICB and the wider Nottingham and Nottinghamshire Integrated Care System.

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 2021/22, the CCG 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 is still a factor in Nottingham and Nottinghamshire 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 continue to work closely with our providers 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 are not being met 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 period continues to be 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 NHS England 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. 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. Meetings 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. Our contract with our alliance of community and voluntary organisations continues to evolve, 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 Annual Engagement Report 2021/22 is available on our website at https://nottsccg.nhs.uk. This describes in full as to how the CCG met its statutory duties in relation to patient and public engagement and provides more information on our engagement activities during last year. *[DN – 2022/23 information to be included in ICB Annual Engagement Report, link to be inserted for final report]*

Reducing Health Inequalities

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. A person's chance of enjoying

good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and access services. Nationally, addressing health inequalities is a recognised factor in addressing the prevention of avoidable illness and in improving overall health outcomes (NHS Long Term Plan, 2019).

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 2021/22 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 NHS England and the ISO standards for business continuity.

The continuing response to COVID-19 remained the main EPRR area of work during the reporting period. 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.

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 * ($ktCO_2e$)		Reductions required from current levels ($ktCO_2e$)	
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 ** ($ktCO_2e$)		Reductions required from current levels ($ktCO_2e$)	
Area	**1990**	**(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 the reporting period, 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. *[DN – Remuneration (salary and pension details) will be provided in the final report).*

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

28 June 2023

Corporate Governance Report

Members Report

Member practices

As at 30 June 2022, the CCG has 123 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)	62. Musters Medical Practice	104. The Medical Centre
21. Clifton Medical Practice	63. Newthorpe Medical Centre	105. The Oaks Medical Centre
22. Collingham Medical Centre	64. Oakenhall Medical Practice	106. The Om Surgery
23. Daybrook Medical Practice	65. Oakwood Surgery	107. The University of Nottingham Health Service
24. Deer Park Family Medical Practice	66. Orchard Medical Practice	108. Torkard Hill Medical Centre
25. Derby Road Health Centre	67. Orchard Surgery	109. Trentside Medical Group
26. East Bridgford Medical Centre	68. Parkside Medical Practice	110. Tudor House Medical Practice
27. Eastwood Primary Care Centre	69. Peacock Healthcare	111. Unity Surgery
28. Elmswood Surgery	70. Plains View Surgery	112. Victoria and Mapperley Practice
29. Family Medical Centre	71. Pleasley Surgery	113. Village Health Group
30. Forest Medical	72. Radcliffe-on-Trent Health Centre	114. Welbeck Surgery
31. Fountain Medical Centre	73. Radford Medical Practice	115. Wellspring Surgery
32. Gamston Medical Centre	74. Rainworth Health Centre	116. West Bridgford Medical Centre
33. Giltbrook Surgery	75. Rise Park Surgery	117. West Oak Surgery
34. Grange Farm Medical Centre	76. Riverbank Medical Services	118. Westdale Lane Surgery
35. Greendale Primary Care Centre	77. Rivergreen Medical Centre	119. Whyburn Medical Practice
36. Greenfield Medical Centre	78. Riverlyn Medical Centre	120. Willowbrook Medical Practice
37. Hama Medical Centre	79. Roundwood Surgery	121. Windmill Practice
38. Hickings Lane Medical Centre	80. Ruddington Medical Centre	122. Wollaton Park Medical Centre
39. Highcroft Surgery	81. Sandy Lane Surgery	123. Woodlands Medical Practice
40. Hill View Surgery	82. Saxon Cross Surgery	
41. Hounsfield Surgery	83. Selston Surgery	

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 to 30 June 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 Manik Arora – GP Representative, Nottingham City

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 reporting period [*DN – guidance is needed as to what we report here in light of the ICB becoming responsible for the 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 was one personal data related incident during the reporting period; however, this was not rated as serious in nature and was 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 the reporting period, the CCG received 48 complaints about local NHS services, of which, four were investigated by the CCG (at the complainants' request), eight were closed by the CCG with no further action taken (no consent received or no further contact from the complainant), and 31 were about ongoing treatment and were redirected to the services to respond directly. As at 30 June, five complaints remained open and transferred in to the new ICB.

As an organisation, we received one Ombudsman complaint in May 2022, which was not subsequently pursued.

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.

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

Governance statement

Introduction and context

NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended).

The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population

Between 1 April 2022 and 30 June 2022, the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

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

In line with the Health and Care Act 2022, Integrated Care Boards (ICB) were established on 1 July 2022 and CCGs were disestablished on 30 June 2022. As such, the period covered by this governance statement (1 April to 30 June 2022) included a focus by the Governing Body and its committees on ensuring the effective management of governance, internal controls and risk to enable the safe transfer of functions to the new organisation.

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

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.

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. Following the arrangements made during the period of national restrictions to limit the spread of Covid-19, the CCG has continued to hold open sessions of the Governing Body virtually, utilising appropriate application software to allow access to members of the public to observe proceedings. Members agreed to continue with these arrangements until the CCG was formally disestablished.

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 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.

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.
- Developing appropriate work programmes for the Governing Body and its committees for the additional period of operation, ensuring that robust oversight and scrutiny arrangements across the CCG's responsibilities continued until the point of CCG disestablishment.

The Governing Body met on three occasions during the reporting period. All meetings were quorate, in accordance with the CCG's Standing Orders, and members achieved an average attendance of 85% during the reporting period.

At these meetings, the Governing Body:

- Received routine reports relating to the CCG's financial position; the quality and performance of commissioned services and major organisational risks.
- Received a summary of findings from the Ockenden Review Final Report and the CCG's position with regard to the local oversight arrangements in place to ensure the implementation of immediate and essential actions. Members were advised that the Local Maternity and Neonatal System had monitored the local progress of actions set out in the interim report (published in 2020) and would now ensure this included achievement of additional actions identified in the final report.
- Received an update on operational planning for 2022/23, noting that whilst the draft plan was based on assumptions required by the national guidance, meeting the trajectories would be challenging. Members were advised that further work would be done to produce more detailed delivery plans, and these would consider the role of Place-Based Partnerships and the importance of Primary Care Networks.
- Approved the expansion of the Targeted Lung Health Check Programme in Nottingham City; replicating the model already in place in Mansfield and Ashfield. In line with the Governing Body's financial limits, a direct contract award was also approved to the proposed service provider.
- Approved joint funding with Nottingham City Council for the provision of planned short breaks for children and young people with complex physical health needs; agreeing a recurrent funding contribution of £285,000 per annum over the next ten years and additional funding for the same period to ensure the accommodation was properly equipped for overnight stays.
- Received the 2022/23 draft financial plans and approved the opening budgets, noting that whilst these covered the full year, they were only applicable to the CCG until its disestablishment on 30 June 2022.
- Received highlight reports from each of its committees 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.

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. The organisation has not conducted a formal review of committee effectiveness during the reporting period, as the short time frame of review would not have supported a meaningful analysis. To provide assurance that committees were discharging their delegated duties, established arrangements continued to routinely report to the Governing Body through the submission of highlight reports, ratified minutes, and other appropriate updates as necessary.

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 members of the Committee are named within the *Members Report* section of this annual report.

The Committee met three times during the reporting period, all meetings were quorate in line with the Committee's terms of reference and its members achieved 83% attendance at meetings.

A particular focus for the Committee during this period was overseeing the completion of a due diligence plan, which had been developed to ensure the safe transfer of staff, property and corporate memory to the new organisation. 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 national requirements.

At its meeting in May, the Committee received the final outcome report from this work which summarised the key findings and highlighted both the liabilities and significant issues which would transfer to the ICB. The Committee was assured that a robust process had been undertaken and the report was subsequently used as a key element of the handover process to the new organisation.

During its meetings, the Committee also:

- Approved the CCG Annual Reports and Accounts for 2021/22, following the receipt of year-end opinions and conclusions from the CCG's internal and external auditors.
- Received comprehensive assurance reports on the CCG's arrangements for health and safety, security and fire compliance.
- Received the output of work performed with colleagues from NHS Bassetlaw CCG to identify existing strategic and live operational risks across both organisations and ensure the appropriate handover of risks to the new ICB. In addition, the Committee scrutinised the period-end position of the CCG's Governing Body Assurance Framework.
- Received the remaining internal audit reports relating to 2021/22 and updates from the CCG's internal auditors relating to their ongoing independent review of the process of transitioning into the ICB through attendance at a number of transition forums.
- Received the 2021/22 annual report from the organisation's counter fraud service, noting that the CCG had submitted a fully compliant Counter Fraud Functional Standard Return for the year. The Committee also approved the Counter Fraud Work Plan for the next year, acknowledging that this would remain under review following the transition to ensure fitness for purpose in the new ICB.

Auditor Panel

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 did not meet during the reporting period.

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 members of the Committee are named within the *Remuneration Report* section of this annual report. The Committee did not meet during the reporting period.

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 twice during the reporting period and both meetings were quorate in line with the Committee's terms of reference. The average attendance achieved by members for these meetings was 88%. Meetings are open to members of the public to attend, in line with the requirements of the delegation agreement. As with arrangements for open meetings of the Governing Body, 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 reporting period, the Primary Care Commissioning Committee:

- Received routine reports in relation to, Primary Care Contracting, finance, operational pressures escalation levels (OPEL), Quality and the primary care workforce.
- Received the Committee's routine risk report, detailing operational risks aligned to the Committee's responsibilities and ensuring the timely progress of mitigating actions.
- Received updates on work being performed to develop the ICB's Primary Care Strategy, ensuring that the CCG was able to feed in key areas of learning and expertise as part of the transition process.

- Received the final Winter Access Fund update and an evaluation of the schemes put in place. Noting that positive outcomes from this will be incorporated into the Primary Care Strategy (as described above).
- Received a summary of practice sign up to Local Enhanced Services 2022/24.

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 twice during the reporting period and the average attendance of members during this period was 80%.

During the reporting period, the Prioritisation and Investment Committee:

- Considered investment proposals and contract awards for a number of business cases within its delegated financial limits. These business cases included the expansion of the targeted lung health check programme in Nottingham City (prior to requesting approval by the Governing Body), a pilot to support community virtual wards and proposals for spend of the NHS England Long COVID-19 allocation for 2022/23.
- Continued to oversee 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.
- Received the Committee's routine risk report, detailing operational risks aligned to the Committee's responsibilities and ensuring the timely progress of mitigating actions.
- Received routine '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 twice during the reporting period and both 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. The average attendance by members at Committee meetings was 82% over this period.

During reporting period, the Quality and Performance Committee:

- Continued to receive the Integrated Performance Report. In particular, discussion at the meetings focused on 104 week waits, Cancer and Mental Health services recovery. The impact of workforce pressures and a shortage of diagnostic capacity was also a focus for the Committee.
- Received an engagement update detailing the key projects underway or completed during the last six months and providing assurance of compliance with legal duties and national standards for patient and public engagement.
- Received routine nursing and quality reports, focussing on particular areas of concern and those under enhanced surveillance.
- Received the draft System Quality Strategy for the ICB, noting the commitment to system working and the twelve shared priorities for quality in 2022/23.
- Received the Committee's routine risk report, detailing operational risks aligned to the Committee's responsibilities and ensuring the timely 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 twice during the reporting period and both 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. The average attendance of members at Committee meetings during this period was 80%.

During the reporting period, the Finance and Resources Committee:

- Received the CCG's finance reports for months twelve of 2021/22 and month one of 2022/23. For 2021/22 the CCG reported a breakeven position. Members recognised this significant

achievement, particularly the achievement of the cash balance target, as this was a significant area of challenge.

- Received an update on the system financial position as at month one and discussed the System Financial Position and plans to reduce the underlying deficit. Members noted that 2022/23 will be a challenging year for many system partners.
- Received a summary of the 2022/23 final submitted financial plan, which described the approach to delivery and monitoring of the in-year financial recovery programme
- Received routine cross provider reports, which provided the in-month position and the year-to-date position on activity.
- Discussed the impact of inflation over and above assumed levels and the ongoing discussions at a national level regarding 'allowable' deficit, which takes these increased costs into account.

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.

For 2022/23, the year's engagement activities and details as to how the CCG has achieved its statutory duties in relation to patient and public engagement will be published via the ICB's Annual Engagement Report at www.notts.icb.nhs.uk.

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 reporting period (1 April 2022 – 30 June 2022), and up to the date of signing this statement.

Discharge of Statutory Functions

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. As described earlier in this governance statement, work has been performed during the reporting period to ensure the safe handover of 'live' risks to the new ICB.

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 monitored through the Corporate Risk Register during the reporting period related to:

- **The potential for health inequalities to be exacerbated across the population of Nottingham and Nottinghamshire if robust processes are not in place to ensure the prompt recovery of services.** 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 Board and its supporting governance structure. Clinical prioritisation of waiting lists is also a key mitigation to this risk. An ICS Health Inequalities Strategy is in place, supported by an ICS Health Inequalities Plan. Addressing health inequalities will continue to be a key priority for the CCG until such time as the new ICB is established.
- **The potential for non-delivery of the CCG's financial duties for period April to June 2022**, 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' due to the COVID-19 pandemic. This, alongside ongoing uncertainties regarding the future financial regime, meant that finance risk

scores remained high during early 2022/23, however, in response to the CCG forecasting to meet its statutory financial duties for the three-month period, the likelihood score of the risk reduced by quarter two 2022/23.

- **The potential for the Nottingham and Nottinghamshire ICS system partners not achieving a collective break-even financial position by the 31 March 2023.** This risk has been managed via the ICS Directors of Finance Group, the development of an ICS Finance Framework and via system-wide resource allocation arrangements. This will be a significant area of focus for the remainder of 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 the first quarter of 2022/23 and will continue within the ICB for the remainder of the financial year.
- **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 quarter one 2022/23. Concerns were initially identified following the outcome of a CQC inspection; with further concerns being raised through local, regional and national 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 will be a key priority for the ICB's Quality and People Committee when established.
- **The potential for primary care staff exhaustion and 'burn out' due to sustained levels of significant pressure on primary care workforce.** This has been further exacerbated by sustained levels of significant pressure of primary care as a result of the COVID vaccination programme, management of long term conditions and the impact of deferrals/delays in secondary care activity. 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 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 quarter one 2022/23. 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.
- **The potential risk of poor patient outcomes and/or experiences as a result of increased secondary care elective (planned care) waiting times, in particular, in relation to cancer patients,** was recognised as a key risk for the CCG during quarter one 2022/23. 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 Board and its supporting governance structure. Clinical prioritisation of waiting lists is also a key mitigation to this risk

- **The potential risk of poor patient outcomes and/or experience as a result of increasing mental health waiting lists,** was also recognised as a key risk for the CCG during quarter one 2022/23. This risk is likely to be exacerbated by rising levels of demand on mental health services, in particular, for children and young people. This risk is managed via monitoring and quality improvement actions with key providers, overseen by the CCG's Quality and Performance Committee. The CCG also influences spend of the Mental Health Investment Standard (MHIS) to address local priorities.

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

Whilst it is not required that conflicts of interest management be independently audited during the reporting period, the CCG's internal audit service has confirmed that the CCG's arrangements remained effective as part of the Head of Internal Audit Opinion work. The CCG achieved an opinion of 'substantial assurance' for its conflicts of interest audit during 2021/22.

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.

During the reporting period, 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.

The CCG submitted its DPST self-assessment for 2021/22 on 30 June 2022, 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 into the quality assurance of analytical models; 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 2022/23, the CCG has received reports relating to:

- Arden and Greater East Midlands Commissioning Support Unit –Payroll Services
- NHS Shared Business Services – Employment Services
- NHS Shared Business Services – Financial and Accounting Services
- NHS Business Services Authority – Prescription Payments Process
- Capita – Primary Care Support
- NHS ESR – Electronic Staff Record Programme

In reviewing the above reports, I have noted that with the exception of the NHS Shared Business Services (Financial and Accounting Services) and Arden and Greater East Midlands Commissioning Support Unit, 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 the reporting period.

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 agreements 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 self-assessment for 2021/22 showed that the CCG had an overall compliance rating of 'Green'.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April – 30 June 2022, 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. Throughout the period we continued to provide transition support to the CCG, through attendance at the ICS Transition and Risk Committee, the Due Diligence Task and Finish Group and the Finance Transition Project Board".

During the reporting period, internal audit issued the following advisory[1] audit reports:

[1] Advisory reports do not provide a formal opinion of assurance; however, any issues identified during the review relating to governance, risk management and control would be highlighted to the organisation's senior management and governing body.

Audit Assignment	Audit objectives	Level of assurance
Primary Care Workforce Development (2122/NNCCG/11)	This was an advisory review that drew general conclusions; a formal audit opinion was not issued. The report concluded that progress had been made in a number of areas to develop and increase the primary care workforce in Nottinghamshire	N/A – advisory only
Emerging Transformation and Efficiency Arrangements (2122/NNCCG/02)	This was an advisory review conducted across the ICSs in Nottinghamshire and Derbyshire with the objective of promoting shared learning in an area of control that was heavily impacted by the COVID-19 pandemic across the whole NHS. The report highlighted a number of key issues for consideration as processes governing the identification and implementation of transformation programmes mature.	N/A – advisory only

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 a number of internal and external assurances received by the CCG during the reporting period, 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 the reporting period.

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 the reporting period are provided in the *Governance Statement* contained within this report.

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	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	1.6%	0%

Pay ratio information

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

The banded remuneration of the highest paid director / member in NHS Nottingham and Nottinghamshire CCG in the reporting period 1 April 2022 to 30 June 2022 was £190k-£195k.This was the same as reported for 2021-2022. The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	32,113	42,121	54,764
Salary component of total remuneration (£)	32,113	42,121	54,764
Pay ratio information	5.99	4.57	3.52
2021/22			
Total remuneration (£)	31,534	42,121	53,219
Salary component of total remuneration (£)	31,534	42,121	53,219
Pay ratio information	5.47	4.01	3.15

During the reporting period, no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £3,250, to £190,000. This was the same as reported for 2021-2022. 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.

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).

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

For the period 1 April 2022 – 30 June 2022:

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100*	(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/Joint Clinical Leader	20-25	0	0	0	0	20-25
Dr James Hopkinson - Joint Clinical Leader	20-25	0	0	0	0	20-25
Amanda Sullivan – Accountable Officer	45-50	0	0	0	0	45-50
Stuart Poynor(1) – Chief Finance Officer/Deputy Accountable Officer	25-30	0	0	0	0	25-30
Rosa Waddingham – Chief Nurse	35-40	0	0	0	0	35-40
Lucy Dadge – Chief Commissioning Officer	30-35	0	0	0	15-17.5	45-50
Dr Adedeji Okubadejo - Secondary Care Specialist	0-5	0	0	0	0	0-5
Dr Manik Arora - GP Representative	20-25	0	0	0	0	20-25
Shaun Beebe - Non-Executive Director	0-5	0	0	0	0	0-5
Susan Clague - Non-Executive Director	0-5	0	0	0	0	0-5
Jon Towler - Non-Executive Director	10-15	0	0	0	0	10-15
Susan Sunderland -Non-Executive Director	0-5	0	0	0	0	0-5
Eleri De Gi bert - Non-Executive Director	0-5	0	0	0	0	0-5

(1) It was agreed that Nottingham & Nottinghamshire CCG's Chief Finance Officer, Mr Poynor, would also fulfil this role for Bassetlaw CCG. 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 for the reporting period is in the range £35,000 to £40,000.

The equivalent full year salaries are the same as reported for 2021-2022 (as per the following table)

For the reporting period 1 April 2021 – 31 March 2022:

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100*	(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/Joint Clinical Leader	95-100	0	0	0	0	95-100
Dr James Hopkinson - Joint Clinical Leader	95-100	0	0	0	0	95-100
Amanda Sullivan – Accountable Officer	160-165	0	0	0	0	160-165
Stuart Poynor(1) – Chief Finance Officer/Deputy Accountable Officer	135-140	0	0	0	0	135-140
Rosa Waddingham – Chief Nurse	120-125	0	0	0	30-32.5	150-155
Lucy Dadge – Chief Commissioning Officer	130-135	0	0	0	35-37.5	165-170
Dr Adedeji Okubadejo -Secondary Care Specialist	5-10	0	0	0	0	5-10
Dr Manik Arora -GP Representative	60-65	0	0	0	0	60-65
Dr Hilary Lovelock - GP Representative	60-65	0	0	0	0	60-65
Dr Richard Stratton -GP Representative	25-30	0	0	0	0	25-30
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
Jon Towler -Non-Executive Director	40-45	0	0	0	0	40-45
Susan Sunderland -Non-Executive Director	10-15	0	0	0	0	10-15
Eleri De Gi bert -Non-Executive Director	10-15	0	0	0	0	10-15

(1) 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.

Pension benefits as at 30 June 2022

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 30 June 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 June 2022	(h) Employers Contribution to stakeholder 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/Deputy Accountable Officer	0	0	0	0	0	0	0	0
Rosa Waddingham - Chief Nurse	0	0	0-5	0	150	0	46	N/A
Lucy Dadge -Director of Commissioning	0-2.5	0-2.5	5-10	15-20	175		201	0

Pension benefits as at 31 March 2022

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 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 stakeholder 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/Deputy Accountable 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 - Director of Commissioning	2.5-5	0-2.5	30-35	65-70	641	39	701	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).

Compensation on early retirement of for loss of office

There were no payments for loss of office made in the period 1 April 2022 to 30 June 2022

Payments to past directors (subject to audit)

There were no payments to past directors in the period 1 April 2022 to 30 June 2022

Staff Report

Number and composition of staff

The following table provides a breakdown of our workforce by pay band and gender as at 30 June 2022:

Pay band	Female	Male	Number
Band 1	0	0	0
Band 2	1	1	2
Band 3	24	3	27
Band 4	32	4	36
Band 5	46	6	52
Band 6	52	22	74
Band 7	71	22	93
Band 8a	68	13	81
Band 8b	32	9	41
Band 8c	19	6	25
Band 8d	9	2	11
Band 9	9	9	18
Very senior managers (non-Governing Body members)	1	2	3
Any other spot salary (non-Governing Body members)	19	14	33
Governing Body members	6	7	13
Totals	**389**	**120**	**509**

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 reporting period:

	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	435.01	5,418	621	959	0	0	6,998
Other	10.47	149	0	0	0	0	149
Total	**445.48**	**5,567**	**621**	**959**	**0**	**0**	**7,147**

Sickness absence data

Sickness absence data for the reporting period has been calculated in accordance with guidance from the Department of Health and Social Care.

Sickness absence data for the reporting period	
Total days recorded sickness absence (FTE)	979.20
Total days available (FTE)	39,590.64
Average annual working days lost due to sickness absence (per FTE)[1]	**5.6%**

[1] The average has been estimated by dividing the estimated number of FTE days sick by the average FTE days available and multiplying by 225 (the typical number of working days per year).

Staff turnover percentage

The staff turnover rate (staff leaving the organisation) for the reporting period was 13.52%. (on a WTE basis).

Staff engagement percentages

The CCG's last reported staff engagement results are from our participation in the 2021 NHS Staff Survey. We achieved a response rate of 84%, above the average for the CCG benchmark group (79%) and implemented actions to address the small areas that were highlighted for improvement. Following our transition to an ICB, staff will be invited to take part in the 2022/23 NHS Staff Survey; the results of which will be reported by the ICB in its first annual report.

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 equ6ality 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 the reporting period.

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. The Act also includes an employment commitment to the CCG's existing staff (below board level) in the transfer of CCG functions to the new organisation and the TUPE/COSOP consultation period ran from 4 April to 3 May. No feedback was received as part of the consultation process, which meant that all staff would commence their employment with the new Integrated Care Board on 1 July 2023.

Expenditure on consultancy

Expenditure on consultancy for the period 1 April 2022 to 30 June 2022 totalled £122,000.

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 30 June 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 30 June 2022	**1**
Of which, the number that have existed:	-
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	-
For between two and three years at the time of reporting	-
For between three and four years at the time of reporting	-
For four or more years at the time of reporting	-

Existing off-payroll engagements have been subject to a risk-based assessment to ascertain whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	1
Of which:	-
No. not subject to off-payroll legislation[2]	-
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	-
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	1
The number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: No. of engagements that saw a change to IR35 status following the consistency review	-

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 2022 and 30 June 2022 are shown in the table below:

	Number
Number of off-payroll engagements of Governing Body members and / or senior officials with significant financial respons bility, during the reporting period	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 reporting period. This figure includes both on-payroll and off-payroll engagements	13

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

[2] *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.*

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		5,857						
£10,000 - £25,000								
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000		160,000						
>£200,000								
Totals		**165,857**		**-**				

Redundancy and other departure costs 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.

Analysis of Other Departures

The CCG agreed no departures where special payments have been made during the reporting period.

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 from page 68.

An audit certificate and report is also included in this Annual Report at page 97.

Annual Accounts

1 April – 30 June 2022

Signed by:

Dr Amanda Sullivan
Accountable Officer

28 June 2023

NHS Nottingham & Nottinghamshire CCG - Accounts for the Period ended 30 June 2022

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

	Note	3 months ending 30 June 2023 £'000	2021-22 £'000
Income from sale of goods and services	2	(1,062)	(11,322)
Other operating income	2	(261)	(1,114)
Total operating income		**(1,323)**	**(12,436)**
Staff Costs	4	7,147	27,444
Purchase of goods and services	5	518,315	2,065,008
Depreciation and impairment charges	5	61	-
Provision expense	5	107	(1,095)
Other Operating Expenditure	5	116	6,000
Total operating expenditure		**525,746**	**2,097,357**
Net Operating Expenditure		**524,423**	**2,084,921**
Finance income		-	-
		3	-
		524,426	**2,084,921**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Period		**524,426**	**2,084,921**
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 right-of-use assets		-	-
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		-	-
Total other comprehensive net expenditure		**-**	**-**
Comprehensive Expenditure for the Period		**524,426**	**2,084,921**

Statement of Financial Position as at 30 June 2022

	Note	30th June 2022 £'000	31st March 2021 £'000
Non-current assets:			
Property, plant and equipment	13	-	-
Right-of-use assets	13a	1,280	-
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		**1,280**	**-**
Current assets:			
Inventories	16	-	-
Trade and other receivables	17	7,431	7,477
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	11	53
Total current assets		**7,442**	**7,530**
Total assets		**8,722**	**7,530**
Current liabilities			
Trade and other payables	23	(84,091)	(96,648)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Lease liabilities	13a	(239)	-
Borrowings	26	-	-
Provisions	30	(938)	(831)
Total current liabilities		**(85,268)**	(97,480)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(76,546)**	**(89,949)**
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Lease liabilities	13a	(1,042)	-
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		(1,042)	-
Assets less Liabilities		**(77,588)**	**(89,949)**
Financed by Taxpayers' Equity			
General fund		(77,588)	(89,949)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(77,588)**	**(89,949)**

The notes on pages 74 to 96 form part of this statement

The financial statements on pages 70 to 73 were approved by the Audit and Risk Committee of NHS Nottingham and Nottinghamshire ICB, with delegated authority from the Board, on 13 June 2023 and signed on its behalf by:

Amanda Sullivan
Accountable Officer

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23				
Balance at 01 April 2022	(89,949)	0	0	**(89,949)**
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 2022	**(89,949)**	**0**	**0**	**(89,949)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23				
Total transition adjustment for initial application of IFRS 16	0	0	0	**0**
Net operating expenditure for the financial year	(524,426)	0	0	**(524,426)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of right-of-use assets	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**
	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 Period	**(524,426)**	**0**	**0**	**(524,426)**
Net funding	536,787	0	0	**536,787**
Balance at 30 June 2022	**(77,588)**	**0**	**0**	**(77,588)**

	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 of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(88,400)**	**0**	**0**	**(88,400)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial Period	(2,084,921)			(2,084,921)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of right-of-use assets	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	0	0	0	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Period	**(2,084,921)**	**0**	**0**	**(2,084,921)**
Net funding	2,083,373	0	0	2,083,373
Balance at 31 March 2022	**(89,948)**	**0**	**0**	**(89,948)**

The notes on pages 74 to 96 form part of this statement

Statement of Cash Flows for the period ended 30 June 2022

	Note	30th June 2022 £'000	31st March 2021 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial Period		(524,426)	(2,084,922)
Depreciation and amortisation	5	61	0
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	46	6,280
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(12,558)	(3,595)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	107	(1,095)
Net Cash Inflow (Outflow) from Operating Activities		**(536,770)**	**(2,083,332)**
Cash Flows from Investing Activities			
Interest received		4	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 (L FT)		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		**4**	0
Net Cash Inflow (Outflow) before Financing		**(536,766)**	**(2,083,332)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		536,787	2,083,373
Other loans received		0	0
Other loans repaid		0	0
Repayment of lease liabilities		(63)	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and L FT		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		**536,724**	**2,083,373**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(42)**	**41**
Cash & Cash Equivalents at the Beginning of the Financial Period		**53**	13
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**11**	**54**

The notes on pages 74 to 96 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 he Group Accounting Manual issued by the Department of Health and Social Care. Consequen ly, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Repor ing 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.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

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 hat service in published documents.

When clinical commissioning group cease to exist on 1 July 2022, the services will continue to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations wi hin the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorp ion 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 liabili ies 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

The Clinical Commissionint Group (CCG) entered into a pooled budget arrangement for Integrated Community Equipment Schemes with 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 CCG makes contributions to the pool.

The second pooled budget is 'The Better Care Fund (BCF)' and is hosted by Nottingham City Council, and jointly commissions services to achieve and local objectives to integrate health and social care services in Nottingham City.

It is between the CCG and Nottingham City Council, and its aims are to improve the quality & efficiency of services.

The CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management informa ion 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 wi h the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds direc ly with value of the performance completed to date.

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

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.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to he customer, and is measured at the amount of the transaction price allocated to that performance obligation.

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 he 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 hat employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the 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 prac ices 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 hat scheme for the accounting period.

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

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

1.10 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, he 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 administra ive purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of heir 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 loca ion and condi ion 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 hose 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 bo h, 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 opera ion 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 he 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 he intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 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 the shorter of the lease term and the estimated useful life.

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

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 The Clinical Commissioning Group as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

-Fixed payments;

-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;

-The amount expected to be payable under residual value guarantees;

-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and

-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

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, 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.

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 he 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 recogni ion 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 he 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 collec ing 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, he 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. Addi ionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's leng hs 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.

1.20 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of he 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 subsequen ly measured at he 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 Liabili ies and Contingent Assets.

1.20.2 Other Financial Liabilities

After initial recogni ion, all other financial liabilities are measured at amortised cost using the effec ive interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate hat exactly discounts es imated 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 me hod.

1.21 Value Added Tax

Most of the activi ies 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 he 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 ei her 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.

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

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

(a) Healthcare contracts: based on the provisional costed activity data provided by the healthcare providers in conjunction with historic experience and using any additional intelligence available. The data is subject to final verification and validation;

(b) Prescribing: calculated by applying the forecast expenditure profile provided by the NHS Business Services Authority to the expenditure incurred during the first 11 [or 10 if month 11 not provided in a timely manner] months of the year, taking into account prior year expenditure. The extent to which any in-year changes to the costs of generic drugs have been reflected in the expenditure profile will be assessed and adjustments made as appropriate. The impact of increased costs due to concessions under the 'no cheaper stock obtainable' policy will be assessed and adjustments made as appropriate. The costs of influenza and pneumococcal vaccinations are recharged to NHS England and the level of recharge for March [and February if information not provided in a timely manner] will be calculated using the profile of such costs incurred in prior years;

(c) Non-contracted activity: based on year to date costs invoiced and prior year expenditure;

(d) Individual packages of care (including continuing healthcare): The primary source of information to estimate the forecast spend will be the lists of patients held for each type of package. An assessment will be made in respect of the likely number of cases and associated costs (based on known costs for the provider or an average cost for the type of care) where care is being provided but funding has not yet been agreed due to delays between assessment and panel/notification to the clinical commissioning group or agreement of the level of costs.

It should be noted that due to the COV D-19 pandemic, contracts for services and payments for non-contracted activity with NHS Trusts and Foundation Trusts have been replaced with block contract arrangements for 2022/23, significantly reducing the level of estimations required. Payments for non-contracted activity during 2022/23 have been restricted to those to other CCGs, providers in the devolved authorities (Scotland, Wales & Northern Ireland) and non-NHS providers.

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 Adoption of new standards

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

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

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

Impact assessment

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

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

The group has utilised three further practical expedients under the transition approach adopted:

a) The election to not make an adjustment for leases for which the underlying asset is of low value.

b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.

c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

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

The CCG has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the CCG's operating lease obligations at 31 March 2022, disclosed in the CCG's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 July 2022.

	TOTAL £000
Operating lease commitments at 31 March 2022	1,246
Impact of discouting at 1 April 2022 using the weighted average incremental borrrowing rate of 0.95%	-12
	1,234
Add Differences in the assessment of the lease term used for future minimum payments at 31 March 2022	1,093
Less Short Term Leases	-746
Less Low Value Leases	0
Less Variable payments not included in the valueation of the lease liabilities	-240
Lease Liability at 1 April 2022	1,341

1.28 New and revised IFRS Standards in issue but not yet effective

- FRS 14 Regulatory Deferral Accounts - Not UK endorsed. Applies to first time adopters of FRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

- FRS 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 2025: early adoption is not therefore permitted.

2 Other Operating Revenue

	30th June 2022 Total £'000	31st March 2021 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	-
Non-patient care services to other bodies	**234**	5,795
Patient transport services	**-**	-
Prescription fees and charges	**316**	3,667
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**511**	1,860
Recoveries in respect of employee benefits	**-**	-
Total Income from sale of goods and services	**1,061**	**11,322**
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	**261**	1,114
Total Other operating income	**261**	**1,114**
Total Operating Income	**1,322**	**12,436**

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	-	23	-	-	-	-	-	-
Non NHS	-	211	-	316	-	-	511	-
Total		**234**		**316**			**511**	

	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	-	234	-	316	-	-	511	-
Total		**234**		**316**			**511**	

Transaction price to remaining contract performance obligations

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

	Period ended 30 June 2022	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies	2021-22 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		2022 23
	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	2,753	26	**2,779**	2,665	123	**2,788**	5,418	149	**5,567**
Social security costs	320	-	**320**	301	-	**301**	621	-	**621**
Employer contributions to the NHS Pension Scheme	638	-	**638**	321	-	**321**	959	-	**959**
Other pension costs	-	-		-	-		-	-	
Apprenticeship Levy	-	-		-	-		-	-	
Other post-employment benefits	-	-		-	-		-	-	
Other employment benefits	-	-		-	-		-	-	
Termination benefits	-	-		-	-		-	-	
Gross employee benefits expenditure	**3,711**	**26**	**3,737**	**3,287**	**123**	**3,410**	**6,998**	**149**	**7,147**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-		-	-		-	-	
Total Net admin employee benefits including capitalised costs	**3,711**	**26**	**3,737**	**3,287**	**123**	**3,410**	**6,998**	**149**	**7,147**
Less Employee costs capitalised	-	-		-	-		-	-	
	3,711	**26**	**3,737**	**3,287**	**123**	**3,410**	**6,998**	**149**	**7,147**

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**	2,294	-	**2,294**
Employer contributions to the NHS Pension Scheme	2,580	-	**2,580**	1,264	-	**1,264**	3,844	-	**3,844**
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**	**14,497**	**12,325**	**624**	**12,949**	**26,624**	**821**	**27,446**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-		-	-		-	-	
Total Net admin employee benefits including capitalised costs	**14,299**	**197**	**14,497**	**12,325**	**624**	**12,949**	**26,624**	**821**	**27,446**
Less Employee costs capitalised	-	-		-	-		-	-	
Net employee benefits excluding capitalised costs	**14,299**	**197**	**14,497**	**12,325**	**624**	**12,949**	**26,624**	**821**	**27,446**

4.2 Average number of people employed

	2022-23			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**435.01**	**10.47**	**445.48**	**429.74**	**7.67**	**437.41**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial Period

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		2022-23 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	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**

	2022-23 Departures where special payments have been made		2021-22 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

	2022-23 Other agreed departures		2021-22 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**-**	**-**

4.5 Pension costs

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

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

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

The 2016 funding valuation 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.

5. Operating expenses

	2022-23 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	380	1,308
Services from foundation trusts	159,525	588,426
Services from other NHS trusts	182,778	735,369
Provider Sustainability Fund	-	-
Services from Other WGA bodies	-	1
Purchase of healthcare from non-NHS bodies	83,655	346,953
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	39,123	161,571
Pharmaceutical services	-	-
General Ophthalmic services	-	-
GPMS/APMS and PCTMS	42,416	177,328
Supplies and services – clinical	412	1,644
Supplies and services – general	2,948	21,730
Consultancy services	122	456
Establishment	946	1,914
Transport	1,989	8,085
Premises	3,703	19,017
Audit fees	150	200
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees	33	163
Legal fees	54	350
Education, training and conferences	80	492
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**518,314**	**2,065,007**
Depreciation and impairment charges		
Depreciation	61	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of right-of-use assets	-	-
Impairments and reversals of intang ble 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	**61**	**-**
Provision expense		
Change in discount rate	-	-
Provisions	107	(1,095)
Total Provision expense	**107**	**(1,095)**
Other Operating Expenditure		
Chair and Non Executive Members	126	501
Grants to Other bodies	-	4,546
Clinical negligence	-	-
Research and development (excluding staff costs)	(28)	(54)
Expected credit loss on receivables	18	182
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	-	825
Total Other Operating Expenditure	**116**	**6,000**
Total operating expenditure	**518,598**	**2,069,912**

6.1 Better Payment Practice Code

Measure of compliance	2022-23 Number	2022-23 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10,745	159,741	39,463	555,593
Total Non-NHS Trade Invoices paid within target	10,722	157,945	38,316	546,263
Percentage of Non-NHS Trade invoices paid within target	**99.79%**	**98.88%**	**97.09%**	**98.32%**
NHS Payables				
Total NHS trade invoices paid in the year	242	333,015	1,012	1,331,001
Total NHS Trade Invoices Paid within target	233	332,814	996	1,330,687
Percentage of NHS Trade Invoices paid within target	**96.28%**	**99.94%**	**98.42%**	**99.98%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2022-23 £'000	2021-22 £'000
Amounts included in finance costs from claims made under this legislation	0	-
Compensation paid to cover debt recovery costs under this legislation	-	-
	0	**-**

7 Income Generation Activities
There were no Income Generation Activities during the Period (21/22: £nil)

8. Investment revenue
There was no Investment Income during the Period (21/22: £nil)

9. Other gains and losses
There were no Other Gains and Losses during the Period (21/22: £nil)

10. Finance costs
There were no Finance Costs during the Period (21/212 £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 N/A covered under Note 13a

13 Property, plant and equipment
The CCG has no Property, Plant and equipment at the year end (21/22 £nil)

13a Leases

13a.1 Right of use assets

2022 23	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 01 April 2022	-	-	-	-	-	-	-	-	-	
IFRS 16 Transition Adjustment	-	1,341	-	-	-	-	-	-	1,341	147
Addition of assets under construction and payments on account				-					-	
Additions	-	-	-	-	-	-	-	-	-	
Reclassifications	-	-	-	-	-	-	-	-	-	
Upward revaluation gains	-	-	-	-	-	-	-	-	-	
Lease remeasurement	-	-	-	-	-	-	-	-	-	
Modifications	-	-	-	-	-	-	-	-	-	
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	
Derecognition for early terminations	-	-	-	-	-	-	-	-	-	
	-	**1,341**							**1,341**	**147**
Depreciation 01 April 2022	-	-	-	-	-	-	-	-	-	
Charged during the Period	-	61	-	-	-	-	-	-	61	30
Reclassifications	-	-	-	-	-	-	-	-	-	
Upward revaluation gains	-	-	-	-	-	-	-	-	-	
Impairments charged	-	-	-	-	-	-	-	-	-	
Reversal of impairments	-	-	-	-	-	-	-	-	-	
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	
Derecognition for early terminations	-	-	-	-	-	-	-	-	-	
Transfer (to) from other public sector body										
Depreciation at 30 June 2022		**61**							**61**	**30**
Net Book Value at 30 June 2022		**1,280**							**1,280**	**117**

Revaluation Reserve Balance for right of use assets

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2022	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 30 June 2022									

13a Leases cont'd

13a.2 Lease liabilities

2022-23	**2022-23 £'000**
Lease liabilities at 01 April 2022	-
IFRS 16 Transition Adjustment	(1,341)
Addition of assets under construction and payments on account	-
Additions	-
Reclassifications	-
Interest expense relating to lease liabilities	(3)
Repayment of lease liabilities (including interest)	63
Lease remeasurement	-
Modifications	-
Disposals on expiry of lease term	-
Derecognition for early terminations	-
Transfer (to) from other public sector body	-
Other	-
	(1,281)

13a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000	**Of which leased from DHSC group bodies £000**
Within one year	(161)	30
Between one and five years	(525)	-
After five years	(558)	-
Balance at 31 March 2022	**(1,244)**	30
Effect of Discounting	**(37)**	
Included in		
Current lease liabilities	(239)	
Non-current lease liabilities	(1,042)	
Balance at 30 June 2022	**(1,281)**	
Balance by counterparty		
Leased from DHSC		-118
Leased from the NHS England Group		-
Leased from NHS Providers		-
Leased from Executive Agencies		-
Leased from Non-Departmental Public Bodies		-1,163
Leased from other group bodies		-
Balance as at 31 March 2023		**(1,281)**

13a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	**2022-23 £'000**	**2021-22 £'000**
Depreciation expense on right-of-use assets	61	-
Interest expense on lease liabilities	-	-
Expense relating to short-term leases	-	-
Expense relating to leases of low value assets	-	-
Expense relating to variable lease payments not included in the measurement o	-	-
Income from sub-leasing right-of-use assets	-	-
Gain/(loss) from sale and leaseback transactions	-	-
Gain/(loss) resulting from COVID-19 related rent concessions	-	-

13a.5 Amounts recognised in Statement of Cash Flows

	2022-23 £'000	**2021-22 £'000**
Total cash outflow on leases under FRS 16	-	-
Net gain/(loss) on transfer by absorption	-	-
Leases	-	-

13a.6 Revaluation
There has been no major revaluation in the Period.

14 Intangible non-current assets
The CCG has no Intangible non-current assets at the Period end (21/22: £nil)

15 Investment property
The CCG has no Investment Property at the Period end (21/22: £nil)

16 Inventories
The CCG has no Inventories at the Period end (21/22: £nil)

17.1 Trade and other receivables

	Current 2022-23 £'000	Non-current 2022-23 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	446	-	1,757	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	-	-
NHS accrued income	-	-	6	-
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	446	-	1,108	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	2,714	-	1,656	-
Non-NHS and Other WGA accrued income	3,332	-	2,480	-
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	(199)	-	(215)	-
VAT	667	-	672	-
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	26	-	14	-
Total Trade & other receivables	**7,432**	**-**	**7,478**	**-**
Total current and non current	**7,432**		**7,478**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	2022-23 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	-	13	-	9
By three to six months	0	99	-	166
By more than six months	24	207	24	181
Total	**24**	**319**	**24**	**356**

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Other financial assets	Total
	£'000	£'000	£'000
Balance at 01 April 2020	(215)	-	**(215)**
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	17	-	**17**
Financial assets that have been derecognised	(1)	-	**(1)**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(199)**	**-**	**(199)**

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

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

20 Cash and cash equivalents

	£'000	£'000
Balance at 01 April 2022	11	53
Net change in year	-	-
Balance at 30 June 2022	**11**	**53**
Made up of:		
Cash with the Government Banking Service	11	53
Cash with Commercial banks	-	-
Cash in hand	-	-
	11	**53**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**11**	**53**

21 Non-current assets held for sale
The CCG has no Non-Current Assets Held for Sale at the Period end (20/21:£nil)

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

23 Trade and other payables	Current 2022-23 £'000	Non-current 2022-23 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	1,474	-	4,765	-
NHS payables: Capital	-	-	-	-
NHS accruals	14,617	-	949	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	15,266	-	29,541	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	29,281	-	36,849	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	127	-	117	-
VAT	-	-	-	-
Tax	272	-	273	-
Payments received on account	-	-	-	-
Other payables and accruals	23,054	-	24,153	-
Total	**84,091**	**-**	**96,647**	**-**
Total current and non-current	**84,091**		**96,647**	
Included in Other payables are outstanding pension contr butions	1,538			

24 Other financial liabilities
The CCG has no Other Financial Liabilities at the Period end (21/22: £nil)

25 Other liabilities
The CCG has no Other Liabilities at the Period end (21/22: £nil)

26 Borrowings
The CCG has no Borrowings at the Period end (21/22: £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 Period end (21/22: £nil)

28 Finance lease obligations
The CCG has no Finance Lease Obligations at the Period end (21/22: £nil)

29 Finance lease receivables
The CCG has no Finance Lease Receivables at the Period end (21/22: £nil)

30 Provisions

	Current 2022-23 £'000	Non-current 2022-23 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-			-
Continuing care	938	-	831	-
Other	-	-	-	-
Total	**938**	**-**	**831**	**-**
Total current and non-current	**938**		**831**	

	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
	-	**-**	**-**	**-**	**-**	**-**	**-**	**831**	**-**	**831**
	-	-	-	-	-	-	-	107	-	**107**
Utilised during the Period	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	-	-	-	-	-	-	-	**-**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**938**	**-**	**938**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	938	-	**938**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 30 June 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**938**	**-**	**938**

31 Contingencies

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

32 Commitments

32.1 Capital commitments

	2022-23 £'000	2021-22 £'000
Property, plant and equipment	-	-
Intangible assets	-	-
Total	**-**	**-**

32.2 Other Financial Commitments

	2022-23 £'000	2021-22 £'000
In not more than one year	62,872	62,153
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	**62,872**	**62,153**

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 2022-23 £'000	Equity Instruments designated at FVOCI 2022-23 £'000	Total 2022-23 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-	-	-
Loans receivable with external bodies	392	-	392
Trade and other receivables with NHSE bodies	2,983	-	2,983
Trade and other receivables with other DHSC group bodies	874	-	874
Trade and other receivables with external bodies	-	-	-
Other financial assets	11	-	11
Cash and cash equivalents			
Total at 30 June 2022	**4,260**	**-**	**4,260**

	Financial Liabilities measured at amortised cost 2022-23 £'000	Other 2022-23 £'000	Total 2022-23 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	481		**481**
Trade and other payables with other DHSC group bodies	26,597		**26,597**
Trade and other payables with external bodies	57,895		**57,895**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 30 June 2022	**84,973**	**-**	**84,973**

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.

	Period to 30th June 2022 £'000	2021/22 £'000
Balance at 1 April		
Income	**1868**	**1644**
Nottinghamshire County Council ASCH&PP	232	1,393
Nottinghamshire County Council CFCS	122	410
Nottinghamshire City Council ASCH & CYP	159	786
Bassetlaw CCG	159	782
NHS Nottingham & Nottinghamshire CCG	1,272	5,772
Other income	22	6
TOTAL INCOME	**3,834**	**10,793**
Expenditure		
Partnership Management & Administration costs	214	933
Contract delivery and collection costs	335	1,451
ICES Equipment	1390	6,436
Minor Adaptations	28	93
Direct Payments	0	6
TOTAL EXPENDITURE	**1,967**	**8,919**
Balance at 31 March	**1,867**	**1,874**
Carry Forward by Partner		
Nottinghamshire City Council ASCH	583	583
Notts County Council - ASCH	1216	1,223
Notts County Council - CYPS	27	27
ICELS Staffing reserves	22	22
Bassetlaw CCG	19	19
Balance at 31 June	**1,867**	**1,874**

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

	Period to 30th June 2022 £'000	2021/22 £'000
Funding		
NHS Nottingham & Nottinghamshire CCG	6883	26,057
Nottingham City Council (Capital)	692	2,768
Nottingham City Council	0	
Nottingham City Council (Improved Better Care Fund)	4029	16,115
Total Funding	**11,604**	**44,940**
Expenditure		
Access & Navigation	538	2,106
Assistive Technology	117	469
Carers	178	714
Co-ordinated Care	4,029	16,115
Capital Grants	692	2,768
Independence Pathway	0	
Programme Costs	0	28
Integrated Care	4,628	17,307
Primary Care	711	2,690
Facilitating Discharge	688	2,657
Housing Related Schemes	23	86
Total Expenditure	**11,604**	**44,940**
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 Period were:

	Period to 30th June 2022 £'000	2021/22 £'000
Income		10,283
Expenditure		-10,283
TOTAL	**0**	**0**

36 NHS Lift investments
The CCG has no LIFT investments at the Period 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	917		119	
The Calverton Practice	353	-	-	-
Rivergreen Medical Centre	245	-	-	-
Department of Health	-	10	-	-
Greater Nottingham Liftco	167			
NEMS Community Benefit	3,287			
NEMS Healthcare Ltd	29			
North Nottingham LIFTCO	44			
Nottingham City GP Alliance	3,270			
Spire Healthcare Ltd	-	535		
University of Nottingham	-	3		
NHS England	425	60	481	392
NHS Trusts	182,795	-	8,256	-
Foundation Trusts	159,971	2	7,353	53
Health Education England	-	-	-	-
Special Health Authorities	(40)	-	5	-
Other Group Bodies	-	-	-	-

38 Third party assets
The CCG has no Third Party Assets (21/22: £nil)

39 Events After the Reporting Period

The Health and Care Act 2022 approved the formation of Integrated Care Boards and for them to take over the functions of the Clinical Commissioning Groups. As a result, NHS Nottingham & Nottinghamshire Clinical Commissioning Group was dissolved on 30 June 2022 and NHS Nottinghama nd Nottinghamshire Integrated Care Board was formed the following day. In line with the provisions of the Group Accounting Manual, assets and liabilities of the Clinical Commissioning Group should be accounted for as a 'transfer by absorption'. The new Nottingham and Nottinghamshrie Integrated Care Board will recognise all of the assets and liabilities as at the date of transfer, 1 July 2022.

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:

Expenditure not to exceed income	2022-23 Target	2022-23 Performance	2021-22 Target	2021-22 Performance
Capital resource use does not exceed the amount specified in Directions	525,749	525,749	2,097,374	2,097,357
Revenue resource use does not exceed the amount specified in Directions	-	-	-	-
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	524,427	524,426	2,084,938	2,084,922
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	-	-	-	-
	5,269	4,696	20,934	18,944

41 Impact of IFRS 16

	£000
Operating lease commitments under IAS 17 at 31 March 2022	1,246
Prior Period adjustment made to Operating Lease Commitments at 31 March 2022	0
Adjusted Operating Lease under IAS17 Total at 31 March 2022	
Incremental Borrowing Rate	0.95%
Operating lease commitments under IAS17 discounted using incremental borrowing rate	1,234
Add: Differences in the assesment of the lease term used for future minimum payments at 31 March 2022.	1,093
Add: Correction of immaterial prior period error in IAS 17 disclosure	
Less: Low value leases	-745
Less: Variable payments not included in the valuation of the lease liabilities	-241
Lease liability at 1 April 2022	**1,341**

41 Analysis of charitable reserves
The CCG has no Charitable Reserves at the Period end (21/22: £nil)

Note 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 2022-23 Number	Total Value of Cases 2022-23 £'000	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Administrative write-offs	4	17	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
	-	-	-	-
Construc ive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**4**	**17**	**-**	**-**

Special payments

	Total Number of Cases 2022-23 Number	Total Value of Cases 2022-23 £'000	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Compensation payments	-	-	-	-
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	-	-
Extra Contractual Payments Treasury Approved	-	-	-	-
Ex Gra ia Payments	-	-	-	-
Ex Gra ia 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 BOARD OF NHS NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE BOARD IN RESPECT 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 three month period ended 30 June 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 30 June 2022 and of its income and expenditure for the three month period 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 on 22 June 2022 as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

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 and NHS Nottingham and Nottinghamshire Integrated Care Board ("the ICB") 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 to the financial statements which explains that on 1 July 2022, NHS Nottingham and Nottinghamshire CCG was 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 respect of this matter.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis as the CCG has been dissolved and its services transferred to another public sector entity, the ICB, and the Accountable Officer has not been informed by the relevant national body of the intention to cease the services previously provided by the CCG. 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 associated with the continuity of services provided by the CCG and transferred to the ICB 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 services provided by the CCG will continue to be provided by the successor body.

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

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, 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. We did not identify any additional fraud risks.

We performed procedures including identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected cash journals and material post close journals.

Identifying and responding to risks of material misstatement related to 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 Board of the CCG and ICB 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.

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 financial reporting aspects of NHS legislation We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

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, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") 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 2022/23. 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 all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 33, the Accountable Officer of the ICB 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 either cease the services provided by the CCG or 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 21(4) and (5) 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 33, 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 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 Board of NHS Nottingham and Nottinghamshire Integrated Care Board in respect 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 Board of the ICB, 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 Board of the ICB, 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 three month period ended 30 June 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
EastWest
Tollhouse Hill
Nottingham
NG1 5FS

30 June 2023