NHS
Redditch and Bromsgrove
Clinical Commissioning Group

Annual Reports and Accounts
2019 / 2020

Contents

Performance Report

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NHS Redditch and Bromsgrove CCG
24th June 2020

Foreword

Welcome to NHS Redditch and Bromsgrove Clinical Commissioning Group's Annual Report and Accounts for 2019/20

This is the Clinical Commissioning Group's (CCG's) final Annual Report as the four CCGs across Herefordshire and Worcestershire have joined to create a new NHS Herefordshire and Worcestershire CCG from 1 April 2020.

The CCG continues to work cooperatively with patients and healthcare providers to deliver cohesive care across Worcestershire. This could not have happened without strong leadership from our executive team who have seen their roles move from CCG specific to encompass a broader focus across the two counties. As a commissioner of health and care services we have continued throughout 2019/20 to work closely with our patient and local residents, provider colleagues, our local authority and the voluntary sector to deliver truly integrated care.

As outgoing chair I wish to thank all current and former members of the CCG Governing Body for their wise and considered decision making, which has always put patients at the heart of everything we do. I would also like to thank all the CCG staff who have risen to the challenge of working across two counties and recently, from March 2020, to the challenges of Covid19.

I hope that you enjoy reading this Annual Report. If you have any comments on it, or the information contained within it, please let us know by contacting our Communications Team at hw.comms@nhs.net.

Dr Richard Davies
Chairman
NHS Redditch and Bromsgrove CCG

Performance overview

There is no doubt that once again this past year has presented us with many challenges. However, despite significant financial pressures and some performance issues with our providers, I am pleased to report that we have made some important improvements across Redditch and Bromsgrove which have made a real difference to our patients, their families and carers.

This overview is designed to provide you with enough information to understand a bit more about our organisation, our purpose, the key risks and challenges to the achievement of our objectives and how we have performed during 2019/20.

Key highlights this year

CCG merger

An application was submitted and approved by NHS England for the four CCGs in Herefordshire and Worcestershire to merge and create a new single CCG on 1 April 2020, called NHS Herefordshire and Worcestershire CCG.

Significant work went into developing the required documentation that had to be submitted as part of this process, as well as into the engagement and consultation with partners, stakeholders and importantly the member GP Practices of the four CCGs. The engagement work was particularly successful, with unanimous and positive support for the proposed merger being received in two of the four CCGs, and with only a small percentage voting against in the other two and with 95% and 87% of Practices voting in favour.

The designate roles on the Governing Body of the new organisation have now been appointed to. Dr Ian Tait has been appointed as the Chair for the new CCG and Dr Martin Lee as the Secondary Care Doctor. Dr Ian Roper, Dr George Henry, Dr Richard Davies and Dr Louise Bramble have been elected as Clinical Leads representing the four previous CCG areas. Rob Parker, Trish Haines, Professor Tamar Thompson OBE and Graham Hotchen have been appointed as Lay Members and Professor Tamar Thompson is also the Vice Chair. Simon Trickett has been confirmed by NHS England as the Accountable Officer and Chief Executive of the new CCG.

These appointments were officially confirmed by the Governing Body at the first meeting of NHS Herefordshire and Worcestershire CCG.

Executive management and staff restructure and reductions

One of the drivers of the management and governance alignment work has been an aim to remove duplication and free up resources so that the four CCGs could live within the 20 per cent running cost reduction that came into place on 1 April 2020. The CCG merger was a key part of the overall plans to reduce running costs by approximately £2 million by April 2020.

Fortunately, a good proportion of this has already been delivered through the CCG management alignment in recent years and through the range of shared leadership posts that are now in place.

A full consultation with staff took place in line with the CCG's Management of Change Policy. The Executive structure was finalised and fully implemented. The final structure was agreed in February 2020, when formal confirmation of appointments to the new roles also took place. The emergence of the new structure has enabled the CCG to operate at an affordable rate within the reduced running cost budget, allowing the CCGs to deliver their legal and statutory duties and critically freed up some capacity to support the development of integrated care systems along with the necessary transformation and improvement of services within the system.

A consultation with all staff regarding the technicality of the TUPE transfer of their employment status from each of the four existing CCGs to the new CCG on 1st April 2020, has also taken place.

EU exit preparations

Following the General Election on 12 December 2019 where a majority Conservative government was elected, it became clear very quickly that the preparations in place and waiting to be instigated by the NHS nationally and locally to mitigate the risks of an "EU Exit No Deal" position would not be required.

Therefore, the planning and execution of No Deal EU Exit modes of operating (Testing, Making Ready and Assuring) have been stood down. This was confirmed by the national team on 9 January 2020.The NHS, nationally and locally, have gained valuable lessons in relation to understanding the resilience we have to managing any uncertainty that the exit may have caused, such as health and social care business continuity, and a full and comprehensive understanding of the NHS supply chain.

It is imperative that our organisational memory in relation to this is maintained. Upon the EU Exit on 31 January 2020, the CCG has operated as normal up until 31 December 2020. This will be considered the transition period during which we will fully prepare for the full EU Exit from 1 January 2021.

NHS Long Term Plan implementation framework

The NHS Long Term Plan (LTP) was published in January 2019 and was subsequently followed by the publication of an implementation framework in June 2019. Work continued with system partners to develop a submission to NHS England and NHS Improvement to describe how this would be delivered in Herefordshire and Worcestershire over the next five years. The response and the detail of this is built upon the engagement work that Healthwatch and other Sustainability and Transformation Partnership (STP) partners, with the involvement of the STP Clinical Reference Group to ensure it is owned, developed and delivered in partnership with clinicians.

The final submission deadline was 15 November 2019 and required both system and organisation-level sign-off. The framework then required sign off from the Joint Commissioning Committee on the 6 November 2019 on behalf of the Governing Bodies.

Primary Care Network development

Over the past year, Primary Care Networks (PCNs) have been developed and are the building blocks of Integrated Care and Integrated Care Systems. All practices are signed up to a PCN Direct Enhanced Service (DES) Contract. Redditch and Bromsgrove CCG are in a strong position to meet the national 100 per cent population coverage target due to work already being undertaken to create and support practices working collectively and with partners.

Ensuring that PCNs flourish and deliver the national and local ambition and vision is a key CCG responsibility. NHS England is producing a PCN Development and Support Prospectus and expects PCNs to be measured and supported against a national PCN Maturity Matrix.

A small cross-county team has started work to identify how the national Maturity Matrix can be built upon to better understand the differing needs of PCNs and to develop a local CCG/ Integrated Care System offer. The role of the clinical Director appointed by each PCN is fundamental to the success of the PCN and building relationships with the wider system. Support for and development of these individuals is therefore critical.

Digital strategy launch

At the beginning of December 2019, the CCGs were invited to submit a proposal to become a Digital First Primary Care Accelerator. NHS Midlands were looking for three STPs in the region to be identified as Accelerator sites. Herefordshire and Worcestershire were one of four STPs invited to present to the regional panel and were confirmed as one of the Accelerator STPs in December 2019.

As part of this work, the CCG facilitated initial access to funding of £800k to support:

- the development of a health and social care app library;
- improved collaboration across Primary Care Networks, as well as access to timely advice and guidance for multi-disciplinary teams;
- trialling video consultations in several PCNs.

Additionally, work is now underway to engage seldom heard groups on how they use health apps, including the NHS app, and how the uptake of digital tools to support self-management, and support people to live healthier lives can be improved.

Work will be progressing over the next 12 months with both the main Worcestershire Trusts to build the required interfaces to enable increased information sharing across care settings.

Mental health transformation funding

As part of the NHS Long Term Plan commitments the three Worcestershire CCGs have enhanced the investment to mental health services within the county for 2019/20. This significant investment includes funding for mental health services across all age ranges totalling in excess of £6 million, when the full year effect and an inflation figure that has been applied across all of the mental health lines in the contract is taken into account.

This is the largest ever investment in local mental health services and should have a significant positive impact on the service offer locally. The investment has taken up a large proportion of the additional CCG allocations that was received for 2019/20 and almost all of the additional funding has been added to the Worcestershire Health and Care NHS Trust contract. Additional investment into eating disorder and personality disorder services, as well as support for increasing access to the IAPT service has been made. There is added capacity for older adult community mental health teams and improved access to the support pathway for those diagnosed with dementia. A new Worcestershire based adult ADHD local diagnostic and review service will also be established.

COVID-19 Pandemic (Coronavirus)

In early March 2020, the World Health Organisation declared a global pandemic as the number of confirmed cases began to rise rapidly outside China and across the world. Across the UK a level four national emergency was declared, and this led to increased levels of planning and operational activity in all regions across the country, with a particular emphasis placed on preparing the NHS for increased demand.

Across Herefordshire and Worcestershire, a multi-agency response team was established, and preparations began with the mobilisation of a local Incident Management Team and Incident Rooms which were coordinated and operated within the CCG offices (and continue to do so post 31 March 2020). The CCG has played a key role in leading and coordinating the local NHS response in accordance with national guidance and response efforts.
As part of our merger preparations, we implemented Microsoft O365 in January 2020 to prepare our multi-location workforce for working effectively in remote areas across the two counties.

This enabled us to rapidly implement home working prior to national COVID19 pandemic guidance around staying and working from home that came into effect in late March, which put us in a good position to focus our teams on leading the system’s crisis response.
In addition, many of our clinical staff were mobilised to support partners and the front line in areas of infection control, testing centres and other clinical roles as required. As the pandemic continues into 2020/21 the new CCG will continue to play a lead role alongside partners across the two counties.

Key challenges this year

Winter pressures

We have seen a tremendously difficult winter despite having better plans in place across the system than ever before. The performance of our providers during this period reflected the significant challenges they faced, with patients at times facing unacceptable delays in being seen and treated by clinicians. This is clearly something that remains top of our agenda as we look ahead to the coming winter and ensuring that we see a great improvement in local performance.

Performance against targets

On the subject of performance, I have to say that unfortunately once again the performance against many of our constitutional standards and targets has simply not been good enough.

The significant pressures faced in urgent care and resultant waits have been well documented through local media coverage, however unfortunately we have also made slower progress than we would have hoped in many key areas, including dementia diagnosis rates and in reducing the length of time patients spend waiting within the A&E departments. These are areas where I expect us to make significant improvements this forthcoming year.

Financial climate

The CCGs have continued to operate a formal financial recovery process during 19/20 – to maintain financial balance and to support the wider system towards financial sustainability. Delivery of savings during the year has proved more challenging, with the more transactional savings opportunities now having been achieved and a much greater dependency on transformational measures. These, by nature, are more complex and require work across a number of organisations. However, the CCG has continued to perform strongly on savings delivery with circa 90 per cent achievement of its savings target of £30.5m across all three Worcestershire CCGs. The challenge moving into 20/21 remains, with a need to support financial recovery measures across the Worcestershire health system – to drive productivity improvement through transformational change.

I also believe that there are greater opportunities for further efficiency savings across the Worcestershire health and care system as a whole as we continue to work in a more joined-up way and reduce some of the organisational boundaries that in the past have resulted in duplication of efforts.

Improving acute services

Of our main providers, Worcestershire Acute Hospitals NHS Trust – which runs our three main acute hospitals in Worcestershire – has continued to face the most challenges and has subsequently been the focus of much of our time as we attempt to support them as best we can.

Our clinicians have spent a lot of time helping them to make the necessary changes to improve their performance and in turn help them to remove the 'special measures' they were placed into by the Care Quality Commission (CQC) back in December 2015.

The Trust received a visit from CQC in May 2019, and the report was published in September. The overall rating was 'requires improvement' and the rating for how it uses its resources was 'inadequate'. Improvements continue to be made by the Trust and CQC welcomed the increased stability but demanded that more work still needs to be done in a number of areas.

We will continue to support them in making these improvements this coming year.

CCG Merger Application

This year we have worked hard on our application to merge the four CCGs across Herefordshire and Worcestershire into one CCG. This included a public consultation in June 2019. There were already close working relationships across the organisations, and after receiving approval from NHS England and Improvement in October 2019, we have conducted a review of executive and management structures and a staff consultation at the end of 2019. Recruitment to Governing Body posts was completed by March 2020, and due to the exceptional efforts of all involved the new Herefordshire and Worcestershire CCG launched on 1 April 2020.

Looking ahead to 2020/21

As of 1 April 2020, NHS Herefordshire and Worcestershire CCG replaced NHS Herefordshire CCG, NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG.

This move is also consistent with the expectation set out in the NHS Long Term Plan that there should be more streamlined commissioning arrangements in place across Herefordshire and Worcestershire.

In terms of addressing the financial challenge and other pressures, we have learnt a lot from our work in the 2019/20 financial year and understand more than ever the need to drive transformational change in the way that care is delivered by working across patient pathways and across organisations.

Much of what we are planning to do will build on what has been achieved in 2019/20. We will need to go further to reduce expenditure where we can without this impacting on the quality of care. We believe there is further to go to reduce prescribing expenditure – particularly around repeat prescribing - to ensure controls around expensive packages of care are working optimally. We also plan to better control our contractual expenditure, particularly with the independent sector and out of county acute hospitals.

Building on the developments this year within urgent care we will be looking to go further to transform the whole urgent care system both in and out of hospital. We believe there is much still to do to improve the way the urgent care system works to ensure coherency and efficiency which will provide benefits both from a patient perspective and also from a performance and cost perspective.

There will also be much greater focus on single programmes of work across Herefordshire and Worcestershire this year as part of the Sustainability and Transformation Partnership, using it as a delivery tool for both continued financial recovery and transformation programmes. By working as a single CCG across the STP footprint, I would expect us to be able to remove a great deal of unnecessary duplication from across our system and increase the amount of resource that we can put into delivering frontline services.

There is no doubt about the significant scale of challenge in front of us in 2020/21. However, we remain confident that we can build on the momentum we have created this year to drive much needed transformational change to improve services for patients whilst achieving further cost efficiencies and better value for money.

Simon Trickett
Accountable Officer

About us

NHS Redditch and Bromsgrove Clinical Commissioning Group (RBCCG) is formed of 21 member GP practices across Redditch and Bromsgrove and is the organisation responsible for arranging health services on behalf of local patients.

We took over responsibility for commissioning high quality hospital, community and mental health services for local patients from Worcestershire Primary Care NHS Trust on 1 April 2013. We have also since assumed responsibility from NHS England for commissioning local GP services.

Serving a registered GP population of more than 179,800 people across Redditch and Bromsgrove, we are responsible for:

- Planning health services, based on assessing the needs of patients
- Paying for services that meet the needs of patients
- Monitoring the quality of the services and care provided to patients.

There are two other NHS commissioning organisations within Worcestershire. NHS South Worcestershire Clinical Commissioning Group (SWCCG) serves South Worcestershire population, and NHS Wyre Forest Clinical Commissioning Group (WFCCG) commissions services for Wyre Forest patients. Although independent organisations with their own statutory duties to fulfil, we are increasingly working more closely together and hold Governing Body Meetings 'in common' and share Lay Members with the other two CCGs.

Together we commission services from a number of NHS and non-NHS providers. The main local providers of secondary services are:

- Worcestershire Acute Hospitals NHS Trust **–** Worcestershire has three Acute Hospitals which are part of Worcestershire Acute Hospitals NHS Trust (WAHT). The Trust provides a full range of acute and emergency hospital-based services from the Worcestershire Royal Hospital in Worcester and the Alexandra Hospital in Redditch, and also provides some services from the Kidderminster Hospital and Treatment Centre.
- Worcestershire Health and Care NHS Trust **–** Worcestershire Health and Care NHS Trust (WHCT) is the main provider of community and mental health services in Worcestershire. It delivers a wide range of services in a variety of settings including people's own homes, community clinics, outpatient departments, community inpatient beds, schools and GP practices. The Trust also provides in-reach services into acute hospitals, nursing and residential homes and social care settings.

We also commission services from providers outside of Worcestershire including:

- Gloucestershire Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Wye Valley NHS Trust.

The population we serve

We serve patients registered with general practices located across Redditch and Bromsgrove. As at 1 April 2020, 179, 805 patients were registered with Redditch and Bromsgrove GPs.

In line with our statutory duties we have contributed to the development of the Worcestershire Joint Strategic Needs Assessment (JSNA) with our partners from Worcestershire County Council.

The JSNA is a collection of information prepared to inform decision making around health and well-being matters at all levels in the county. Originally introduced to inform decisions of the Worcestershire Health and Well-being Board; we consider the remit of the JSNA to be much wider than that, providing a first port-of-call for health and well-being related evidence in Worcestershire.

The JSNA sets out a number of key messages about the nature of the local population we serve and which informs our commissioning plans, specifically:

- Worcestershire has an ageing population and this trend is projected to continue. In future years there is expected to be a large increase in the number of older people and in particular in the very oldest age groups.
- People with learning disabilities experience inequalities across many areas of their lives and particularly in relation to their health. They have more healthcare needs and life expectancy for people with learning difficulties is much lower than for the overall population. Reducing this gap is a key priority for Worcestershire.
- In Worcestershire, 22.4% of children in Reception year were classified as having excess weight in 2017/18. By year 6, the number with excess weight has risen to almost 1 in 3 children.
- The rate of vaccination for Measles, Mumps and Rubella (MMR) in Worcestershire has fallen and is now at 92.2%, and there is wide variation across GP practices. This is lower than the rate required to limit disease spread.
- It is estimated that 65% of adults in Worcestershire are carrying more weight than is healthy. This is higher than the national estimate.
- In Worcestershire the overall rate of smoking has been declining and it is estimated that currently around 12% of adults smoke. This is lower than the national rate.
- The number of people with dementia in Worcestershire is forecast to increase by 56% between 2019 and 2035 from 9,560 to 14,905.
- Nearly half of older people in Worcestershire have an illness that affects their daily activities. This equates to 63,000 people currently and numbers are projected to increase by 38% in the next 15 years.
- It is estimated that in 2019, 20,110 people aged 65 and over were providing unpaid care in Worcestershire, this is forecast to grow by 28% to 25,670 by 2035.

The JSNA can be found on Worcestershire County Council's website at:
http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1500/jsna_summaries

Our vision and values

Our vision is to *'work together to promote high quality, affordable healthcare'.*

The vision above is supported by 12 values, which set out what we care about as an organisation and helps to define how we want to behave. We developed these with the help of clinicians, patients and local people:

- Fair, ethical and transparent
- Patient safety and experience
- Partnerships matter
- We will listen and respond
- Right care, right place, right time – evidence based
- Patient choice matters
- Privacy, dignity and mutual respect
- Working together with member practices
- Promote good health and wellbeing
- Opportunities for service redesign and innovation
- Value for money will be secured
- A good employer.

Key challenges

Our biggest challenges are consistent with those that are faced by our partners across Herefordshire and Worcestershire and are being addressed as part of our Sustainability and Transformation Partnership. These challenges can be categorised under three broad categories: health and well-being, care and quality, and finance and efficiency.

Health and Well-being

- Closing the gap between life expectancy and healthy life expectancy
- Addressing the significant variation in premature mortality rates across Herefordshire and Worcestershire
- Tackling premature mortality concerns for specific conditions
- Reducing the gap in mortality rates between advantaged and disadvantaged communities
- Improving outcomes for children and young people which are lower than expected for the population we serve
- Improving mental health and well being
- Tackling unhealthy lifestyles, such as poor diet, smoking, alcohol and physical inactivity.

Care and quality

- Addressing the lack of capacity and resilience in primary care and general practice
- Improving social care provider capacity and quality
- Supporting Worcestershire Acute Hospitals NHS Trust to implement the CQC special measures improvement plan
- Improving performance for urgent care
- Improving performance against elective care referral to treatment times and access to mental health services
- Improving performance of cancer waiting times
- Increasing dementia diagnosis rates
- Improving outcomes from maternity services.

Finance and efficiency

- Helping to address the total financial challenge for the wider Herefordshire and Worcestershire system by the end of 2020/21
- Achieving an appropriate balance between the need to live within individual financial control totals in the short term and the delivery of a balanced and sustainable system
- Developing an implementation plan to address the significant disparity in the scale of the financial challenge across the STP footprint.

Our approach to tackling these challenges is described in the next section.

Our strategic approach

Implementing the Long Term Plan across Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP)

We recognise the importance of all local health and care providers and commissioners working together to provide the best services we can. In Herefordshire and Worcestershire local healthcare organisations have been working together in partnership for some time (often referred to as a Sustainability and Transformation Partnership, or STP).

Now these relationships are in place we are developing even closer ways of working at a system level (ICS) to ensure patients get the safest, most effective and efficient services when they are needed.

To help achieve this we have developed a 5 year plan to improve services for local people. This plan is based on the NHS Long Term Plan and is underpinned by the core principles and values of the NHS which people trust and recognise.

This will mean that some services will change for local people and the workforce in our efforts to work together to improve health outcomes. There are many reasons why we need to change services to improve outcomes for our growing population:

- We have more demand on healthcare services
- In some areas we do not have enough staff with the right expertise to provide a resilient and reliable service all the time
- We also have financial pressures.

All of these reasons can lead to longer waiting times or even delays and cancellations in getting the care or treatment people need.

Through our public and patient conversations over the last few years it is clear how much local people value the NHS and social care services. But we have also heard consistently how services are sometimes fragmented and confusing, particularly for those with more than one condition requiring the support of different professionals and disciplines. We have also heard how people want improvements in mental health services, and greater consideration of the impact of service changes on carers and families.

Our core priority areas

There are some key areas where we need to change things or think a bit differently. Some of this is about how we develop the services we provide, but others require a step change in how we think about healthcare, our individual responsibilities around self-care and where care is provided and by who.

- Integrated primary and community services
- Urgent care
- Elective care
- Cancer care

- Mental health

We continue to work together on a number of other key programmes including children and young people, learning disabilities and autism, GP and PCN development and local maternity services, as well as other disease specific improvements (for example stroke, diabetes, respiratory and cardiovascular disease)

These areas are supported by a number of areas which are critical for success, including strong clinical leadership, sustaining and developing our workforce, digital solutions, personalisation and prevention, population health management, clinical service sustainability and a common approach to quality improvement.

All of these will be underpinned by a consistent communications and engagement approach.

Worcestershire Joint Health and Wellbeing Strategy 2016/21

The Worcestershire Health and Wellbeing Board brings together relevant stakeholders from across health, social care, Worcestershire County Council, local district authorities, and the voluntary sector to assess local needs and produce a coordinated strategy for responding to them. Our Chief Clinical Officer and Chair are active members of the Worcestershire Health and Wellbeing Board and lead our organisation's involvement with this work.

The Worcestershire Joint Health and Wellbeing Strategy (2016/21) sets out the Health and Wellbeing Board's vision and priorities for 2016 to 2021. We were actively involved in the development of the Joint Health and Wellbeing Strategy, which sets the context for other health and wellbeing plans and for commissioning of NHS, public health, social care and related children's services.

The strategy is supported by the Joint Strategic Needs Assessment (JSNA) and was developed in line with S116B(1)(b) of the Local Government and Public Involvement in Health Act 2007. The CCG supports the three overarching priorities identified over the next five years:

1. Improving mental health and wellbeing
2. Increasing physical activity
3. Reducing the harm caused by alcohol.

In this strategy we have placed a stronger emphasis on prevention too, working together with partners to meet the rising tide of avoidable ill-health. We will be trying to stop problems before they start, and to resolve them quickly if they do arise.

The strategy provides a basis for us - as commissioners of NHS health and care services - as well as for commissioners of public health, social care and related services, to integrate commissioning plans and pool budgets wherever possible, using the powers under Section 75 of the NHS Act 2006 where appropriate. Our local commissioning plans are therefore produced within the context of this document.

We have continued to consult regularly on a formal and informal basis with the Health and Wellbeing Board, its membership and its Chair. In particular we consult with the Health and Wellbeing Board on our strategies and plans, such our STP Plan, and how this is aligned with and contributes to the delivery of the Worcestershire Joint Health and Wellbeing

Strategy. There also remains extensive dialogue with colleagues from the Health and Wellbeing Board outside of the formal meetings.

For more information the Worcestershire Joint Health and Wellbeing Strategy can be found on our website at www.redditchandbromsgroveccg.nhs.uk/about-us/strategy/.

Herefordshire and Worcestershire Operational Plan (2019 to 2022)

As we move towards becoming a single Herefordshire and Worcestershire CCG within an Integrated Care System, we have developed a single 'system' plan with our system partners. This is a 3 year strategic plan describing how we will deliver our Long Term Plan commitments, with annual operating delivery plans sitting beneath this. These describe the key actions we will take to deliver the Long Term Plan, how we will deliver performance against the NHS constitutional standards and other performance requirements as well as the arrangements that we have in place for quality assurance. As we move forward we will be updating these plans to ensure we capture the learning from our system response to the Coronavirus Covid-19 pandemic.

Better Care Fund

The Better Care Fund (BCF) is a mechanism for us to create a pooled budget with the other two Worcestershire CCGs and Worcestershire County Council using powers contained in Section 75 of the NHS Act 2006.

The budget is then used to support the commissioning of a number of services that contribute to the delivery of integrated care in line with the Worcestershire Joint Health and Wellbeing Strategy and our own plans, as well as supporting the provision of social care.

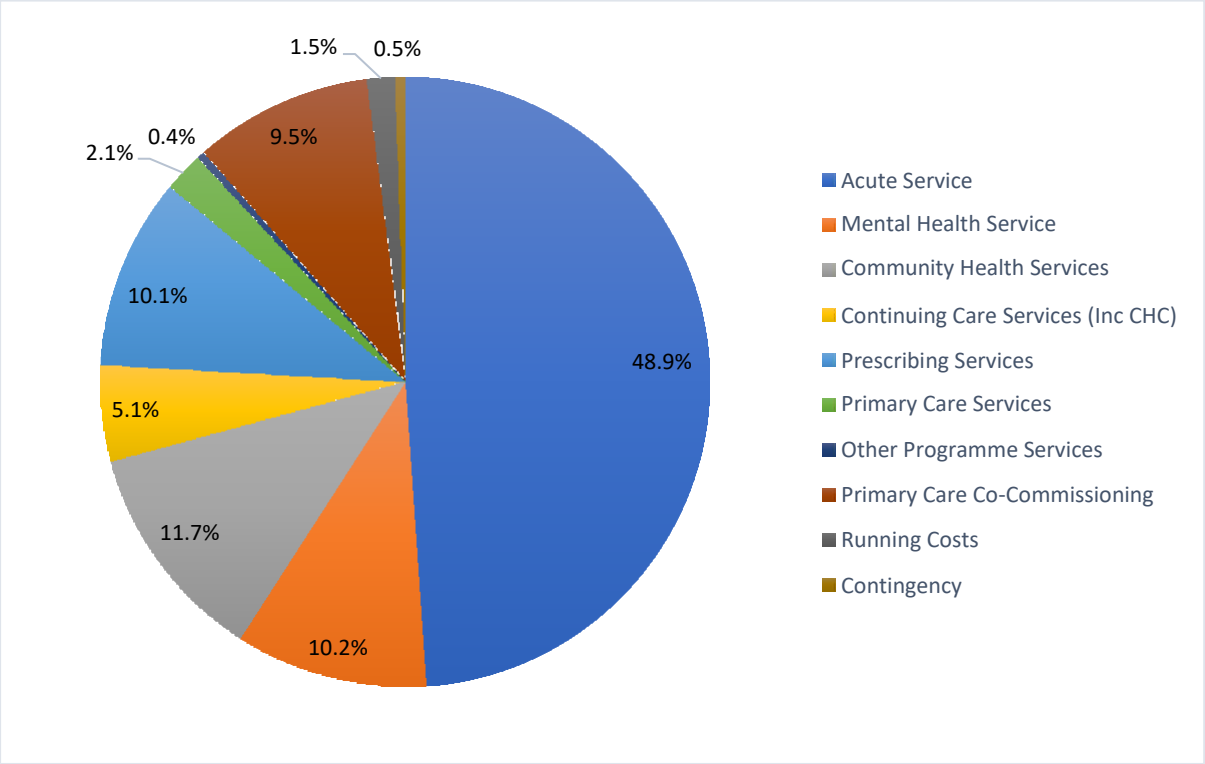
Although not 'new' money, the BCF sets an ambitious challenge to integrate health and social care. The scale and scope of the Better Care Fund is determined by the Worcestershire Health and Wellbeing Board in line with specific national conditions.

In Worcestershire the focus for intervention from the BCF is to support people who are currently, or who are at risk of becoming, heavily dependent on health and adult social care services to live their normal lives. Within Worcestershire the BCF for 2019/20 is £39.8 million, of which we have contributed £12 million, with the majority of the remainder coming from the other two Worcestershire CCGs.

For more information the Worcestershire BCF Plan can be found on our website at www.redditchandbromsgroveccg.nhs.uk/about-us/strategy/.

Finance summary

Where the money was spent in 2019/20



Delivering our Financial Plan

We have delivered against both our Financial Plan for 2019/20 and the Mental Health Investment Standard.

The total CCG cumulative deficit carried forward is £8.293million, against the planned carry forward deficit of £8.271m – an in-year improvement of £22k.

Working jointly with South Worcestershire and Wyre Forecast CCGs we were able to deliver and delivered £27.07m (89%) of its £30.05m saving target.

The delivery of the Financial Plan for 2019/20 was not without challenge – we saw increases in expenditure within Secondary Care (significantly emergency activity at Worcestershire Acute, with a corresponding increase in expenditure against the 999 Ambulance contract and Ambulance Handover fines, and out-of-county activity); prescribing (pressures around NCSO drug availability and a price movement in relation to Category M drugs); Continuing Healthcare costs and the impact of funding the GP indemnity Payment.

Financial Allocation for 2020/21

Planning for 2020/21 has been at a new Herefordshire and Worcestershire CCG level with the new CCG being established from 1 April 2020.

Our income predominately comes through an approved NHS England allocation which is based on a national funding formula – with allocations and control totals set by NHSE/I.

Recurrent commissioner allocations take account of changes relates to 2020/21 tariff inflation, movements in population sizes, pay awards and changes in commissioner responsibilities.

The CCG is planning to deliver a balanced financial plan; and demonstrate an increase in mental health services in line with their overall programme allocation growth as a minimum.

We also hold unallocated contingency reserves to manage any additional costs as part of our agreed financial plans of 0.5%.

As part of delivering a balanced plan the CCG will need to deliver a £36m recurrent cost improvement programme which will help improve the underlying financial position of the CCG.

As part of delivering a balanced plan the CCG will need to deliver a £36m recurrent cost programme which will help improve the underlying financial position of the CCG.

Current allocations - based on the national funding formula allocated under a place-based process - show that against the CCG programme budget the distance from target remains at 4.99% at the end of 2020/21. This still leaves the CCG significantly underfunded based on the current NHS funding formula. This is funding that could be utilised to support the significant financial pressures within the Worcestershire Health economy. Whilst the distance from target is within the NHS England policy of 5%, this leaves the CCG with added financial pressure.

As part of the place-based funding formula our Primary Care allocation remains above fair share funding. On top of this pressure initial modelling shows that implications of the new GP Contract for 2020/21 will leave the CCGs within Worcestershire with a significant financial pressure. This will continue to present a financial challenge to the Co-Commissioning Committee in terms of how it balances its overall Primary Care budgets for 2020/21.

System Planning

With the implementation of the first year of the five year System Operational Plans demonstrating how, as a health economy, we plan to deliver against the published system control totals – with for 20/21 50% of the financial recovery fund tied to system performance rather than in previous years provider performance.

At the time of writing, the CCG continues to work within the framework of COVID-19 national responses – with the suspension of the long-term planning regime and the imposition of block contracts continues until 1 August 2020.

The system planning now turns to restoration and how we get back to business as usual

Going concern

The CCG has produced its accounts on a going concern basis; this is in line with the Department for Health Group Accounting Manual for 2019/20 which state that we are a going concern unless we have been informed that there is an intention for the CCG to be dissolved without the transfer of function to another entity. The Covid-19 national emergency situation that arose at the end of the financial period and remains ongoing brings a new set of circumstances for the CCG. As a result of this NHS planning processes have ceased, however the government has made a pledge to the country and the NHS:

The Chancellor of the Exchequer committed in Parliament last week that "Whatever extra resources our NHS needs to cope with coronavirus – it will get." So ***financial constraints must not*** *and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.*

We believe that this situation does not therefore lead to material uncertainty about the going concern of the CCG.

Performance analysis

Development and performance during 2019/20

This section describes our performance over the past year. As well as the development of the organisation it sets out how we have performed against some of the requirements set out in the Health and Social Care Act 2012.

We developed a set of strategic objectives for 2019/20 based on the following areas of work:

1. Improving care and quality

Ensuring the commissioning of high quality, safe and effective health care with an emphasis on making significant improvements at:

- Worcestershire Acute Hospitals NHS Trust in the areas of urgent care, elective waiting times and cancer
- Worcester Health and Care NHS Trust in the area of mental health.

2. Delivery of GP Forward View and Integrated Care Plan

Developing a new model of care and delivery plan that supports sustainable primary care and the effective integration between primary, secondary, community and social care services consistent with integrated care principles

3. Financial Recovery and Sustainability

Sustaining financial recovery by the delivery of the Worcestershire financial recovery plan, facilitating long term financial sustainability.

Sustainable development

Sustainability in this context is about the smart and efficient use of natural resources, to reduce both immediate and long term social, environmental and economic risks. The cost of all natural resources is rising and there are increasing health and wellbeing impacts from the social, economic and environmental costs of natural resource extraction and use.

Sustainability has been recognised at a national level as an integral part of delivering high quality healthcare efficiently. The Department of Health Manual for Accounts states that all NHS bodies are required to produce a Sustainability Report as part of their wider Annual Report, to cover their performance on greenhouse gas emissions, waste management, and use of finite resources, following HM Treasury guidance.

The key principle behind this type of reporting is that it provides NHS organisations with an opportunity to demonstrate how sustainability has been used to drive continuous environmental, health and wellbeing improvements in their organisation, and in doing so, unlock money to be better spent on patient treatment and care. Published sustainability reporting also enables organisations to showcase their achievements with staff, patients and other stakeholders, providing an opportunity to inspire positive behaviours in the wider community. Furthermore, once established across the board, organisation wide reporting can constitute a transparent, comparable and consistent framework for assessing their own environmental impact and benchmark it against that of other NHS organisations and public sector bodies, a commonplace practice in the private sector.

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

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions by 28% by 2020 (using 2013 as the baseline year).

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. Sustainability is considered as part of our procurement processes (in terms of environmental and social impact).

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). We will be putting together an SDMP in the near future for consideration by our Governing Body.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has identified the need for the development of a Governing Body-approved plan for future climate change risks affecting our area.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a commissioner, evidence of this commitment will need to be provided in part through contracting mechanisms. More information on these measures is available here: https://www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Improve quality

Under Section 14R of the Health and Social Care Act 2012 we have a duty to continuously improve the quality of services that we commission and improve outcomes for patients.

We consider the components of quality (patient safety, clinical outcomes and patient experience) to be central to our function as effective commissioning bodies. During 2019/20 the continued contribution of the Quality Team ensured that each commissioning decision was subject to a robust Quality Assurance process, and - where required- a full Quality Impact Assessment.

We work in close partnership with our commissioning and provider partners to ensure that all quality issues across the health economy in Worcestershire have appropriate oversight and scrutiny. Areas of commissioned service quality that require improvement or achieve progress are shared with senior management and Executives at the Quality, Performance and Resource Committee in Common for Worcestershire, and with the CCG Governing Body, in public.

The use of patient narrative and experience continues to support commissioners to consider the impact of commissioning plans and decisions. This supports the CCG to meet our statutory duty to evaluate the achievement of improvement in the safety and experience of healthcare in Worcestershire and ensure that service delivery is consistent with commissioning objectives to meet the needs of those who need them.

Key quality improvement achievements in 2019/20 include:

- Recognition by NHS England of the continued positive performance in Transforming Care for people with a learning disability or autism in Worcestershire, supporting proactive case management to enable care close to home for those who have high levels of complex need and the minimal use of restrictive hospital placements.
- Working with a wide range of partners, including experts by experience and family carers, to ensure that learning emerging from the Learning Disability Mortality Review programme (known as LeDeR) across Worcestershire influences local practice. During 2019/20 this included the promotion of flu vaccinations for people with a learning disability and their carers, the promotion of key education for family and paid carers on the importance of bowel health and the inclusion of the needs of people with a learning disability in key programmes to deliver best practice end of life care.
- Recognition by NHS England of assurance processes in place to ensure that robust learning is agreed and implemented following the reporting of adverse events by provider organisations.
- Working collaboratively with partners across commissioning and provider organisations to continue to implement a Suicide Prevention Strategy and underpinning suicide reduction plan.
- Working in collaboration with key partners including Worcestershire Acute Hospitals NHS Trust, Worcestershire Health and Care NHS Trust, Maternity Voices and Public Health, across the Local Maternity System , progressing programmes of work to reduce stillbirths and implement Continuity of Care for local expectant mothers.
- Overseeing delivery of a number of incentivised quality improvement schemes within provider organisations (Commissioning for Quality and Innovation- CQUIN) in areas including six month follow up reviews for survivors of stroke, follow up within 72 hours

of discharge from a mental health inpatient bed and high impact actions to reduce the frequency of in-patient falls.

- Working closely with Worcestershire Acute Hospitals NHS Trust to identify and make progress in areas of patient safety improvement. Improvements in infection prevention and control practices have been supported by joint quality walk-through visits undertaken by senior nurse leaders of the CCGs and Trust .A workshop in February 2020 embedded the development of a system approach to understanding and addressing the factors that influence unexpected mortality for patients. The CCG Safeguarding Team worked closely with Trust colleagues to re-visit areas identified as requiring improvement by the Care Quality Commission and ascertain that required improvements were sustained.
- Working closely with partners in the roll out of a programme of education and support to effectively embed the use of the ReSPECT form to support advance care planning. An example of this has been through the implementation of an NHSE funded initiative to increase the identification of those people with severe frailty who might benefit from the opportunity for further discussion about their preferences.
- Commissioning and delivery bespoke training packages regarding the application of the Mental Capacity Act and issues relating to domestic abuse, to enhance the safeguarding of people within the Worcestershire population
- Providing expert support to inform Worcestershire County Council's Children's Social Services Alternative Delivery Model to implement "Worcestershire Children First" during 2019/20
- Embedding the integration of the CCG's Safeguarding Team across Herefordshire and Worcestershire, sharing good practice and continuing to improve safeguarding systems.
- Contributed to the development and implementation, as a key system partner alongside the local authority and Chief Officer of Police, to Worcestershire's Safeguarding Children Partnership Plan. This followed changes to the previous duties of Local Safeguarding Children Boards, introduced by the Children and Social Work Act 2017, to make safeguarding arrangements that respond to the needs of children in their area.
- Worked in close partnership with Local Authority (Public Health), in their role as Child Death Review (CDR) Partners, to review and implement processes to undertake Child Death Reviews in order to meet the statutory requirements under the Children Act 2004 (the Act) revised by the Children and Social Work Act 2017. The CDR Partners for Herefordshire and Worcestershire have formed a joint Child Death Overview Panel which will review all child deaths in those areas.
- Working closely with Registered Care Home providers to further embed an outbreak toolkit in order to minimise the spread of infectious outbreaks. This included support to ensure the recognition and early identification of the need to implement measures to minimise transmission. This work has proved to be invaluable in the early recognition of outbreaks during the initial phase of the COVID-19 pandemic toward the end of 2019/20.
- The successful achievement and further continuous improvement of quality metrics for Continuing Healthcare (CHC) provision. This included embedding training, processes and an infrastructure to ensure that all those eligible for a Personal Health Budget had opportunity to be partners in determining their health funded package of

personalised care. A CHC Communication Working Group, inclusive of key stakeholders, has influenced a reduction in new Appeals and a reduction in complaints compared to 2018/19.

- Worked closely with regional partners to quality assure the transition to a new provider of the local delivery of the NHS 111 service, forming part of the West Midlands Integrated Urgent Care service.
- Ensuring the smooth integration of the Quality Team in preparation for the merger of four CCGs on 1st April 2020, sharing good practice and strengthening the systems in place to ensure the continuous quality improvement of services commissioned by the NHS across Worcestershire and Herefordshire.

Principles for Remedy

We always aim to conform with the Parliamentary and Health Service Ombudsman's 'Principles for Remedy', which defines good practice in dealing with complaints. Specifically, it ensures that we are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement.

In 2019/20 we received 89 complaints about services that we commission. The complaints are categorised as follows:

Subject	Number of complaints
Commissioning - CHC	27
Commissioning - other	32
Provider - Acute	11
Provider - Community	11
Provider - NHS111	2
Provider - Independent Sector	3
Provider - Ambulance	2
Provider - Nursing Home	1
Total	**89**

Patient and public involvement

Under Section 14Z2 of the Health and Social Care Act 2012 we have a duty to involve the public in our commissioning plans and decisions that we make as a commissioning organisation. Our Communication and Engagement Strategy sets out the strategic direction for communication and engagement activities, aiming to ensure that we involve patients, public, staff, clinicians and stakeholders in our decision-making process.

We recognise the fundamental importance and benefit of ensuring that our decisions are shaped through effective communication and engagement with the local population and we use the Engagement Cycle as part of our commissioning and engagement planning. The Engagement Cycle is a strategic tool that helps to identify who needs to do what, in order to engage communities, patients and the public at each stage of commissioning.

Our strategy, culture and systems sit at the centre of 'The Engagement Cycle'. This includes our Engagement Framework which was refreshed in 2018 to reflect our Worcestershire wide working.

It includes:

- Patient Advisory Group (PAG) – meeting bi-monthly
- PPI Lay Representative on the Governing Body – presents PPI Highlight report including notes from PAG
- Worcestershire Involvement Network (WIN) – monthly update
- PPGs and their virtual network – event on 6 October 2019 and regular emails
- Supporting Lay Members (SLM) – new roles x3 localities to work across the health system
- Integrated Care Patient and Stakeholder Groups – chaired by the SLMs (paused since Autumn 2019)
- Partners across the Sustainability and Transformation Partnership (STP) including local Councils, Health Providers, Healthwatch and Voluntary & Community Sector (VCS) organisations
- Engagement team and working across the STP – fortnightly meetings with colleagues

The importance of Engagement is more prevalent now than ever before and to guarantee we are always on top of our engagement work. Work applications such as Verto and Office 365 provide cloud-based work collaboration and project management services to the CCGs. They hold all the information of each project currently being worked on and helps to identify when engagement work needs to be carried out. Having this overarching system makes sure nothing is missed.

Patient experience

Patient Experience is a vital part of The Engagement Cycle as well as being a fundamental part of delivering and ensuring Quality. Transforming Participation in Health and Care (NHSE 2013) outlined statutory guidance for CCGS regarding the requirement to understand and learn from the patient experience of the CCG's local population.

The patient and public voice provides NHS organisations, irrespective of whether it has a provider or commissioning focus, with a reminder of the core purpose of the organisation. Patient stories continue to be a key focus of the Quality, Performance and Resource Committee that reports directly to the Governing Body. Examples of the experience of health services by members of our local population are gathered and are presented by the Lay Member for Patient and Public Involvement and Quality. During 2019/20 patient stories have focused upon a range of agreed themes including access to Urgent Care, experiences of elective care services and treatments, the use of maternity services and stroke services.

A Patient Experience Dashboard enables key members of the Executive Team and Lay Members of the CCGs to have insight into provider reported outcomes for patient experience. This includes the Friends and Family Test, which we have supported our providers to implement, in addition to examples posted on NHS Choices.

Key highlights

Our major achievements this year have included:

Joint Working across Herefordshire and Worcestershire
We have been working across Herefordshire and Worcestershire, our Sustainability and Transformation Partnership (STP) footprint for a couple of years. In April 2019 following a staff consultation, the Communications and Engagement Team across the four CCGs merged and formed one team. This has reduced duplication and made working on the following projects more straightforward.

Consultation on the Future of Herefordshire and Worcestershire CCGs
In June 2019, we consulted with stakeholders and the public across the two counties to hear views and garner support for our application to merge the four CCGs across Herefordshire and Worcestershire, in line with the Long Term Plan.

Mental Health Strategy Listening
During the Autumn we conducted a listening engagement exercise about Mental Health. We wanted to find out what patients, carers and the public thought of Mental Health Services and what they would do to improve them. We then undertook further co-production sessions in February and March 2020 with a wide range of stakeholders (public members and staff) to examine at the strategy in more detail. This information has been used to shape the STP Mental Health Strategy across Herefordshire and Worcestershire.

Holding a Worcestershire wide Patient Participation Group (PPG) Event
In October 2019, we held our second PPG event focusing on making networks and supporting PPGs. The CCG provided a wide range of information and tools to support PPGs and invited PPG representatives to attend and share best practice. In addition, we hosted a marketplace for voluntary and community sector organisations to connect with the individual PPGs. There were over 70 attendees from PPGs across Worcestershire.

Seeking representative views

We have sought out seldom heard groups, communities and people by using non-traditional engagement methods, as we appreciate everyone has different engagement needs that go beyond the routine engagement methods. This work includes:

- Young People - through our regular Youth Takeover Day activities and links with our local secondary schools and looked after children.
- Older people – we have engaged with the Older People's Consultative Group on topics such as the Integrated Team and the Integrated Care for Older People (ICOPE).
- Continually being part of the Worcester Diocesan Health and Wellbeing Group, ensuring that their large network of churches and parishes are aware of issues in the health service.
- Through partnership with SpeakEasy NOW and St Richard's Hospice, we have promoted events to support the learning disabled, their families and carers to prepare them to make plans for growing older and end of life.
- As part of our role on the Worcestershire Maternity Voices Partnership, we have engaged with pregnant and postnatal parents on topics such as skin-to-skin contact and promoting membership to the Worcestershire Maternity Voices Partnership.
- Working with the Voluntary and Community Sector (VCS) to support engagement with seldom heard groups such as carers, about the Integrated Care of Older People (ICOPE) through work with the Worcestershire Association of Carers.
- We have undertaken engagement on loneliness and social isolation, as part of the re-procurement of a loneliness support service. As a result of this engagement, the age limit for the service has been lowered from 50 to 18.
- We have promoted various engagement opportunities to our LGBTQIA+ community, through engagement surveys for Healthwatch Worcestershire and NHS England.

Looking ahead to 2020/21

From the 1 April 2020 the three Worcestershire CCGs will merge with Herefordshire CCG to form NHS Herefordshire and Worcestershire CCG. We will be working to establish an engagement framework for the new organisation, with a focus on local face to face engagement.

We will continue to support Primary Care Networks and their Patient Participation Groups, by providing engagement advice and support.

We shall maintain our engagement support on the development of the Mental Health Strategy and support the co-production of its' workstreams.

Reducing health inequality

Under Section 14T of the Health and Social Care Act 2012 we have a duty to reduce health inequalities for patients across Redditch and Bromsgrove. Our Herefordshire and Worcestershire Sustainability and Transformation Plan states:

> *'There is a gap in mortality rates between advantaged and disadvantaged communities, particularly in Worcestershire. The range of years of life expectancy across the social gradient at birth is 7.8 years in Worcestershire and 4.9 in Herefordshire. In our rural areas, health inequalities can be masked by sparsity of population but we know differences exist which need to be tackled, including issues of access.'*

This demonstrates the acknowledgement of this issue and the particular challenge our rural geography poses. The STP continues to explain that we plan to tackle health inequalities particularly in mental health, learning disabilities and by promoting self-care and prevention. The index of multiple deprivation is used to rank areas, with those in decile 1 being in the most deprived 10% of areas nationally, through to decile 10 which are the 10% least deprived areas.

Health inequalities are not a problem we can tackle in isolation. Our approach has been to work in partnership with Worcestershire County Council, Public Health, our member GP practices, the Voluntary and Community Sector and patients themselves through co-production.

We have embedded the Learning Disabilities Mortality Review (LeDeR) programme across Worcestershire. By building on the strong foundations Worcestershire partners have, through an established Steering Group, five key Priority Action work groups were agreed to secure progress in areas of concern that will improve health outcomes and reduce premature death amenable to quality health care.

We have conducted a successful Social Prescribing Pilot over the last couple of years and as part of the national Directed Enhanced Service in 2019/20 this is now available for all patients across Herefordshire and Worcestershire. Social Prescribing is a way of enabling primary care services to refer patients with social, emotional or practical needs to a range of local non-clinical services. Low level mental health and social isolation are common reasons for referral, and for all ages, not just the older population. Following these results, and feedback from the Social Prescribers, the Loneliness and Isolation Service has considered expanding its age range from over 55 years old, to over 18 years old.

The CCG has match funded the Hospital Discharge worker specifically for homeless people. This post is now employed by Worcester City Council on behalf of the District Councils in Worcestershire and works across the hospitals. She ensures homeless people are supporting in hospital and that appropriate plans for discharge are in place. Once they have been discharged, she supports the patient to sustain their tenancy.
The CCG worked with Healthwatch Herefordshire and Healthwatch Worcestershire to conduct an engagement exercise regarding eight priorities from the Long Term Plan, including Health Inequalities. The two Healthwatch's particularly targeted seldom heard groups and conducted several focus groups with them, including young people and the learning disabled. The results from this engagement exercise were published in June 2019 and informed the latest Long Term Plan submission.

Our seldom heard engagement (detailed in the patient and public involvement section above) also includes engagement which aims to reduce health inequalities by increasing our knowledge and understanding of some of these groups.

Equality, inclusion and human rights

This section of the report sets out how the CCGs have been demonstrating 'due regard' to the Public Sector Equality Duty (equality duty). In the past year, equality and diversity and human rights have been central to the work of the CCG, in making sure that there is equality of access and treatment within the services the organisations commission.

Much of this work has been furthered through effective partnership work on reducing health inequalities by engaging with the local community, patients and the public. Another key area of progress has centred around embedding the Equality Impact and Risk Analysis process within the programme management system VERTO.

We are committed to ensuring that Equality, Inclusion and Human Rights is a central core to business planning, staff and workforce experience, service delivery and community and patient outcomes.

Legal Compliance

We continue to work to show due regard to the aims of the equality duty through meeting the requirements of the Equality Act 2010 by adopting appropriate policies and procedures as set out below:

Workforce

Redditch and Bromsgrove CCG, Wyre Forest CCG, and South Worcestershire CCG have robust policies and procedures in place which help to ensure that all staff are treated fairly and with dignity and respect and are committed to promoting equality of opportunity for all current and potential employees. We are aware of the legal equality duties as a public sector employer and service commissioner and have equality and diversity training in place for all staff. One to one Equality Impact Staff training sessions have taken place in 2019/20 and further training will be scheduled throughout 2020/21 when the four CCGs merge into one organisation so that all staff will have had face to face training in addition to online training for Equality, Inclusion and Human Rights.

Equality Impact and Risk Assessment (EIRA) Process

The EIRA toolkit has been developed to help us to identify potential and actual inequalities thus enabling the service proposed to be more inclusive of groups who are seldom heard and will equip staff to respond appropriately to any inequalities identified.

We have emphasised to staff the importance of undertaking EIRAs at the time of developing and reviewing policies and redesign of services. To equip staff with the necessary skills in undertaking the EIRAs, one to one training has been established for staff that are responsible for policy development and service redesign.

Our commissioners have carried out a range of equality analysis and human rights screening when carrying out their duties to ensure that we are paying 'due regard' to the three aims of the equality duty and the Human rights Act. Our Clinical Executive Committee is the governance mechanism where service redesigns and key decisions are taken around commissioning and decommissioning of services. We have put in place mechanisms where

all policies and services consider the impact on age, disability, gender, race, religion or belief, sexual orientation, gender re-assignment and human rights principles before approval is given. The organisational online programme known as VERTO requires all commissioners and authors of projects and proposals to undertake EIRA process. The Equality and Inclusion Business Partner quality reviews the equality analysis and provides support, advice and guidance as necessary.

A key success in 2019/20 has been the establishment of an STP Equality Group, comprising of all key stakeholders, bringing together commissioning organisations and Providers in Herefordshire and Worcestershire. The STP equality group has been working on a joint approach on key areas around equality and inclusion. One of the key successes has been the establishment of a unified EIRA process which has been adapted by all statutory providers including Worcestershire County Council. There is now a more unified and consistent method of undertaking equality impact analysis enabling greater partnership work on joint projects.

Equality Strategy 2017-2021 and Equality Objectives

Progress has been made in respect of the Equality Objectives since being established in 2017. The Equality Objectives established are as follows:

Equality Objective 1	*Ensure patients, service users, carers, protected groups, staff and wider public have a say in improving access to services and patient experience. Inclusion of seldom-heard groups for engagement in commissioning*
Equality Objective 2	*Monitoring of contracted services for Equality and Inclusion compliance as part of the contract with Providers and an active role in the procurement process*
Equality Objective 3	*Ensure all policies, strategies, service specifications, business plans, and commissioning/decommissioning projects undertake an Equality Impact and Risk Analysis and outcomes shared with appropriate CCG governance committee for consideration and action*
Equality Objective 4	*Training for staff and Governing Board members on roles and responsibilities under the Equality Act 2010, developed and delivered*

Our Equality Impact and Risk Analysis (EIRA) process has key questions around engagement and consultation in respect of commissioning/decommissioning services in respect of **Equality Objective 1.** As part of the EIRA process, meaningful engagement and consultation, directed specifically at groups where the impact is greatest, is advised to ensure that seldom heard groups and communities' voices are heard in respect of improving access to services and patient experience

For **Equality Objective 2**, equality and inclusion questions are now embedded as part of the procurement process and several procurement projects have been evaluated thus far. There have been ongoing provider checks for statutory and mandated compliance in respect of the obligations contained under the Equality Act 2010 and NHS England mandated requirements. Non-compliance with requirements are escalated to the quality and contracts team for further action.

For **Equality Objective 3,** training has been delivered to relevant staff on the importance of completing the EIRA forms on all projects in the summer of 2019. All the projects and

proposals on the CCGs' online VERTO system now direct commissioning staff to complete the EIRA paperwork before the project can be approved. More work needs to be undertaken to ensure that all committees are checking for EIRA completion - not only on projects and proposals but also on key organisational policies and decisions. A single Equality Impact Assessment framework has now been established across the demographic area of Herefordshire and Worcestershire.

Governing board training on roles and responsibilities was delivered in 2017, in respect of the Public-Sector Equality Duty, **(Equality Objective 4).** Training will be developed and delivered to all CCG employees on Equality and inclusion ensuring that staff and Governing Board members are aware of their duties under the legislation post the establishment of the new organisation from 1st April 2020.

Equality Delivery System 2

We have adopted the EDS2 as our performance toolkit to support us in demonstrating our compliance with the three aims of the Public Sector Equality Duty.

The main purpose of the EDS is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using EDS, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

The EDS grading process provides our Governing Body with an assurance mechanism for compliance with the Equality Act 2010 and enables local people to co-design our equality objectives to ensure improvements in the experiences of patients, carers, employees and local people.

This year, with approval of NHS England and Improvement, the CCGs, as part of the STP equality group, have put themselves forward to be a pilot for the EDS3 framework when this is launched. There has been delay in the launch of the EDS3 framework, therefore this action will be carried over to 2020/21. We are looking to work more collaboratively with our Providers and County Council and will endeavour to work on joint goals where this is feasible.

Performance monitoring of Providers and Procurement

The contracts with our providers are a mechanism through which we can gain assurance that Equality, Diversity and Human Rights requirements are complied with when planning services for patients and the public. In order to achieve this, we have continued to monitor compliance with the requirements set out in the Equality Act 2010 including NHS mandated equality requirements. All non-compliance feeds into the contract team and - where appropriate - providers are challenged and queries have been made when information has not been forthcoming. This will continue going forward into the 2020/21 contract.

We are required by law to make sure that when services are commissioned from providers, there are assurance mechanisms in place to assess compliance with equality legislation. We have already strengthened the procurement process by the inclusion of key equality questions at the Pre-Qualification (PQQ) stage. Furthermore, we have continued to plan to ensure that all contracts and Service Level Agreements (SLAs) contain information requirements around duties and responsibilities under the Equality Act 2010.

Meeting Human Rights requirements

Through the Equality and Diversity training and Equality Impact Risk Assessment completion, we have ensured that Human Rights screening on all core commissioning activity is undertaken. All Human Rights Screening outcomes are embedded into the Equality Analysis for commissioner consideration.

Workforce Race Equality Standard (WRES)

We continue to collate and publish Workforce Race Equality Standard data. Our Governing Body will ensure, through overview and reporting processes, that the organisation continues to give due regard to using the WRES indicators to help improve workplace experiences, and representation at all levels within the workforce, for Black Asian and Minority Ethnic (BAME) staff. We will also seek assurance, through the provision of evidence, that Providers are implementing the NHS Workforce Race Equality Standard.

Accessible Information Standard (AIS)

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. We are committed to the implementation of the AIS and therefore have included information on the Standard on our website which directs patients and the public on how to access information in an accessible format. We have also continued to monitor the main providers for compliance on the Accessible Information Standard.

Priorities for 2020/21 and beyond

The following list describes the areas which the CCG will prioritise and will form part of the work plan for 2020/21:

1. Development of a new Equality Strategy and Equality Objectives for Herefordshire and Worcestershire CCG (HWCCG)
2. Development equality and inclusion action plan for HWCCG.
3. Development and delivery of Board development training for all HWCCG.
4. Annual Review of Equality Objectives 2017-2021
5. Continued work on NHSEI standards and requirements
6. Work in partnership with colleagues across the STP footprint on equality and inclusion projects.
7. One to one training for appropriate commissioning staff on the Equality Impact and Risk Assessment process.
8. Implementation of new guidance and policies from NHSEI
9. Staff training on Equality, Inclusion, Diversity and Human Rights
10. Better and on-going engagement with seldom heard communities should be a focus for the new organisation therefore more collaborative work with the communications and engagement team. This will help the CCG to better understand the health needs and priorities for the communities that we serve.

11. Incorporate the revised Equality Delivery System 3 into the organisational action plan and devise action plan for the evaluation of appropriate goals and outcomes
12. Quality review of Provider annual report on equality
13. Continued work within the procurement process on equality evaluation

Our performance

We have a duty to improve the quality of services we commission, to promote the NHS Constitution, to provide information on the safety of services provided, and to reduce health inequalities.

Our mechanism for doing this has been the establishment of a performance framework that identifies where we do, or do not, meet the standards expected.

There are two main requirements on us as a CCG for which we are accountable:

- Delivery of NHS Constitution requirements
- Delivery of national and local quality requirements.

NHS Constitutional Targets achievement is a priority to the CCG. During 2019/20 performance has not been at the level across a number of areas that the CCG expects or commissions.

The main provider where performance has been challenged has been at Worcestershire Acute Hospitals NHS Trust where the CCG commissions the majority acute services for Worcestershire residents.

We have continued to challenge performance below expected standards through a number of routes but use the NHS Standard Contractual route to formalise Remedial Action Plans (RAPs) with providers.

We describe below our performance for each of the NHS Constitution indicators:

Indicator		Target	Achieved
A&E waits	Patients should be admitted, transferred or discharged within four hours of their arrival in an A&E Department	95%	75.82%
	Trolley waits in A&E < 12 hours	0	933
Referral to Treatment waiting times for non-urgent consultant led treatment	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	93%	84.25%
	Number of 52 week waiters on an incomplete pathway	0	0
Cancer - 2-Week Waits	Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	85.01%
	Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	47.02%
Cancer Waits - 31-Days	Maximum one month (31 day) wait from diagnosis to first definite treatment for all cancers	96%	96.01%

Indicator		Target	Achieved
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	82.86%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%	100%
	Maximum 31 day wait for subsequent treatment where that treatment is a course of Radiotherapy	94%	97.31%
Cancer Waits - 62-Days	Maximum two months (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	64.26%
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	88.37%
	Maximum 62 day wait for first definitive treatment following a consultant decision to upgrade the priority of the patient (all cancers)	94%	73.24%
Diagnostic Test Waiting Times	Patients waiting for a diagnostic test should have been waiting less than six weeks	99%	97.41%
Category A ambulance calls	Red performance – response average within 7 minutes	00:07:00 hh:mm:ss	00:07:10 hh:mm:ss
	Ambulance handover times - % < 30 minutes (Worcestershire Acute position)	85%	75.02%
Mixed Sex Accommodation Breaches	Minimise breaches	0	136
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within seven days of discharge from psychiatric inpatient care during the period	95%	97.71%
	IAPT - % of patients with depression and/or anxiety disorders who receive psychological therapies	22% by Mar 20	22.9%
	IAPT recovery - % of patients who have completed treatment who are moving to recovery	50%	51.8%
	% of people that wait six weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	75%	90%

Indicator		Target	Achieved
	% of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	95%	100.00%
	% of people that wait six weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	75%	80%
	% of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	95%	98.18%
	Estimated diagnosis rate for people with dementia for those patients aged 65+	67%	63.71%
Health Care infections	Incidence of healthcare associated infections - MRSA	0	2
	Incidence of healthcare associated infections – C Difficile	41	32

** Figure represents combined performance across Worcestershire*

Improving Performance

The achievement of constitutional standards and key performance measures has been recognised as a key priority for the CCG and the local health economy. Consequently, these areas were captured within the CCG's three Corporate Objectives for 2019/20; thereby ensuring that they are embedded as core areas of strategic focus.

Within the Board Assurance Framework (BAF), quarterly milestones have been identified for the delivery of trajectories. Progress is monitored through the application of Red/Amber/Green (RAG) ratings. If a red or amber rating is applied, commentary is provided which pinpoints the key factors accounting for non-delivery along with the remedial actions planned.

Many enablers across different organisational functions have also been identified, which include the importance of achieving effective and mutually beneficial partnership working with Worcestershire Acute Hospitals NHS Trust. Where potential issues have been noted, these are flagged with remedial actions developed. Based on this information, any strategic risks are identified which pose a threat to the achievement of these objectives. Similarly, any operational areas of risk associated with performance and quality are captured within the CCG's Risk Register.

This mode of reporting provides a whole system approach to the reporting and management of performance against quality, patient safety and constitutional standards, as the BAF clearly shows the interdependent relationship of how objectives produce quarterly milestones which in turn require a series of enablers to be delivered; and how delivery could

be threatened by the strategic risks. It also promotes focused and coordinated analysis by having key information included within a single framework.

The CCG has a robust governance infrastructure and the role of the different groups promotes detailed and triangulated analyses of performance issues and key risk factors, thus, shaping the action plans developed by the CCGs. Furthermore, at Worcestershire Acute Hospitals NHS Trust, the Quality Improvement Review Group (QIRG) continues to oversee progress against the Care Quality Commission action plan, whilst the CCGs also attend the Trust Quality Governance Committee where there is now appropriate executive level challenge to areas of care quality and performance that require progressing.

Improvement and Assessment Framework

In addition to the NHS Constitution Indicators set out above, the Improvement and Assessment Framework for CCGs provides greater visibility and accountability around whole system effectiveness and to provide specific indicators to be incorporated in Sustainability and Transformation Partnerships. The framework covers four domains:

- Better Health (this section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve)
- Better Care (this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas)
- Sustainability (this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends)
- Leadership (this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest).

The latest published annual rating for all CCGs is 'Good'. This relates to the 2018/19 Improvement and Assessment Framework. This relates to the 2018/19 Improvement and Assessment Framework. Details can be found at:

https://www.nhs.uk/mynhs/services.html
https://www.england.nhs.uk/commissioning/regulation/ccg-assess/iaf/

For 2019/20, there is a transition to the NHS Oversight Framework, with information available via NHS England at:

https://www.england.nhs.uk/publication/nhs-oversight-framework-for-2019-20/

Accountability Report

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24th June 2020

Corporate Governance Report

Members Report

Our GP membership

There are 21 GP member practices which form NHS Redditch and Bromsgrove CCG. They are as follows:

Redditch and Bromsgrove Surgeries

Barnt Green Surgery, 82 Hewell Road, Barnt Green, Birmingham, B45 8NF
Catshill Surgery, 36 Woodrow Lane, Catshill, Bromsgrove, B61 0PU
Churchfields Surgery, BHI Parkside, Stourbridge Road, Bromsgrove, B61 0AZ
Cornhill Surgery, 65 New Road, Rubery, Birmingham, B45 9JT
Crabbs Cross Medical Centre, Kenilworth Close, Crabbs Cross, Redditch, B97 5JX
Crabbs Cross Surgery, Kenilworth Close, Crabbs Cross, Redditch, B97 5JX
Davenal House Surgery, 28 Birmingham Road, Bromsgrove, B61 0DD
Elgar House Surgery, Church Rd, Redditch, B97 4AB
Glebelands Surgery, The Glebe, Belbroughton, Stourbridge, DY9 9TH
Hillview Medical Centre, Bromsgrove Rd, Redditch, B97 4RN
Hollyoaks Medical Centre, 229 Station Road, Wythall, B47 6ET
Hollywood Medical Practice, Beaudesert Road, Hollywood, Birmingham, B47 5DP
Maple View Medical Practice, Tanhouse Lane, Church Hill, Redditch, B98 9AB
New Road Surgery, 46 New Road, Bromsgrove, B60 2JS
New Road Surgery, 104 New Road, Rubery, Birmingham, B45 9HY
Ridgeway Surgery, 6/8 Feckenham Road, Astwood Bank, Redditch, B96 6DS
St John's Surgery, BHI Parkside, Stourbridge Road, Bromsgrove, B61 0AZ
St Stephen's Surgery, Adelaide St, Redditch, B97 4AL
The Bridge Surgery, 8 Evesham Road Redditch, B97 4LA
The Dow Surgery, William St, Redditch, B97 4AJ
Winyates Health Centre, Winyates, Redditch, B98 ONR

Our Governing Body

Our Governing Body is clinically-led, including four GPs, a registered nurse and a Secondary Care Doctor, all of whom have day-to-day knowledge of the health problems that residents face.

Its role is to ensure that we have appropriate arrangements in place to exercise our functions effectively, efficiently and economically, and in accordance with the generally accepted principles of good governance, the NHS Constitution and our own local Constitution.

Simon Trickett is our Accountable Officer for the organisation. Simon is responsible for the overall leadership of the organisation, for championing the NHS Constitution and assumes overall responsibility for the Quality, Innovation, Productivity and Prevention (QIPP) programme and the strategic direction of the CCG.

Our Governing Body meets in formal public sessions six times a year. It is provided with accurate, timely and clear information so it can maintain full and effective control over strategic, financial, operational, compliance and governance issues. The full membership of the Governing Body is detailed within the Governance Statement.

Committees

Our Governing Body is supported by a number of committees and sub-committees who meet on a regular basis throughout the year to review, assess, and regulate the activities and responsibilities of the organisation. The details of these committees, including Audit Committee, and the membership of each one can be found within the Governance Statement.

Each year we aim to assess the effectiveness of our committees by inviting members to rate and comment upon a number of key areas relating to each committee's operation. In order to do this, a set of questions are devised, which are shaped by national surveys, to form a local template. This is subsequently distributed in an electronic survey format to each committee member. Intelligence derived from these surveys has previously resulted in amendments to committee terms of reference, the scheme of delegation and our Constitution.

Appraisals

All Governing Body Members are appraised each year. The performance of our Accountable Officer is appraised by the members of our Remuneration Committee, which includes Lay Members and CCG Clinical Chair.

Register of Interests

It is an essential feature of the NHS that CCGs should be able to commission a range of community-based services, including primary care services, to improve quality and outcomes for patients.

Where the provider for these services might be a GP practice, CCGs will need to demonstrate that those services meet clear criteria including that the appropriate procurement approach is used. These services will be commissioned using the NHS standard contract.

CCGs could also make payments to GP practices for promoting improvements in the quality of primary medical care (e.g. reviewing referrals and prescribing); or carrying out designated duties as healthcare professionals in relation to areas such as safeguarding.

Consequently, conflicts of interest are likely to arise where GPs who provide healthcare services also input into commissioning decisions about those services in their area. It is how these conflicts are managed that will ensure public funds are spent appropriately and that confidence and trust between the public, patients and GPs is maintained.

Our Governing Body is not aware of any relevant audit information that has been withheld from our external auditors, and members of our Governing Body take all necessary steps to

make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

We have a Conflicts of Interest Policy in place, publicly available Register of Interests and Register of Procurement Decisions. All of these can be found on our website at http://www.redditchandbromsgroveccg.nhs.uk/about-us/conflicts-of-interest/

Personal data related incidents

No personal data related incidents were reported to the Information Commissioner's Office during 2019/20 year.

Emergency Planning

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

The CCG is a Category 2 responder and is assessed by NHS England on its management of emergency planning and resilience by providing an annual NHS Emergency Preparedness, Resilience and Response Core Standards return.

The CCG's Governing Body received a report on the results of the Core Standards assurance process in September 2019, which indicated that the CCG was 'Substantially Compliant'. The CCG also works with its key providers to support and monitor their compliance with the Core Standards.

The CCG has in place a Major Incident Response Plan which sets out how the CCG will support NHS England and where necessary, co-ordinate the local NHS response in the event of an emergency or major incident. The CCG also has a Business Continuity Plan which ensures that in the event of a significant incident threatening personnel, buildings or operational structure, its critical activities can still be delivered. Both plans are regularly tested and reviewed in line with statutory and non-statutory requirements.

The CCG is an active member of the Local Health Resilience Partnership (LHRP) and represents the local health economy at the Worcestershire Tactical Coordinating Group (TCG) in the event that an incident requires multi-agency command and control arrangements to be instigated at a County level.

The CCG has a team of senior managers providing on call cover 24 hours a day, 7 days a week, who are trained in line with National Occupational Standards and who regularly have opportunities to participate in multi-agency exercises.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

NHS Redditch and Bromsgrove CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Simon Trickett to be the Accountable Officer of NHS Redditch and Bromsgrove 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 financial statements in the form and on the basis set out in the Accounts Direction. The financial statements 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 net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health 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 Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, and subject to the disclosures set out below (eg. directions issued, s30 letter issued by internal auditors), I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information
- That the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24th June 2020

Governance Statement

Introduction and context

NHS Redditch and Bromsgrove Clinical Commissioning Group (CCG) is a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2019, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006

Scope of responsibility

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

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance arrangements and effectiveness

The 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 is accountable for exercising the statutory functions of the group. However, it may grant authority to act on its behalf to any of its members, its Governing Body, its employees or committees of the group as expressed through the group's scheme of delegation and committees' terms of reference. The members of the group meet monthly as Redditch and Bromsgrove Practice Forum. The group has delegated all decision making to the Governing Body with these exceptions:

a) Agreement to change the group's constitution*
b) Approve the vision, values and overall strategic direction of the group
c) In exceptional circumstances if a member of the group continually behaves inconsistently to the terms of reference and despite attempting to resolve the

situation utilising dispute resolution process, the approval to dismiss members of the group*

d) Approval of applications to be a member of the group*
e) Ratify the appointment of elected members of the CCG Governing Body
f) Approve the removal of elected members of the CCG Governing Body
g) Approve the appointment of the Chair of the CCG Practice Forum

* Subject to NHSE Approval Process

The group remains accountable for all of its functions, including those that it has delegated.

Governing Body

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 role of the Governing Body, the types of decisions taken by the Governing Body or delegated to committees or Executive Officers are detailed in the scheme of delegation and reservation.

Roles and Responsibilities

The Governing Body voting membership in 2019/20 and attendance rates were as follows:

Name	Role	In office during 2019/20	Attendance
Dr Richard Davies	Chair and Clinical Lead	1 April 2019 – 31 March 2020	5/6
Dr Carl Ellson	Strategic Clinical Lead	1 April 2019 – 31 March 2020	3/6
Simon Trickett	Accountable Officer	1 April 2019 - 31 March 2020	6/6
Dr Jonathan Leach	Governing Body GP Member	1 April 2019 – 31 March 2020	5/6
Dr Moheb Shalaby	Governing Body GP Member	1 April 2019 – 31 March 2020	3/6
Mari Gay	Chief Operating Officer	1 April 2019 – 31 March 2020	4/6
Mark Dutton	Chief Finance Officer	1 April 2019 – 31 March 2020	4/6
Lisa Levy	Chief Nurse and Director of Quality	1 April 2019 – 31 March 2020	6/6

Rob Parker	Lay Member for Finance and Governing Body Vice Chair	1 April 2019 – 31 March 2020	6/6
Sarah Harvey Speck	Lay Member for Patient, Public Involvement and Quality	1 April 2019 – 31 March 2020	5/6
Trish Haines	Lay Member for Primary Care	1 April 2019 – 31 March 2020	6/6
Dr Martin Lee	Secondary Care Doctor	1 April 2019 – 31 March 2020	6/6
Fred Mumford	Lay Member for Audit and Governance	1 April 2019 – 31 March 2020	6/6

Re-elections & Appointments to the Governing Body

The CCG Constitution sets out the arrangements for election and re-election of members of the Governing Body

Commitment

All Governing Body members allocate time as per a statement of appointment and are in line with national guidance. The frequency of attendance at meetings is monitored throughout the year. The allocation of time is reviewed regularly against the portfolio of responsibilities and adjusted accordingly.

Development

Together with an ongoing programme of individual and organisational development, bi-monthly Governing Body Development sessions take place.

Evaluation and Effectiveness

Individual performance reviews for Governing Body members were completed in 2019/20 and the effectiveness of the Governing Body and committees is reviewed annually. NHS England reviews the performance of the CCG quarterly. This also included a review of the CCG's Improvement Assessment and Framework which examined whether the Governing Body operates effectively as a team. Redditch and Bromsgrove CCG was rated as green across all domains. The CCG has maintained the nationally required Governing Body composition and membership through 2019/20.

Meetings of the Governing Body

The Governing Body met six times during 2019/20 and held all meetings at alternative locations in the Worcestershire area. The dates of the meetings were published at least three months in advance and papers were made available to members and the public through the CCG's website seven days prior to the meeting. Members of the public are invited to put questions to the Governing Body at least 24 hours prior to the meeting and the Governing Body welcome the opportunity to provide a response.

The Governing Body continues to concentrate on strategic issues whilst assuring itself of the performance of the whole organisation. The work of the Governing Body has focused on:

- Review and approval of strategic commissioning plans, including Sustainability and Transformation Partnership (STP) and Integrated Care Plans
- Review and oversight of the Herefordshire and Worcestershire Merger Programme
- Review and approval of shared governance proposals
- Monitoring of quality, performance and finance
- Review of progress against the financial recovery/sustainability programme
- Monitoring of the activities and decisions taken by the Governing Body's committees.

The Governing Body reviews the effectiveness of the CCG and the Governing Body members and references stakeholder surveys, individual appraisals, NHS England assurance reports and feedback, staff surveys and delivery against commissioning and financial plans.

The organisation development plan is refreshed at intervals informed by staff and stakeholder surveys, individual development plans and the outcome of the self- assessment.

Committees of the Governing Body

To support the Governing Body in carrying out its duties effectively, committees reporting to the Governing Body are formally established. The committees detailed below commenced the year operating as committees in common across the Worcestershire CCGs. In year, in line with the development of shared governance proposals, Audit Committee and Primary Care Commissioning Committee commenced in common operation with Herefordshire CCG.

- Audit Committee – Commenced in common operation with Herefordshire CCG from October 2019
- Remuneration Committee – Commenced in common operation with Herefordshire CCG from September 2019
- Primary Care Commissioning Committee – Commenced in common operation with Herefordshire CCG from May 2019

Committees in common enable the CCGs to work efficiently by holding meetings at the same place at the same time. This governance arrangement facilitates aligned decision making while ensuring that each CCG remains fully accountable for the decisions they make.

The remit and terms of reference of these committees were reviewed during the year to ensure robust governance and assurance. Each of these committees report into their

respective Governing Bodies through particular mechanisms, which may include submission of minutes, summary reports and any reports by exception.

Audit Committee

This committee provides assurance on integrated governance, risk management, internal control, internal and external audit, counter fraud and security management financial reporting. During 2019/20 the key areas of work of the committees were:

- Integrated governance, risk management and internal control
- Oversight and approval of corporate documentation relating to the planned CCG merger
- Approving internal and external audit plans, reviewing progress against these and receiving assurance on actions taken following audits
- Reviewing counter fraud work programme and reports
- Monitoring the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance
- Review of systems for financial reporting to the CCG, including those of budgetary control.

The membership of the committee in 2019/20 was as follows:

Name	Role	Membership of the committee during 2019/20
Fred Mumford (Chair)	Lay Member for Audit and Governance	1 April 2019 – 31 March 2020
Carol Thompson	Co-opted Lay Member	1 April 2019 – 8 August 2019
David Wigley	Co-opted Lay Member	1 April 2019 – 8 August 2019
Rob Parker	Lay Member for Finance	1 April 2019 - 31 March 2020
Dr Martin Lee	Secondary Care Doctor	1 April 2019 - 31 March 2020

Remuneration Committee

This committee makes recommendations to the Governing Body on determinations about pay and remuneration including salary awards and pension as well as other terms and conditions of employment contracts. During 2019/20 the key areas of work of the committee were:

- Make decisions about the remuneration of GP, Lay and Secondary Care Clinicians and other Governing Body members.
- Approve the remuneration and conditions of service of the Accountable Officer and VSM staff.
- Review the performance of the Accountable Officer and other staff on VSM contracts and approve annual salary awards, if appropriate;

- Approve the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms excluding ill health and normal retirement for all employees;
- Consider the severance payments of the Accountable Officer and other staff on VSM contracts and approve these seeking HM Treasury approval as appropriate in accordance with the guidance “Managing Public Money” (HM Treasury.gov.uk).
- Agreeing any significant changes to the number of sessions of Governing Body Members

The membership of the committee in 2019/20 was as follows:

Name	Role	Membership of the committee during 2019/20
Rob Parker (Chair)	Lay Member for Finance	1 April 2019 – 31 March 2020
Fred Mumford	Lay Member for Audit and Governance	1 April 2019 – 31 March 2020
Dr Martin Lee	Secondary Care Doctor	1 April 2019 – 31 March 2020
Dr Richard Davies	Governing Body Clinical Chair	1 April 2019 – 31 March 2020

Primary Care Commissioning Committee

NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. The function of the committee is to evaluate service proposals and make decisions regarding the commissioning and primary care services, ensuring all decisions are underpinned by robust clinical advice and within agreed governance arrangements. The committee focused on the following key areas of work during 2019/20:

- General Medical Services (GMS), Primary Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)
- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”)
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes).

The membership of the committee in 2019/20 was as follows:

Name	Role	Membership of the committee during 2019/20
Trish Haines (Chair)	Lay Member for Primary Care	1 April 2019 - 31 March 2020
Sarah Harvey- Speck (Vice Chair)	Lay Member for Patient, Public Involvement and Quality	1 April 2019 - 31 March 2020
Simon Trickett	Accountable Officer	1 April 2019 - 31 March 2020
Lynda Dando	Director of Primary Care	1 April 2019 - 31 March 2020
Mark Dutton	Chief Finance Officer	1 April 2019 - 31 March 2020

Joint Committees

Legislative Reform Order which amended sections 14Z3 and 14Z9 of the NHS Act 2006 means that CCGs are able to form joint committees in order to undertake collective strategic decisions. The following joint committees are in place across the Worcestershire CCGs (NHS Redditch and Bromsgrove, South Worcestershire and Wyre Forest CCGs)

- Quality, Performance and Resources Joint Committee (QPR)
- Clinical Executive Joint Committee
- Financial Recovery Board (FRB)

QPR Joint Committee

The committee focused on the following key areas of work during 2019/20:

- Monitor the quality and safety of all services (primary, secondary and tertiary care, including the independent sector) commissioned by the CCGs for its total population.
- Promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience
- To seek assurance relating to financial governance across the CCGs, in terms of securing value for money and sound financial stewardship.
- Receive reports detailing all commissioner and provider performance targets, set both nationally and locally, and seek appropriate assurances that these are met.
- Where possible provide assurance to the CCGs Governing Bodies on these areas of responsibility; highlight areas of limited assurance and make recommendations where necessary.
- Identify and mitigate risk associated with quality performance & resources

The membership of the committee across all three CCGs in 2019/20 was as follows:

Name	Role	Membership of the committee during 2019/20
Martin Lee (Chair)	Secondary Care Doctor	1 April 2019 - 31 March 2020
Sarah Harvey Speck (Vice Chair)	Lay Member for Patient, Public Involvement and Quality	1 April 2019 - 31 March 2020
Rob Parker	Lay Member for Finance	1 April 2019 - 31 March 2020
Trish Haines	Lay Member for Primary Care	1 April 2019 - 31 March 2020
Tricia Lowe	Supporting Independent Lay Member	1 April 2019 - 31 March 2020
Dr Richard Davies	Redditch and Bromsgrove Clinical Chair	1 April 2019 - 31 March 2020
Dr Anthony Kelly	South Worcestershire Clinical Chair	1 April 2019 - 31 March 2020
Dr Tristan Brodie	Wyre Forest Governing Body GP	1 April 2019 - 31 March 2020
Dr George Henry	GP Quality Lead	1 April 2019 - 31 March 2020
Lisa Levy	Chief Nurse and Director of Quality	1 April 2019 - 31 March 2020
Mari Gay	Chief Operating Officer and Lead Executive for Quality and Performance	1 April 2019 - 31 March 2020
Simon Trickett	Accountable Officer	1 April 2019 - 31 March 2020
Mark Dutton	Chief Finance Officer	1 April 2019 - 31 March 2020
Dr Carl Ellson	Strategic Clinical Lead	1 April 2019 - 31 March 2020

Clinical Executive Joint Committee

The committee focused on the following key areas of work during 2019/20:

- Lead and oversee the development of the CCG's commissioning strategy and annual commissioning intentions, ensuring local health needs and service issues are addressed within available resources.
- Lead and oversee the annual commissioning cycle, ensuring it is clinically led, supports improvements in health and health outcomes and enables a whole system wide transformation.
- Through receipt of highlight reports, consider and approve recommendations relating to the following:
    - STP Work Programmes, for areas which are not within the scope of the Herefordshire and Worcestershire Joint Committee
    - Integrated Care Systems, as taken forward through the Alliance Boards
- Receive and consider updates relating to any projects managed on the Verto system, for which Clinical Executive is the responsible committee
- Sign off Clinical Policies and Strategies pertaining to Worcestershire only.
- Receive and approve outline business cases within Worcestershire for proposed developments and service changes, ensuring appropriate clinical, financial and quality input and challenge has been part of the process
- Receive reports/ recommendations from the Clinical Innovation Group (CIG)
- Receive quarterly reports from the Area Prescribing Committee on the use of drugs in Worcestershire and where necessary make decisions in relation to drug use and the utilisation of resources
- Oversee procurement activity and provide assurance to the Governing Bodies that this is being carried out effectively and appropriately, through receipt of a quarterly highlight report
- Review the CCGs Communications and Engagement Strategy prior to submission to Governing Bodies.

The membership of the committee across all three CCGs in 2019/20 was as follows:

Name	Role	Membership of the committee during 2019/20
Simon Trickett (Chair)	Accountable Officer	1 April 2019 - 31 March 2020
Mari Gay (Vice Chair)	Chief Operating Officer and Lead Executive for Quality and Performance	1 April 2019 - 31 March 2020
Sarah Harvey- Speck	Lay Member for Patient, Public Involvement and Quality	1 April 2019 - 31 March 2020
Fred Mumford	Lay Member for Audit and Governance	1 April 2019 - 31 March 2020
Dr Martin Lee	Secondary Care Doctor	1 April 2019 - 31 March 2020
Dr Carl Ellson	Strategic Clinical Lead	1 April 2019 - 31 March 2020
Dr Richard Davies	Redditch and Bromsgrove Clinical Chair	1 April 2019 - 31 March 2020
Dr Anthony Kelly	South Worcestershire Clinical Chair	1 April 2019 - 31 March 2020

Dr Louise Bramble	Wyre Forest Clinical Chair	1 April 2019 – 31 March 2020
Mark Dutton	Chief Finance Officer	1 April 2019 - 31 March 2020
Ruth Lemiech	Director of Strategy	1 April 2019 - 31 March 2020
Lisa Levy	Chief Nurse and Director of Quality	1 April 2019 - 31 March 2020

Financial Recovery Board

The committee focused on the following key areas of work during 2019/10:

- Development and approval of a robust Financial Recovery and Sustainability Plan, with intensive oversight throughout the course of the year
- Ensure that the actions contained within the plans are delivered and report to the Governing Bodies on progress.
- Provide assurance to the Governing Bodies on the sufficiency of actions to secure delivery of in year financial targets and progress towards medium term financial sustainability.
- Make specific recommendations to the Governing Bodies of any additional actions that may be necessary.
- Take decisions on actions necessary to support delivery of the plans, within approved delegated limits.

The membership of the committee across all three CCGs in 2019/20 was as follows:

Name	Role	Membership of the committee during 2019/20
Robert Parker (Chair)	Lay Member for Finance	1 April 2019 - 31 March 2020
Fred Mumford (Vice Chair)	Lay Member for Audit and Governance	1 April 2019 - 31 March 2020
Sarah Harvey- Speck	Lay Member for Patient, Public Involvement and Quality	1 April 2019 - 31 March 2020
Trish Haines	Lay Member for Primary Care	1 April 2019 - 31 March 2020
Tim Tebbs	Financial Sustainability Director	1 April 2019 - 31 March 2020
Simon Trickett	Accountable Officer	1 April 2019 - 31 March 2020
Mark Dutton	Chief Finance Officer	1 April 2019 - 31 March 2020
Mari Gay	Chief Operating Officer and Lead Executive for Quality and Performance	1 April 2019 - 31 March 2020
Lisa Levy	Chief Nursing Officer and Director of Quality	1 April 2019 - 31 March 2020
Dr Carl Ellson	Strategic Clinical Lead	1 April 2019 - 31 March 2020
Lynda Dando	Director of Primary Care	1 April 2019 - 31 March 2020

Ruth Lemiech	Director of Strategy	1 April 2019 - 31 March 2020
Dr Anthony Kelly	GP Chair SWCCG	1 April 2019 - 31 March 2020
Dr Louise Bramble	GP Chair WFCCG	1 April 2019 - 31 March 2020
Dr Richard Davies	GP Chair RBCCG	1 April 2019 - 31 March 2020
Emily Godfrey	Head of PMO	1 April 2019 - 31 March 2020

Furthermore, Herefordshire & Worcestershire Joint Commissioning Committee is a joint committee with the following CCGs:

- NHS Herefordshire CCG
- NHS Redditch and Bromsgrove CCG
- NHS South Worcestershire CCG
- NHS Wyre Forest CCG

The purpose of the joint committee is to:

- Provide a joined up strategic approach to the commissioning of heath and care services, enabling the CCGs to work effectively with providers to ultimately deliver improved quality of outcomes for patients
- Provide strategic leadership and decision making relating to the transition to future commissioning arrangements
- Oversight and, where appropriate, approval of the CCGs merger work programme
- Provide strategic leadership in relation to the development of new integrated care systems arrangements and make recommendations accordingly to the CCG Governing Bodies
- Provide strategic decision making relating to the implementation of STP programmes and lead the development of commissioning strategies for joint clinical transformation programmes.
- Lead the joint commissioning of those services, identified in the joint clinical transformation programmes and provide a mechanism for joint decision making which will ensure quality and service outcomes are an integral part of the commissioned pathway
- Receive and approve outline business cases for proposed developments and service changes, ensuring appropriate clinical, financial and quality input and challenge has been part of the process
- Enable the Herefordshire and Worcestershire CCGs to manage financial risks more effectively
- Sign off STP Clinical Policies and Strategies
- Act as the lead committee for Organisational Development (OD) and Human Resources (HR) including:
    - Review the OD strategy prior to submission to Governing Bodies.
    - Receive and approve HR policies, reports and highlight reports at agreed intervals and monitor any staff related trends.

    - Ensure that a meaningful appraisal process is in place and embedded within the organisations.
    - Maintain close links with the Staff Councils and receive their reports as required.
    - Review organisational training and development needs.
- Act as the lead committee for the following services including approval of strategies, policies and reports:
    - Equality and Inclusion
    - Business Continuity and Emergency Planning
    - Health and Safety
- Receive and consider highlight reports relating to IT matters, making decisions as required
- Reduce unwarranted variation across the STP footprint in the range and quality of services available to people living across the footprint by improving outcomes in areas that are below average and driving up outcomes overall

The core membership of the committee across all four CCGs in 2019/20 was as follows:

Name	Role	Membership of the committee during 2019/20
Dr Anthony Kelly	Clinical Chair, South Worcestershire CCG	1 April 2019 - 31 March 2020
Dr Richard Davies	Clinical Chair, Redditch and Bromsgrove CCG	1 April 2019 - 31 March 2020
Dr Louise Bramble	Clinical Chair, Wyre Forest CCG	1 April 2019 – 31 March 2020
Dr Ian Tait	Clinical Chair, Herefordshire CCG	1 April 2019 - 31 March 2020
Simon Trickett	Accountable Officer	1 April 2019 - 31 March 2020
Mark Dutton	Chief Finance Officer	1 April 2019 - 31 March 2020
Jill Sinclair	Chief Finance Officer, Herefordshire CCG	1 April 2019 – 31 March 2020
Trish Haines	Lay Member for Primary Care, Worcestershire CCGs	1 April 2019 - 31 March 2020
Prof Tamar Thompson OBE	Lay Member for Primary Care, Herefordshire CCG	1 April 2019 - 31 March 2020
Sarah Harvey Speck	Lay Member for Patient, Public Involvement and Quality, Worcestershire CCGs	1 April 2019 - 31 March 2020
Diane Jones MBE	Lay Member for PPI, Herefordshire CCG	1 April 2019 - 31 March 2020

The group has also formed a joint committee with the local authority – Worcestershire Integrated Commissioning Executive Officers Group.

The purpose of the joint committee is to:

- Progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents through
- Commission integrated services (in the context of the Joint Strategic Needs Assessment (JSNA), Health and Wellbeing Strategy (HWB), the Children and Young Peoples Plan and the Five Year Strategic Plan and other relevant strategic plans across the Council and CCGs)
- Ensure effectiveness, safety and improved experience of services commissioned under the section 75 agreement and section 256 agreements
- Work within the budgets delegated from partners' governing bodies
- The scheme of delegation of the governing bodies through the powers delegated to lead officers (the Director of Adult Services and Health, the Director of Children's Services and the CCG Accountable Officers

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG’s statutory duties

Risk management arrangements and effectiveness

The CCG actively encourage a risk aware organisational culture that is open and supportive, while ensuring robust accountability. Organisational culture and the behaviours of leaders play a vital role in the development of good governance, as highlighted by the Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). It is important that we promote and embed a culture of transparency, openness and honesty throughout the CCG to ensure risks are properly identified, evaluated, documented and managed. The CCG is committed to an approach which minimises risks wherever possible,

providing a robust framework that is underpinned by the concepts of effective governance and other systems of internal control enabling the identification and management of strategic and operational risks.

The three CCGs in Worcestershire (Redditch and Bromsgrove CCG, South Worcestershire CCG and Wyre Forest CCG) operate a shared corporate objectives framework, which reflects the common strategic challenges that the organisations face within the health economy. Similarly, a shared risk management process is adopted for both strategic and operational risks. These are managed through the following mechanisms:

- Countywide risk management strategy
- Consistent format of the Governing Body Assurance Framework with countywide objectives and risks
- Shared operational risk register

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 risk management strategy forms part of the control framework for the Worcestershire CCGs and defines the risk management processes of the whole organisation. It is reviewed at scheduled intervals and sets out the responsibilities and common methodologies for the assessment and the management of risks identified at all levels of the organisation. The strategy sets out the Worcestershire CCGs approach to risk and the accountability arrangements including the responsibilities of the Governing Body and its sub-committees, clinical members, directors, contractors and individual employees. It defines the risk management process including risk identification, analysis and evaluation which will be undertaken to ensure delivery of the strategy and the capacity to handle risk across the organisation and its member practices.

The strategy defines the risk scoring matrix which is used for all risks, both clinical and non-clinical, incidents and complaints within the organisation. The strategy outlines the elements of the Assurance Framework and the process for maintaining and monitoring it. New risks identified for inclusion on the risk register or Board Assurance Framework are assessed for likelihood and severity using a 5 x 5 risk matrix in accordance with the risk management strategy.

Using this matrix, both target and projected risk scores are identified. Target risk scores represent the aspirational outcome that the organisation wishes to achieve should all mitigating actions be successfully implemented, whilst projected risk score are used in-year to reflect the likely year end position. Any gaps between target and projected risk scores will inform the basis of analysis and any recovery actions that are identified.

The risk management process observes the following principles:

- A culture where risk management is considered an essential and positive element in the provision of healthcare

- Risk reduction and quality improvement should be seen as integral and part of routine activities
- Risk management often works within a statutory framework which cannot be ignored
- A risk management approach should provide a supportive structure for those involved in adverse incidents or errors by enabling a no-blame culture
- Managing risk is both a collective and an individual responsibility
- Every organisation should strive to understand the causes of risk, and the importance of addressing issues
- Where organisations commission services on the CCG's behalf, for example the Worcestershire County Council's Integrated Commissioning Unit, the CCG must be sighted on any risks connected to the commissioning activity and record them as appropriate in line with this strategy.

Risks can be identified by anybody, anywhere and risk identification is an integral part of CCG's everyday activities. Some specific ways of identifying risks include:

- Horizon scanning
- Formal risks assessment exercise (for example health & safety)
- Lessons learnt following an incident or a complaint
- Discussion at a Governing Body / Committee Level
- Completing / reviewing a Project Business Case
- Performance discussions with providers.

Strategic risks are managed through the Governing Body Assurance Framework (GBAF) process. GBAF provides a structured approach to management of strategic risks that, if not managed appropriately, could compromise the achievement of the organisational objectives. These risks are assigned to Executive Leads and are proactively managed by individual committees, whereby committees will receive tailored extracts of the assurance framework which fall within their remit. The Audit Committee seeks assurance regarding the Assurance Framework and scrutinising controls and assurances which are in place to mitigate strategic risks. The Governing Body has an overarching responsibility for monitoring risks contained within the GBAF.

Operational risks are recorded on the shared Worcestershire Risk Register, which detail mitigating actions, controls and assurances. Each risk has an assigned executive lead, risk lead and lead committee responsible for review assigned. The lead committee receives full detail of all red rated risks (Risks scored 15 or above in line with the 5x5 matrix), whilst responsibility for the management of all moderate and low rated risk is devolved to committee level; which ensures that risk management is embedded at each layer of the organisation. However, the lead committee is notified of any changes in risk score, new risks opened and closed, irrespective of the risk score.

It is noted that information which informs the CCG's risk management processes is often drawn from various partner organisations, including the main secondary care provider. The CCG's Quality and Business Intelligence Teams have robust processes in place to assess the quality and timeliness of data that is received. Should any lack of assurance exist, this is escalated accordingly and, where appropriate, documented as a data quality risk on the CCG's Risk Register.

Additionally, risk management training was delivered to a number of teams, which provided an overview of the processes for the identification, recording, monitoring and management of both strategic and operational risks.

Risk Assessment

The key strategic risks to delivery of the strategic objectives for the CCG during 2019/20 were:

- **DUE** to sustained Emergency Department (ED) pressures and the A&E Delivery Board workplan actions being delayed and potentially not having the required impact, **THEN** there will be a consistent failure to achieve the 4 hour Emergency Access standard **RESULTING** in a lack of assurance of the impact of ED pressures upon patient safety and experience and continued poor performance
- **DUE** to the agreed cancer recovery actions potentially failing to deliver the required improvements **THEN** the 62-day cancer standard (85%) will not be achieved **RESULTING** in delayed patient treatment
- **DUE** to the CCG recovery delivery plan not producing the desired outcomes **THEN** there will be an inability to achieve the dementia diagnosis rates **RESULTING** in a continued gap between dementia prevalence and diagnosis
- **DUE** to providers potentially being unable to retain/recruit the required workforce **THEN** the necessary workforce expansion will not take place **RESULTING** in an inability to deliver against a number of mental health performance standards
- **DUE** to workforce concerns, access to diagnostics and poor performance against Sentinel Stroke National Audit Programme (SSNAP) indicators **THEN** there is a lack of assurance regarding the effectiveness of the stroke pathway **RESULTING** in a potentially adverse impact upon patient outcomes
- **DUE** to the impact of delays in Referral to Treatment (RTT) performance **THEN** there is a lack of assurance for commissioned services **RESULTING** in longer waits for patients and potentially adverse impacts on patient safety and experience
- **DUE** to potentially insufficient workforce resource within maternity and neonatal services **THEN** the required transformational change will not be delivered **RESULTING** in an inability to successfully implement plans and achieve performance standards
- **DUE** to potential inter-agency disputes around CHC patient eligibility **THEN** this may impact upon timely eligibility decisions **RESULTING** in potential delayed transfers of care, retention of workforce and achievement of financial efficiencies
- **DUE** to reliance on workforce resource and collaboration across statutory partners for the delivery of learning disabilities care **THEN** it will adversely impact upon the ability to develop a new framework of independent community providers **RESULTING** in the required range of support services not being delivered, thereby impeding delivery of the Transforming Care Partnership (TCP) and admission avoidance across the health and social care footprint
- **DUE** to clinicians not adhering to local prescribing guidance **THEN** inappropriate items may be prescribed **RESULTING** in an inability to meet the national Anti-Microbial Stewardship (AMS) indicators and an increase in unwarranted variation

- **DUE** to willingness and capacity of key partners to engage and share information across shadow integrated care systems **THEN** there could be potential failure to achieve required alignment **RESULTING** in an adverse impact upon the CCGs ability to achieve the year end outcomes
- **DUE** to a lack of clinical and strategic consensus in respect of the Clinical Sustainability Strategy **THEN** there could be difficulties in agreeing the baseline clinical assessment and priority areas for service development **RESULTING** in progress being impeded
- **DUE** to presently misaligned incentives across the system **THEN** there may be a lack of shared understanding regarding the proposed clinical model and benefits of engagement for all partners **RESULTING** in lack of consensus across partners
- **DUE** to potential non achievement of a number of key GP recruitment and training initiatives **THEN** there may be a lack of shared understanding regarding the proposed clinical model and benefits of engagement for all partners **RESULTING** in lack of consensus across partners and an inability to implement new models of working
- **DUE** to the financial recovery workstreams not delivering the required profile of savings **THEN** there may be extremely limited scope for mitigations and financial headroom **RESULTING** in potential deterioration of the financial position and underlying surplus

For each strategic risk, it is ensured that adequate controls, actions and assurances are in place to effectively mitigate the risks identified. Where appropriate, these are agreed with local partners within the health economy and jointly monitored. The progress and impact of actions are reported to the Governing Body through bi-monthly updates which captures detail from reports submitted to Quality Performance and Resources Committee, Clinical Executive and Primary Care Commissioning Committees.

The Audit Committee reviews the adequacy of the Board Assurance Framework bi-monthly at each meeting and also receives reports from each committee chair, which summarise the salient points relating to the review of the quarterly milestones and strategic risks.

Other sources of assurance

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

An annual internal audit review has been undertaken, for which the CCGs have been provided with significant assurance.

Data Quality

Through regular reviews of Governing Body and committee effectiveness, the quality of the data used is assessed and has been found to be acceptable.

It is, however, acknowledged that there are data quality issues from provider organisations, which has been captured on the risk register and is being managed appropriately

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively

Due to the COVID-19 outbreak the IG Toolkit submission was extended to 30 September 2020. However, this created an issue for CCGs who were due to merge in April 2020 as they were required by NHS Digital to still publish the IG Toolkit by the end of the financial year and agree an improvement plan going forward.

In accordance with the NHS Digital process, the CCG's IG Toolkit was submitted as standard as standards not fully met – improvement agreed.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have a suite of policies to support staff in their roles and with their responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. The Information Governance and Data Security and Protection Policies and the Risk Management Strategy set out how information and data risks are assessed managed and controlled. This consists of proactive risk assessments on key information assets, investigation of information related incidents and review of information related complaints.

Information governance aims to support the delivery of high quality care by promoting the effective and appropriate use of information. The Information Governance Assurance framework is formed by those elements of law and policy from which applicable IG standards are derived, and the activities and roles which individually and collectively ensure that these standards are clearly defined and met.

There have been no reportable breaches involving personal data reported to the Information Commissioner's Office (ICO) in 2019/20.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, the CCG has an appropriate framework and environment is in place to provide quality assurance of business critical models. A policy exists to ensure that changes, initiated as a consequence of commissioning decisions made by the CCGs of Worcestershire, are fully assessed for their impact on quality. Impact assessment must consider the positive impact expected on healthcare quality, ensure that any known or expected negative impact on quality is robustly assessed and understood and ensure that any potential unintended negative consequences are identified and sufficiently mitigated.

The CCGs operate a centralised project management system which ensures that all projects are subject to a consistent and rigorous process of analysis, thereby ensuring that appropriate quality assurance can be obtained.

Third party assurances

During 2019/20, the CCG commissioned the following services from the Midlands and Lancashire Commissioning Support Unit (CSU):

- Business intelligence
- Procurement
- Information Technology
- Workforce Data
- Corporate Services (Equality and Inclusion, Information Governance and Freedom of Information).

The CCG has a service level agreement in place with the CSU and manages the performance of the individual services on a monthly basis.

Control Issues

The CCG has identified the following control issues and key mitigating actions:

- **Delivery of Control Totals and QIPP Target**
    - Full PbR (Payment by Results) contract in place overseen through Contract Management Board and internal CCGs Committees.
    - Identification of QIPP opportunities aligned to provider CIPS (Cost Improvement Plans) to reflect over-arching strategy of taking costs out as a Health Economy rather than as individual organisations.
    - System ICS (Integrated Care System) Executive Forum and ICS Finance Forum provide oversight of system financial position, challenges and risks.
    - Full financial risk share agreed across the Worcestershire CCGs.
    - Dedicated, senior Financial Sustainability Director engaged across Worcestershire CCGs.
    - Delivery of an FRP (Financial Recovery Plan) which sets out the actions to be taken to achieve a balanced position during 19/20, and the further actions necessary to address the underlying deficit at the 19/20 exit point.
    - FRB (Financial Recovery Board) established and meeting monthly, which provides executive oversight of the process. Extra-ordinary FRB meetings scheduled in between FRB meetings as required – to seek further assurance on high risk areas, review exceptions and agree recovery actions.
    - Detailed Deep Dive Confirm and Challenge Sessions undertaken for programme areas of concern, largely in the area of demand management schemes, with the purpose of outlining the status of the overall programme, providing updates on each of the core schemes including progress against milestones, enabling detailed interrogation of plans and confirmation of the gross and risk adjusted position and additional actions required.
    - Further reviews of capacity and capability undertaken to ensure the necessary resource is in place and that delivery is at the requisite scale and pace, as well as strengthening reporting arrangements for FRB.
    - Weekly position update reviewed at the CCGs Executive Leadership Team.

- **Urgent Care and Patient Flow**
    - Continued implementation of the AEDB (A&E Delivery Board Improvement Plan), overseen through the A&E Delivery Board which meets monthly. Recent implementation of a System Improvement Board chaired by the CCGs Accountable Officer, with enhanced 30/60/90 day implementation across plans.
    - Worcestershire System Senior Ops Leads meet fortnightly to analyse performance and delivery of the AEDB Plan. Escalation of issues to COOs (Chief Operating Officers) as necessary.
    - Additional measures aimed at improving operational performance are the staging of several MADE (Multiagency Accelerated Discharge) events.
    - Appointment of a dedicated Director of Capacity and Flow for Worcestershire Acute Trust.

- Front door and GP streaming specifications agreed with WAHT - Commitment provided that the system will start to see improved levels of streaming.
- New 111 provider, West Midlands Ambulance Service, appointed from November 2019, with a focus upon reducing ambulance dispositions.
- A Demand and Capacity plan has been produced which demonstrates the internal and external interventions required to reduce handover delays and eliminate corridor care. All organisations have signed up to deliver against this plan. Capacity analysis shows a further demand and shortfall of beds. 33 beds opening in February 2020.
- Enhanced NHSI support.
- Pathway optimisation for discharges, working closely with all system partners. Enhancing capacity in pathway 1 to 110 discharges per week
- During the COVID19 outbreak, the system witnessed a 30% reduction in ED based activity, some of this reduction would be as a result of normal patient behaviour but other reductions would have been through patients accessing pre-ED care and also the recognition that they could self-care through various forms, such as pharmacies. it is incumbent on the system to learn lessons from this pattern of behaviour and not simply see a return to high levels of potentially inappropriate ED attendances. This will form a key strand of work as the system returns to normal operational business.
- ED and Discharge Management processes were also substantially enhanced during COVID 19 result in quicker ED throughput, speciality referral and EAS performance. From a Discharge Management perspective, processes were introduced which significantly reduced the wait for DTA pathways. Such measures are key transformational steps for the system and significant focus will be on maintaining these post – COVID 19.

- **Delivery of RTT Standard**
  - The RTT recovery plan is reviewed monthly by Elective Care Executive, to ensure delivery.
  - Weekly micromanagement of waiting lists - with every patient at 38 weeks being monitored weekly to reduce risk of breaches. Monitored via internal performance management and via system Elective Care Board in Worcestershire.
  - With the exception of Pain Management, Urology, Gynaecology and Oral Surgery all other specialties expected to meet target of zero breaches over 40 weeks.
  - An agreed elective care transformation plan in place with four key priorities focussing on alternative pathways within; Ophthalmology, Dermatology, MSK and outpatient follow-ups.
  - WAHT have developed a Diagnostics Action Plan, which is subject to regular review. Diagnostics performance improvements noted over Q2 and into Q3.
  - Demand and Capacity analysis including backlog and waiting list information reviewed and monitored on ongoing basis by divisions with support.
  - External capacity has been agreed to support Orthodontics, Urology, Ophthalmology and Endoscopy using Sub-Contracting arrangements with local Independent Sector providers.

- Ongoing work to recruit to both Consultant and Nurse vacancies.

- **Delivery of Cancer 2 Weeks Wait and 62 Day Standard**
  - Worcestershire Elective and Cancer Executive is a monthly forum through which CCGs and Acute Trust review performance issues.
  - New 2 Week Wait referral form was issued in July 2019 with mandated fields to ensure patients arrive with up to date information / test results to minimise delays whilst within the acute setting.
  - New triage process commenced in Urology to confirm whether patient is suitable for straight to test/investigation/outpatient appointment.
  - Delays in histology reporting have been discussed with view to reducing turnaround time for suspected cancer to seven days.
  - Clinical review of pathways and realignment of skill mix to better manage capacity in Dermatology.
  - Additional resource identified through 2019/20 transformation funding for Patient Trackers to monitor patients progress through a cancer pathway.
  - Any patient at risk of breaching 104 days will have a plan, reviewed daily and followed up accordingly. Failure to comply with actions will be escalated for monitoring at weekly Performance Management Group.
  - Harm review process in place for all patients treated post 104 day wait, with review by the Cancer Team and reported to Cancer Alliance Board.
  - Trust undertaking audit on use of the new referral form at practice level, which will feedback to the CCGs.
  - Consultants to join daily Cancer Team call and escalate concerns/delays (particularly tertiary centre issues) and have been approached to undertake waiting list initiatives.
  - Ongoing work to recruit to both Consultant and Nurse vacancies.

- **Delivery of Dementia Diagnosis Rates**
  - System-wide sign up to local Herefordshire & Worcestershire Dementia Strategy, with good level of voluntary/community sector and patient groups involvement.
  - DAST (Dementia Assessment Support Team) triage list is now cleared (down from four weeks), service now able to triage on the day of referral.
  - DAST waits from referral to diagnosis are now down to 8 weeks.
  - DAST expansion has been undertaken and induction of all new staff complete.
  - Number of referrals has increased and are more appropriate, which increases the number requiring diagnostic clinic appointments.
  - Advanced Nurse Practitioner staff are in training and likely to see the benefit of these posts by September 2020 when they will be running clinics. Will therefore be less reliant on doctors for all diagnoses.
  - Support for primary care to diagnose moderate/late stage dementia. Collaborative protocols between Community Hospitals and DAST services being developed with ICOPE (Integrated Care for Older People) programme, along with a rollout programme

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

Review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. It is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.
The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control includes committees reviewing their work plans and responsibilities against the annual work plan and allocated areas of responsibility. The Audit Committee receive assurance on committee effectiveness and the Board Assurance Framework.
NHS Shared Business Services (NHS SBS) provides finance and accounting services to the CCG. In order to provide users of these services with greater assurance about the quality of the NHS SBS's control environment, the Directors of NHS SBS have engaged PricewaterhouseCoopersLLP (PWC) to review the controls of NHS SBS. The CCG is aware that PWC were unable to complete all their testing relating to SBS and this forms part of their qualified opinion. However, we do not believe as a result of this limitation of scope that this poses a risk to the CCG or will impact upon the economy, efficiency and effectiveness of its resources.

Delegation of Functions

The CCG has a number of functions which are provided through commissioning support units and other providers. The Associate Director of Corporate Services assumes overarching responsibility for the sound delivery of the functions, with the workstream leads requested to provide monthly scores on the effectiveness of service delivery. This is kept under review and features as part of the regular meetings between the Associate Director of Corporate Services and the commissioning support unit Accounts Lead. Each of the functions would be subject to review and oversight by the relevant Governing Body committee, as detailed within the committee's terms of reference. Each Governing Body committee reports into Governing Body via a highlight report/submission of minutes, which would include any risks to delivery by exception, any evidence of internal control failures; and commentary by committee chairs/CCG directors. The internal audit programme is agreed at the Audit Committee and is designed to encompass all key CCG functions, with insights drawn from the Governing Body Assurance Framework as required. This will provide further assurance on the arrangements for delegated services and functions within the CCG.

Counter Fraud arrangements

The CCGs continue to be committed to the elimination of any form of fraud, bribery or corruption, and to adhere to the NHS Counter Fraud Standards. The Chief Finance Officer (CFO) maintains responsibility for overseeing counter fraud work. The CCGs contracts the services of CW Audit Services to provide counter fraud services. The nominated Counter Fraud Specialist (CFS), is a fully accredited Professional CFS, and registered with NHS Counter Fraud Authority. The CFS is contracted to undertake counter fraud work proportionate to identified risks, the role is also to raise awareness, promote the counter fraud, bribery and corruption culture and investigate allegations.

The CFS attends CCG's Audit Committee and provides detailed progress reports for scrutiny.

This year the emphasis has continued to be on raising staff awareness on Fraud, Bribery and Corruption, to this end the CFS has continued to provide directed awareness sessions to all staffing groups, including GP Practice managers and staff. The CFS has also visited GP Practices to give advice specifically around the security of prescription forms, and then share good practice with all. The CFS has produced and distributed quarterly counter fraud newsletters. Fraud alerts have also been issued by the CFS as required to ensure the CCGs are aware of current local and national fraud risks. The CFS has worked with the CCGs to ensure all new policies or in the case of any significant changes to existing policies have adequate counter fraud measures included. A staff awareness survey was also distributed to CCGs staff following an awareness session, the purpose of the questions was to measure the level of awareness within the CCGs of the relevant policies in place to help combat fraud bribery and corruption, along with questions around knowledge of the counter fraud service.

Again this year in accordance with standard 1.4 of the NHS Counter Fraud Standards for Commissioners 2021, a comprehensive risk assessment has been completed in 2019/20 to identify fraud, bribery and corruption risks. The CFS considers risks identified from historical work, national cases and NHS CFA data, with assistance from the CCGs, risks have been recorded in line with the CCGs risk management policy and included on the appropriate risk register. The risk assessment was then used to create a risk based annual work plan and to direct proactive fraud resources towards relevant 'at risk' organisational areas and activities. Progress will be monitored and results fed back to audit committee.

Prevention arrangements are a key part of an organisation's defence against fraud, bribery or corruption. Therefore, deterring and preventing dishonesty is a key component in combating internal or external fraud, bribery and corruption**.**

Head of Internal Audit Opinion

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

Roles and responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;

- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HOIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit & Governance Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

Limitations inherent to the internal auditor's work

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of a risk-based plan generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

The Opinion

The purpose of my draft annual Head of Internal Audit Opinion (HOIA) is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This HOIA informs the Governing Body in the completion of its Annual Governance Statement.

My overall opinion is that:

Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

The **basis** for forming my opinion is as follows:

1. An initial assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the current range of individual opinions arising from risk based audit assignments, contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.
3. Any reliance that is being placed upon third party assurances.

The **commentary** below provides the context for my opinion and together with the Opinion should be read in its entirety.

The design and operation of the Assurance Framework and associated processes

I have reviewed the overall arrangements the Governing Body has in place to conduct its review of the system of internal control. This has entailed reviewing the way in which the Governing Body has identified the principal risks to achieving its objectives, the identification of controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these risks are being effectively managed. I have approached this by examining the Assurance Framework documents that you have in place and also by giving consideration to the wider reporting to the Governing Body that informs its assessment of the effectiveness of the organisation's system of internal control.

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2019/20 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The system of internal control based on internal audit work undertaken

My Opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. An internal audit plan for 2019/20 was developed to provide you with independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this our internal audit plan was divided into two broad categories; work on the financial systems that underpin your financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that you had identified in your Assurance Framework. I am satisfied that we have completed sufficient work during the course of the year to provide my Head of Internal Audit Opinion.

The assurance levels provided for all assurance reviews undertaken is summarised below:

Area of Audit	Level of Assurance Given
Financial systems	Significant assurance
Budget Setting & QIPP Planning	Significant assurance
QIPP Performance	Significant assurance
Financial & QIPP Delivery	Significant assurance
Conflicts of Interest	Significant assurance
GBAF Interim review	Significant assurance
Performance Management	Significant assurance
Primary Care Commissioning	Significant assurance
Continuing Healthcare (CHC)	Significant assurance

Following up of actions arising from our work

For all reviews we have agreed action plans with management and will continue to monitor the implementation of these plans over the coming months. Outstanding actions are reported at each meeting of the Audit Committee and they take a proactive approach to monitoring them and requesting follow up audit work where there are areas of concern.

All recommendations and agreed actions are uploaded to a central web-based database as and when reports are finalised. Management are then required to update the status against agreed actions. This is a self-assessment and is supplemented by our independent follow-up reviews where this is deemed necessary (for example, following the issue of a limited or moderate assurance report). The status of agreed actions as at 13th March 2020 is shown below:

Summary	1 Critical	2 High	3 Medium	4 Low	Total
Due by (13/03/20)	0	0	5	1	6
In progress but not completed	0	0	3	0	3
Outstanding (not yet started)	0	0	2	1	3

Reliance on third party assurances

In arriving at my overall opinion I have sought to place reliance on third party assurances where appropriate.

The NHS SBS service auditor report for the period 1st April 2019 to 31st March 2020 was received and reviewed. The report provides a qualified opinion. Following this review, we can confirm that there are no issues or concerns we wish to highlight within this opinion.

Kristina Woodward
Assistant Director of Audit
CW Audit Services
Kingston House
438-450 High Street
West Bromwich
B70 9LD

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 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 is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion

There have been no significant control issues identified in 2019/20. There have been no serious lapses in internal control including information governance or conflict of interest breaches.

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24th June 2020

Remuneration Report

Remuneration Policy

We have established a Remuneration Committee in line with our constitution, standing orders and scheme of delegation. The purpose of the committee is to make recommendations to our Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group; and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

The following Governing Body members are members of the committee:

- Rob Parker | Lay Member for Audit and Governance (Chair)
- Martin Lee | Secondary Care Doctor
- Dr Richard Davies | RBCCG Chair

Other individuals such as the Accountable Officer, Chief Operating Officer and any HR lead and external advisers are sometimes invited to attend for all - or part of - any meeting as and when appropriate. However, they do not remain in attendance for discussions about their own remuneration and terms of service.

The main responsibilities of the Remuneration Committee are to:

- Recommend to the Governing Body the remuneration of GP and Lay Governing Body members
- Recommend to the Governing Body the remuneration and conditions of service of the Accountable Officer and senior team
- Review the performance of the Accountable Officer and other senior team members and recommending annual salary awards, if appropriate
- Recommend to the Governing Body the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms excluding ill health and normal retirement for all employees
- Consider the severance payments of the Accountable Officer and other senior staff, and recommend seeking HM Treasury approval as appropriate in accordance with the guidance ‘Managing Public Money’
- Identify and nominate the approval of the Governing Body candidates to fill non-member practice places on the Governing Body.

Senior manager remuneration

The tables on the following pages set out the remuneration and pension benefits for our senior managers in 2018/19 and 2019/20.

Salaries and allowances (2019/20)(Subject to Audit)

Name	Salary (bands of £5000)	Expense Payments (taxable) to nearest £100	Performance pay & bonuses (bands of £5000)	Long term performance pay & bonuses	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5000)	Total Salary of shared staff (bands of £5000)
	£	£	£	£	£	£	£000
Louise Bramble	-	-	-	-	-	-	-
Tristan Brodie	5-10	-	-	-	0-2.5	10-15	30-35
Adam Cole	-	-	-	-	-	-	-
Lynda Dando *	20-25	1,500	0-5	-	2.5-5	25-30	105-110
Richard Davies	70-75	-	-	-	22.5-25	95-100	-
Mark Dutton *	25-30	1,900	0-5	-	5-7.5	35-40	130-135
Carl Ellson	40-45	-	-	-	-	40-45	135-140
David Farmer	-	-	-	-	-	-	-
Mari Gay	35-40	-	0-5	-	2.5-5	40-45	120-125
Trish Haines	0-5	-	-	-	-	0-5	15-20
Sarah Harvey-Speck	0-5	-	-	-	-	0-5	15-20
George Henry	15-20	-	-	-	5-7.5	20-25	60-65
Rupen Kulkarni	-	-	-	-	-	-	-
Jonathan Leach	30-35	-	-	-	12.5-15	45-50	110-115
Martin Lee *	5-10	-	-	-	-	5-10	35-40
Ruth Lemiech	25-30	-	-	-	7.5-10	35-40	90-95
Lisa Levy *	20-25	1,000	0-5	-	2.5-5	25-30	100-105
Fred Mumford	0-5	-	-	-	-	0-5	15-20
Lucy Noon **	25-30	-	-	-	0-2.5	25-30	90-95
Robert Oliver	0-5	-	-	-	-	0-5	15-20
Rob Parker	5-10	-	-	-	-	5-10	20-25
Scott Parker *	15-20	-	-	-	35-37.5	50-55	85-90
Moheb Shalaby	-	-	-	-	-	-	-
Simon Trickett *	30-35	2,200	0-5	-	0-2.5	35-40	160-165

All salaries, excluding the chairs, are split across Redditch and Bromsgrove, Wyre Forest and South Worcestershire CCGs.
Expense Payments (taxable) relate to car allowances
*Salaries are also shared with Herefordshire CCG
**Salary payment includes payments under the mutually agreed redundancy scheme (MARS)

The Chair costs are 100% attributed to this CCG. The following salary costs are split with NHS Herefordshire CCG: L Dando (25%), M Dutton (25%), M Lee (20%), L Levy (25%), S Parker (25%) and S Trickett (25%).The remainder of their costs are split across NHS South Worcestershire CCG (50%), NHS Redditch & Bromsgrove CCG (30%) and NHS Wyre Forest CCG (20%).

Salaries and allowances (2018/19) (Subject to Audit)

In 2018/19 all executive posts were split across NHS South Worcestershire CCG (50%), NHS Redditch and Bromsgrove CCG (30%) and NHS Wyre Forest CCG (20%).

Name	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Total salary of shared staff (bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000
Louise Bramble	10-15	-	-	-	0-2.5	0-5	45-50
Tristan Brodie	5-10	-	-	-	5-7.5	10-15	20-25
Adam Cole	0-5	-	-	-	-	0-5	0-5
Lynda Dando	25-30		0-5		10-12.5	40-45	95-100
Richard Davies	70-75	-	-	-	40-42.5	115-120	-
Mark Dutton	30-35		0-5		5-7.5	40-45	115-120
Carl Ellson	40-45	-	-	-	-	40-45	135-140
David Farmer	0-5	-	-	-	0-2.5	0-5	15-20
Mari Gay	30-35		0-5		0-2.5	30-35	115-120
Sarah Harvey-Speck	0-5	-	-	-	-	0-5	15-20
Trish Haines	0-5	-	-	-	-	0-5	15-20
George Henry	15-20	-	-	-	5-7.5	25-30	60-65
Rupen Kulkarni	0-5	-	-	-	0-2.5	0-5	5-10
Jonathan Leach	30-35	-	-	-	17.5-20	50-55	110-115
Martin Lee	5-10	-	-	-	-	5-10	30-35
Ruth Lemiech	25-30	-	-	-	15-17.5	40-45	90-95
Lisa Levy	25-30		0-5		2.5-5	30-35	95-100
Fred Mumford	0-5	-	-	-	-	0-5	15-20
Lucy Noon	25-30	-	-	-	0-2.5	25-30	85-90
Robert Oliver	0-5	-	-	-	-	0-5	5-10
Rob Parker	5-10	-	-	-	-	5-10	20-25
Simon Trickett	30-35	-	0-5	-	7.5-10	40-45	145-150

All senior managers excluding Dr Richard Davies are shared across the three Worcestershire CCGs. In addition, Simon Trickett is also shared with NHS Herefordshire CCG (25% paid by Herefordshire CCG).

Pension benefits (2019/20)(Subject to Audit)

Name	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash equivalent transfer value at 31 March 2020	Cash equivalent transfer value at 1 April 2019	Real increase in cash equivalent transfer value
	£000	£000	£000	£000	£000	£000	£000
Tristan Brodie	0-2.5	0-2.5	10-15	35-40	201	190	2
Lynda Dando **	0-2.5	2.5-5	25-30	85-90	0	685	0
Richard Davies	0-2.5	0-2.5	20-25	40-45	348	314	16
Mark Dutton	0-2.5	0-2.5	30-35	70-75	496	454	16
Mari Gay	0-2.5	2.5-5	50-55	155-160	1,121	1,043	36
George Henry	0-2.5	0-2.5	10-15	25-30	265	235	14
Jonathan Leach	2.5-5	*	20-25	*	372	306	42
Ruth Lemiech	0-2.5	0-2.5	20-25	45-50	354	317	17
Lisa Levy	0-2.5	2.5-5	35-40	110-115	775	718	27
Lucy Noon	0-2.5	0-2.5	25-30	85-90	635	682	0
Scott Parker	7.5-10	*	5-10	*	83	0	71
Simon Trickett	0	0-2.5	45-50	0-5	608	0	607

**Member is over NRA, therefore a 2020 CETV calculation is not applicable
*No lump sum applicable as Section 2008 Member

Pension benefits (2018/19)(Subject to Audit)

Name	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 1 April 2018	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Louise Bramble	0-2.5	0-2.5	10-15	25-30	164	170	0
Tristan Brodie	0-2.5	2.5-5	10-15	40-45	226	172	46
Lynda Dando	0-2.5	5-7.5	25-30	80-85	685	565	91
Richard Davies	2.5-5	0-2.5	15-20	40-45	314	239	57
Mark Dutton	0-2.5	0-2.5	30-35	65-70	454	360	68
David Farmer	0-2.5	0-2.5	0-5	10-15	80	72	4
Mari Gay	0-2.5	0-2.5	45-50	145-150	1,043	898	102
George Henry	0-2.5	0-2.5	10-15	25-30	235	187	33
Rupen Kulkarni	0-2.5	0-2.5	20-25	70-75	531	490	25
Jonathan Leach	2.5-5	*	15-20	*	306	216	67
Ruth Lemiech	2.5-5	2.5-5	20-25	40-45	317	231	67
Lisa Levy	0-2.5	2.5-5	35-40	105-110	718	603	85
Lucy Noon	0-2.5	0-2.5	30-35	95-100	682	585	67
Simon Trickett	2.5-5	*	50-55	*	606	477	102

*No lump sum applicable as Section 2008 Member

NHS Pensions are using pension and lump sum date from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud Judgement.

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.

During the year, the Government announced that public sector pension schemes will be required to provide the same indexation in payment on part of a public service scheme pensions known as the Guaranteed Minimum Pension (GMP) as applied to the remainder of the pension i.e. the non GMP. Previously the GMP did not receive full indexation. This means that with effect from August 2019 the method used by NHS Pensions to calculate CETV values was updated. So the method in force at 31 March 2020 is different to the method used to calculate the value at 31 March 2019. The real increase in CETV will therefore be impacted (and will in effect include any increase in CETV due to the change in GMP methodology)

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 effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Losses and special payments (Subject to Audit)

There was one loss and no special payment cases in 2019/20.

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

	Total Number of Cases	**Total Number of Cases**	**Total Number of Cases**	**Total Number of Cases**
	2019-20	**2019-20**	**2018-19**	**2018-19**
	Number	**£'000**	**Number**	**£'000**
Administrative write-offs	-	-	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	--	-	-	-
Cash losses	1	0	-	-
Claims abandoned	-	-	-	-
Total	1	0	-	-

Pay multiples (Subject to Audit)

The table below demonstrates the relationship between the remuneration of the highest-paid member of the Clinical Commissioning Group and the median remuneration of the workforce:

	2019-20	2018-19
Banded remuneration range of the highest paid member	£145,000 - £150,000	£140,000 - £145,000
Mid-point of the banded annualised remuneration of the highest paid member	147,500	142,500
Median of the annualised remuneration of workforce	37,570	36,644
Pay multiple (ratio of highest paid member to median workforce)	3.93	3.89
Range of annualised staff remuneration excluding the highest paid member	£4,344 - £144,304	£2,200 - £144,304

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

The banded remuneration of the highest paid director/member in Redditch and Bromsgrove CCG in the financial year 2019/20 was £145,000 - £150,000 (2018/19 £140,000 - 145,000). This was 3.93 times (2018/19 3.89) the median remuneration of the workforce, which was £37.750 (2018/19 £36,644).

In 2019/20 (2018/19 no employee) no employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £145,000 to £150,000 (2018/19 £140,000 to £145,000).

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.

Non-disclosure of information

No disclosures have been omitted under GDPR Article 21.

Staff Report

Staff numbers and costs

Staff composition

The total breakdown of people employed by NHS Redditch and Bromsgrove CCG (based on 31 March 2020) is as follows:

Staff Grouping	Female		Male		Total
	Headcount	%	Headcount	%	
Governing Body	5	35.7%	9	64.3%	**14**
Other Senior Management (Band 8C+)	9	69.2%	4	30.8%	**13**
All Other Employees	35	77.8%	10	22.2%	**45**
Total	**49**	**68.06%**	**23**	**31.94%**	**72**

The workforce analysis by Band (based on 31 March 2020) is as follows:

Pay Band	Headcount	Pay Band	Headcount
Apprentice	0	Band 8A	9
Band 1	0	Band 8B	9
Band 2	0	Band 8C	6
Band 3	2	Band 8D	1
Band 4	1	Band 9	0
Band 5	4	Medical	10
Band 6	6	VSM	10
Band 7	14	Gov Body (off payroll)	0

The workforce analysis by Function (based on 31 March 2020 for the combined staff of Redditch and Bromsgrove CCG and Wyre Forest CCG) is as follows:

Staff category	Permanent Staff	Other Staff	Total Staff
Administration and Estates	44	3	47
Medical and Dental	-	12	12
Nursing, Midwifery and Health Visiting	6	1	7
Other	-	-	0
Scientific, Therapeutic and Technical	-	-	0
Total	**50**	**16**	**66**

Staff costs (2019/20)(Subject to Audit)

Employee Benefits	Permanent employees			Other		
	Admin	Programme	Total	Admin	Programme	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	1,742	586	2,328	15	12	28
Social security costs	183	63	246	0	0	0
Employer contributions to the NHS Pension Scheme	365	74	439	0	0	0
Apprenticeship Levy	4	0	4	0	0	0
Gross employee benefits expenditure	**2,324**	**723**	3,047	**15**	**12**	**28**
Total - Net admin employee benefits expenditure including capitalised costs	**2,324**	**723**	3,047	**15**	**12**	**28**
Net employee benefits excluding capitalised costs	**2,324**	**723**	3,047	**15**	**12**	**28**

Staff costs (2018/19)(Subject to Audit)

Employee Benefits	Permanent employees			Other		
	Admin	Programme	Total	Admin	Programme	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	1,593	529	2,122	54	42	96
Social security costs	172	58	231	0	0	0
Employer contributions to the NHS Pension Scheme	206	77	282	0	0	0
Apprenticeship Levy	4	0	4	0	0	0
Gross employee benefits expenditure	1,975	664	2,639	54	42	96
Total - Net admin employee benefits expenditure including capitalised costs	1,975	664	2,639	54	42	96
Net employee benefits excluding capitalised costs	1,975	664	2,639	54	42	96

Organisational Development

At the time of our formation the we developed a CCG-specific organisational development plan to set out the early developmental tasks necessary to create an effective CCG and support the workforce in delivering the organisational objectives.

Although we remain independent organisations with statutory duties to fulfil, we now work increasingly more closely with the other two Worcestershire CCGs to help meet some of the common challenges that we face. We have therefore this year developed a new joint organisational strategy which outlines the approach and actions required for us to move forward together in a truly collaborative manner while ensuring that we also remain fit for purpose.

We recognise that successful organisations ensure that all objectives and priorities are aligned to the corporate vision but they also have a clear and single set of values that defines “how things are done” and ‘how we behave.

As each of the CCGs are maintaining their own set of organisational values, one of our local priorities has been the development of a Behavioural Framework. This has been designed by staff to set a consistent culture for the CCGs in Worcestershire, with a set of shared behaviours that have been agreed by the CCG executives and the workforce. There are four pillars of our Behavioural Framework as set out below:

- Learning and Improvement
- Communication and Contribution
- Leadership and Management
- Well-being

While the Behavioural Framework provides a suitable framework for describing the OD priorities set out in our organisational strategy, they have also started to be used this year in supporting value-based recruitment as well as to inform staff appraisal discussions.

Sickness absence data

Proxy Working Days version (as per new guidance) **Redditch and Bromsgrove CCG / Wyre Forest CCG**		
FTE-Days Available	**FTE-Days Lost to Sickness Absence**	**Average working days lost**
12273.75	420.5	7.71

Our approach to the effective management of sickness absence includes:

- Developing the role of line and senior managers in their engagement with managing absence and the health and welfare of their staff
- Monitoring, measuring and understanding absence
- Managing sickness absence when it happens

- Tackling the underlying causes of absence
- Assessing any underlying causes of absence, especially where they might be improved through better organisation and job design
- Helping people to remain in work when they have health problems and facilitating their return to work following illness or injury (this can include making reasonable adjustments in line with our duty as an employer e.g. changes to duties, shifts or hours, changes to the place of work, allowing staged/phased return to work)
- Creating a working environment where people can be provided with the support and encouragement to take responsibility for improving their own health
- Supporting early intervention where applicable, such as occupational health services, counselling and confidential employee assistance support
- Applying HR / Health and Safety-related policies such as Health and Safety, Lone-working, Respect in the Workplace, Working Time and Stress Awareness policies

Staff policies

We consult and engage with our staff on key HR policy development. Each policy is developed in draft and then shared with staff for consideration at Staff Council. Policies are then ratified and signed off by our Clinical Executive Team before being circulated to staff and the senior management. We have a system of regularly refreshing our HR policies and ensure that we have appropriate policies in place to ensure equal opportunities for all. This includes the same development opportunities and training being offered to all staff without discrimination and recognises that adaptations we may need to make for some individuals to ensure access to training and development is the same across the organisation.

We have approved a range of policies to enable people with disabilities to work for us. People with disabilities who meet the minimum criteria for a job vacancy are guaranteed an interview. The adjustments that people with disabilities might require in order to take up a job or continue working in a job are proactively considered. All employees undertake mandatory equality and diversity training which includes awareness of a range of issues impacting on people with disabilities.

We offer equal opportunities for all members of our team and are committed to building a workforce whose diversity reflects the community we serve. We recognise the specific needs of individuals whether it is access to the CCG offices where we are based, time and space to pray privately or recognising individual needs when they attend for interview or on appointment.

Everyone who works for us is treated fairly and equally. Our contracts of employment reflect our values and job descriptions fit both the needs of the CCG and those who work for us regardless of age, disability, race, nationality, ethnic origin, gender, religion, beliefs, sexual orientation, domestic and social circumstance, employment status, HIV status, gender reassignment, political affiliation or trade union membership.

Trade Union Facility Time

Table 1: Relevant union officials

Number of employees who were relevant union officials during 2017/18	Full-time equivalent employee number
0	0

Table 2: Percentage of time spent on facility time

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

Table 3: Percentage of pay bill spent on facility time

Total cost of facility time	0
Total pay bill	0
% of the total pay bill spent on facility time	0

Table 4: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time	0

Expenditure on consultancy

During 2019/20 the following was spent on consultancy fees:

	2019/20	2018/19
	£'000	£'000
Consultancy expenditure	35	3

Off-payroll engagements (non-payroll expenditure)

Table 1: All off-payroll engagements as at 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	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	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

We can confirm that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax, and where necessary, that assurance has been sought.

Table 2 - All new off-payroll engagements, or those that reached six months in duration. between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months:

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

Table 3 - Off-payroll engagements of Governing Body members and/or senior officers with significant financial responsibility, between 1 April 2019 and 31 March 2020

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	24

Exit packages (Subject to Audit)

Listed below are the exit packages agreed in 2019/20.

	Other agreed departures	
	Number	**Bands of £5k**
Less than £10,000	4	10-15
£10,001 to £25,000	1	15-20

Analysis of Other Agreed Departures 2019/20.

	Other agreed departures			
	2019/20		**2018/19**	
	Number	**Bands of £5k**	**Number**	**Bands of £5k**
Mutually agreed resignations (MARS) contractual costs	5	25-30	-	-

Parliamentary Accountability and Audit Report

NHS Redditch and Bromsgrove 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 within the Financial Statements of this report.

An audit certificate and report is also included in this Annual Report at page 72.

Annual Accounts

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24th June 2020

Data entered below will be used throughout the workbook:

Entity name:	NHS Redditch and Bromsgrove Clinical Commissioning Group
This year	2019-20
Last year	2018-19
This year ended	31-March-2020
Last year ended	31-March-2019
This year commencing:	01-April-2019
Last year commencing:	01-April-2018

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The Primary Statements:

Notes to the Accounts

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

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(1,777)	(858)
Other operating income	2	(232)	(256)
Total operating income		**(2,009)**	**(1,114)**
Staff costs	3	3,074	2,735
Purchase of goods and services	4	248,977	235,105
Depreciation and impairment charges	4	39	39
Other Operating Expenditure	4	438	433
Total operating expenditure		**252,528**	**238,312**
Total Net Expenditure for the Financial Year		**250,519**	**237,198**
Comprehensive Expenditure for the year		**250,519**	**237,198**

The 2019/20 position includes the use of the Worcestershire financial risk share which was approved by the CCG Governing Body in March 2019
The CCG made a surplus of £0.021m

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Non-current assets:			
Property, plant and equipment	7	64	103
Total non-current assets		64	103
Current assets:			
Inventories	8	240	230
Trade and other receivables	9	10,785	8,359
Cash and cash equivalents	10	505	109
Total current assets		**11,530**	8,698
Total assets		**11,594**	8,801
Current liabilities			
Trade and other payables	11	(17,373)	(14,099)
Total current liabilities		**(17,373)**	(14,099)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(5,779)**	(5,298)
Financed by Taxpayers' Equity			
General fund		(5,779)	(5,298)
Total taxpayers' equity:		**(5,779)**	(5,298)

The notes on pages 7 to 22 form part of this statement

The financial statements on pages 3 to 6 were approved by the Governing Body on 24/06/2020 and signed on its behalf by:

Chief Accountable Officer
Simon Trickett

Statement of Changes In Taxpayers Equity for the year ended 31 March 2020

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20		
Balance at 01 April 2019	(5,298)	(5,298)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(5,298)**	**(5,298)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20		
Net operating expenditure for the financial year	(250,519)	(250,519)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(250,519)**	**(250,519)**
Net funding	**250,038**	**250,038**
Balance at 31 March 2020	**(5,779)**	**(5,779)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19		
Balance at 01 April 2018	(5,567)	(5,567)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(5,567)**	**(5,567)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19		
Net operating costs for the financial year	(237,198)	(237,198)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(237,198)**	**(237,198)**
Net funding	**237,467**	**237,467**
Balance at 31 March 2019	**(5,298)**	**(5,298)**

The notes on pages 7 to 22 form part of this statement

Statement of Cash Flows for the year ended 31 March 2020

	Note	**2019-20 £'000**	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(250,519)	(237,198)
Depreciation and amortisation	4	39	39
(Increase)/decrease in inventories	8	(10)	(2)
(Increase)/decrease in trade & other receivables	9	(2,426)	(375)
Increase/(decrease) in trade & other payables	11	3,274	143
Net Cash Inflow (Outflow) from Operating Activities		**(249,642)**	(237,393)
Net Cash Inflow (Outflow) before Financing		**(249,642)**	(237,393)
Cash Flows from Financing Activities			
Parliamentary Funding Received		250,038	237,467
Net Cash Inflow (Outflow) from Financing Activities		**250,038**	237,467
Net Increase (Decrease) in Cash & Cash Equivalents	10	**396**	74
Cash & Cash Equivalents at the Beginning of the Financial Year		**109**	35
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**505**	109

The notes on pages 7 to 22 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.
NHS Redditch and Bromsgrove CCG was dissolved on 31 March 2020 having joined with NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Herefordshire CCG to establish NHS Herefordshire and Worcestershire CCG with effect from 1 April 2020. This followed approval of the application at the NHS England and Improvement Regional Support Group - Midlands Region on 14 October 2019 and again on 24 February 2020 to confirm that conditions had been met.

The CCG has produced its accounts on a going concern basis; this is in line with the Department for Health Group Accounting Manual for 2019/20 which state that we are a going concern unless we have been informed that there is an intention for the CCG to be dissolved without the transfer of function to another entity. The Covid-19 national emergency situation that arose at the end of the financial period and remains ongoing brings a new set of circumstances for the CCG. As a result of this NHS planning processes have ceased, however the government has made a pledge to the country and the NHS:
The Chancellor of the Exchequer committed in Parliament last week that “Whatever extra resources our NHS needs to cope with coronavirus – it will get.” So financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.
We believe that this situation does not therefore lead to material uncertainty about the going concern of the CCG.

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 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.
A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.
A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.
The clinical commissioning group entered a pooled budget arrangement with Worcestershire County Council, NHS South Worcestershire CCG and NHS Wyre Forest CCG, in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the Worcestershire Better Care Fund and note 14 to the accounts provides details of the income and expenditure relating to this arrangement. The clinical commissioning group accounts for its share of the assets, liabilities, income, and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.4 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the 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 the cost of the training funded.

1.5 Revenue from NHSE Resource Allocation

The CCG receives annual revenue resource allocations from NHS England to fund net operating expenditure. Revenue resource allocations are accounted for by crediting the General Fund when the funding is drawn down to meet payments as they fall due. Resource allocations are not accrued as receivable.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

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

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

1.6.2 Retirement Benefit Costs

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

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

1.7 **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.

1.8 **Property, Plant & Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.8.2 **Measurement**

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

1.8.3 **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.

1.9 **Leases**

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

1.9.1 **The Clinical Commissioning Group as Lessee**

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

1.10 **Inventories**

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula.

1.11 **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.

1.12 **Provisions**

The clinical commissioning group has no provisions as at 31 March 2020
NHS England has a provision in its accounts relating to historical claims that were outstanding in respect of CCG patients as at the demise of the former Worcestershire Primary Care Trust

1.13 **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.

1.14 **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.

Continuing Healthcare Risk Pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning groups contribute annually to a pooled fund, which is used to settle the claims.

1.15 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.15.1 **Financial Assets at Amortised cost**

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

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

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

1.15.3 **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.

1.16 **Financial Liabilities**

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

1.17 **Value Added Tax**

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

1.18 **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 about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.18.1 **Critical Accounting Judgements in Applying Accounting Policies**

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

As disclosed in note 14 to the financial statements, the CCG is party to a section 75 agreements in relation to the Better Care Fund (BCF) in Worcestershire. The substance of each programme that forms part of the BCF Pooled Budget has been assessed under IFRS 11: 'Joint Arrangements'.

As detailed in note 14, individual BCF programmes have been assessed as either:

- Joint Commissioning arrangements under which each Pool Partner is deemed to have joint control and in accordance with IFRS 11, accounts for their share of expenditure and balances with the end provider. For these arrangements, the parties are judged by management to meet the criteria for joint control. A joint operation is in place and the parties have the power, exposure, and rights to variable returns from their involvement and the ability to use their powers to affect the returns.
- Lead commissioning arrangements under which the lead commissioner accounts for expenditure with the end provider and other partners report transactions and balances with the lead commissioner. For these arrangements, the judgement of management is that a joint arrangement does not exist, and the lead commissioner is judged to be acting as a 'principal' with control over specified goods and services being commissioned.
- Sole control arrangements under which the provisions of IFRS 11 do not apply. For these arrangements, the judgement of management is that there is no collective control and that no other are parties involved in the commissioning of services."

As disclosed in note 14, the CCG is also party to a section 75 agreement for the commissioning of mental health and learning disability services. Management has determined that the substance of this agreement is that it is an aligned commissioning arrangement rather than a pooled budget arrangement. Under IFRS 15, the CCG has determined that it has control of the commissioning of these services.

1.18.2 **Key Sources of estimation uncertainty**

The following are the key assumptions that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Partially completed spells (based on workings by NHS provider trusts). The estimates by providers have been updated based on work in progress in the hospitals as at 31 March 2020. These will be settled as part of the April and May actual activity paid once discharged from hospitals (£927k 2019-20, £900k 2018-19).
- Maternity prepayments (based on workings by NHS provider trusts). The estimates have been updated based on the outstanding treatment at the year end (£1,324k 2019-20, £1,221k 2018-19).
- Prescribing position for March 2020 (based on April-January Itemised Prescribing Payment (IPP) forecast for February and March). This will be resolved during May when the final year-end position is reported (£4.05m 2019-20, £3.75m 2018-19).
-Continuing Healthcare accruals - NHS South Worcestershire CCG derives the accruals for continuing healthcare services based on the CHC database and then passes on the relevant charges via a debtor/creditor relationship with NHS Redditch and Bromsgrove CCG (£79k 2019-20, £377k 2018-19)

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases - The Standard is effective 1 April 2021 as adapted and interpreted by the FReM. The standard requires all leased assets to be recognised on the lessee's Statement of Financial Position by moving away from the current Finance/Operating Lease model to a single accounting model for all leases. We are not able to quantify the impact of the standard due to the uncertainty caused by current circumstances.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. The impact of this standard is unlikely to be material

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

2 Other Operating Revenue

	2019-20 Total	2018-19 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	-	16
Non-patient care services to other bodies	1,777	842
Total Income from sale of goods and services	**1,777**	**858**
Other operating income		
Other non contract revenue	232	256
Total Other operating income	**232**	**256**
Total Operating Income	**2,009**	**1,114**

Revenue in this note does not include cash received from NHS England, which is drawn directly into the bank account of the CCG and credited to general fund

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

	Non-patient care services to other bodies
	£'000
Source of Revenue	
Non NHS	1,777
Total	**1,777**

	Non-patient care
	£'000
Timing of Revenue	
Point in time	1,777
Total	**1,777**

3. Employee benefits and staff numbers

3.1 Employee benefits	Total Permanent Employees £'000	Other £'000	2019-20 Total £'000
Employee Benefits			
Salaries and wages	2,328	28	2,356
Social security costs	246	-	246
Employer Contributions to NHS Pension scheme	439	-	439
Apprenticeship Levy	4	-	4
Termination benefits	29	-	29
Gross employee benefits expenditure	3,046	28	3,074
Total - Net admin employee benefits including capitalised costs	3,046	28	3,074
Net employee benefits excluding capitalised costs	3,046	28	3,074

3.1 Employee benefits	Total Permanent Employees £'000	Other £'000	2018-19 Total £'000
Employee Benefits			
Salaries and wages	2,122	96	2,218
Social security costs	231	-	231
Employer Contributions to NHS Pension scheme	282	-	282
Apprenticeship Levy	4	-	4
Gross employee benefits expenditure	2,639	96	2,735
Total - Net admin employee benefits including capitalised costs	2,639	96	2,735
Net employee benefits excluding capitalised costs	2,639	96	2,735

Employer contributions to NHS Pension Scheme increased in 2019/20 as a result of the latest actuarial valuation increasing the employer contribution rate from 14.38% to 20.6%. This increase was paid for within the CCG's net partliamentary funding.

3.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**53**	**1**	**54**	**50**	**2**	**52**

3.3 Exit packages agreed in the financial year

	2019-20	
	Other agreed departures	
	Number	Bands of £5k
Less than £10,000	4	10-15
£10,001 to £25,000	1	15-20

Analysis of Other Agreed Departures

	2019-20		2018-19	
	Other agreed departures		Other agreed departures	
	Number	Bands of £5k	Number	Bands of £5k
Mutually agreed resignations (MARS) contractual costs	5	25-30	-	-

3.4 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.

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

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

4. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,293	1,216
Services from foundation trusts	34,962	33,171
Services from other NHS trusts	131,248	119,816
Purchase of healthcare from non-NHS bodies	27,850	30,172
Prescribing costs	27,308	25,616
Pharmaceutical services	371	-
GPMS/APMS and PCTMS	24,990	24,216
Supplies and services – clinical	(123)	(115)
Supplies and services – general	196	211
Consultancy services	35	3
Establishment	542	484
Premises	184	178
Audit fees *	50	49
Other non statutory audit expenditure		
· Other services	12	-
Other professional fees	27	40
Legal fees	31	45
Education, training and conferences	1	3
Total Purchase of goods and services	**248,977**	**235,105**
Depreciation and impairment charges		
Amortisation	39	39
Total Depreciation and impairment charges	**39**	**39**
Other Operating Expenditure		
Chair and Non Executive Members	189	205
Inventories Consumed	230	228
Expected credit loss on receivables	19	-
Total Other Operating Expenditure	**438**	**433**
Total operating expenditure	**249,454**	**235,577**

* Audit fees shown are inclusive of VAT

In accordance with SI 2008 no. 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements)
Regulation 2008, the CCG must disclose the principal terms of the limitation of the auditors liability. This is detailed as follows:

- For all defaults resulting in direct loss or damage to the property of the other party - £2m limit
- In respect of all other defaults, claims, losses or damages arising from the breach of contract, misrepresentation, tort, breach of statutory duty or otherwise - not exceed the greater of the sum of £2m or a sum equivalent to 125% of the contract charges paid or payable to the supplier in the relevant year of the contract.

5 Better Payment Practice Code

Measure of compliance	**2019-20 Number**	**2019-20 £'000**	2018-19 **Number**	2018-19 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,818	60,199	3,554	58,584
Total Non-NHS Trade Invoices paid within target	3,670	59,981	3,463	56,969
Percentage of Non-NHS Trade invoices paid within target	**96.12%**	**99.64%**	**97.44%**	**97.24%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,197	174,251	2,114	162,611
Total NHS Trade Invoices Paid within target	2,143	173,043	2,033	158,682
Percentage of NHS Trade Invoices paid within target	**97.54%**	**99.31%**	**96.17%**	**97.58%**

The CCG aims to pay 95% of invoices (by value and number) within 30 days.

The total value of invoices paid in the year in this note differs to Note 5 - Operating expenses, due to in year movements on payables, non-cash prescribing costs and payments made by this CCG on behalf of NHS Wyre Forest CCG and NHS South Worcestershire CCG

6. Operating Leases

As lessee

6.1 Payments recognised as an Expense			**2019-20**			2018-19
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense						
Minimum lease payments	86	1	**87**	83	1	**84**
Total	**86**	**1**	**87**	**83**	**1**	**84**

6.2 Future minimum lease payments			**2019-20**			2018-19
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payable:						
No later than one year	85	1	**86**	86	1	**87**
Between one and five years	79	2	**81**	46	2	**48**
Total	**164**	**3**	**167**	**132**	**3**	**135**

The lease payments and future minimum lease payments disclosed above relate to Barnsley Hall, Barnsley Court and Acton House

7 Property, plant and equipment

2019-20	Information technology	Total
	£'000	£'000
Cost or valuation at 01 April 2019	195	195
Cost/Valuation at 31 March 2020	**195**	**195**
Depreciation 01 April 2019	92	92
Charged during the year	39	39
Depreciation at 31 March 2020	**131**	**131**
Net Book Value at 31 March 2020	**64**	**64**
Purchased	64	64
Total at 31 March 2020	**64**	**64**
Asset financing:		
Owned	64	64
Total at 31 March 2020	**64**	**64**

7.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	0	5

8 Inventories

	Consumables £'000	Total £'000
Balance at 01 April 2019	230	**230**
Additions	240	**240**
Inventories recognised as an expense in the period	(230)	**(230)**
Balance at 31 March 2020	**240**	**240**

9 Trade and other receivables	Current 2019-20 £'000	Current 2018-19 £'000
NHS receivables: Revenue	6,696	5,756
NHS prepayments	1,324	1,221
Non-NHS and Other WGA receivables: Revenue	2,223	657
Non-NHS and Other WGA prepayments	553	723
Expected credit loss allowance-receivables	(19)	-
VAT	8	2
Total Trade & other receivables	**10,785**	**8,359**
Total current and non current	**10,785**	**8,359**

9.1 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000
By up to three months	60	894	228	319
By three to six months	-	1,000	-	-
By more than six months	65	126	365	39
Total	**125**	**2,020**	**593**	**358**

£10k of the amount above has subsequently been recovered post the statement of financial position date

9.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Lifetime expected credit losses on trade and other receivables-Stage 2	(19)
Total	**(19)**

10 Cash and cash equivalents

	2019-20	2018-19
	£'000	£'000
Balance at 01 April 2019	109	35
Net change in year	396	74
Balance at 31 March 2020	**505**	**109**
Made up of:		
Cash with the Government Banking Service	505	109
Cash and cash equivalents as in statement of financial position	**505**	**109**
Balance at 31 March 2020	**505**	**109**

11 Trade and other payables	**Current 2019-20 £'000**	Current 2018-19 £'000
NHS payables: Revenue	6,890	4,072
NHS accruals	927	900
Non-NHS and Other WGA payables: Revenue	1,006	1,425
Non-NHS and Other WGA accruals	8,180	7,334
Social security costs	45	41
Tax	36	37
Other payables and accruals	289	290
Total Trade & Other Payables	**17,373**	**14,099**
Total current and non-current	**17,373**	**14,099**

Other payables include £265k outstanding pension contributions at 31 March 2020 (£248k at 31 March 2019)

12 Financial instruments

12.1 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.

12.1.1 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.

12.1.2 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.

12.1.3 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.

12.1.4 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.

12.1.5 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.

12 Financial instruments cont'd

12.2 Financial assets

	Financial Assets measured at amortised cost	
	2019-20 £'000	**2018-19 £'000**
Trade and other receivables with NHSE bodies	5,780	2,031
Trade and other receivables with other DHSC group bodies	1,050	3,433
Trade and other receivables with external bodies	2,089	949
Cash and cash equivalents	505	109
Total at 31 March 2020	**9,424**	6,522

12.3 Financial liabilities

	Financial Assets measured at amortised cost	
	2019-20 £'000	**2018-19 £'000**
Trade and other payables with NHSE bodies	5,102	2,526
Trade and other payables with other DHSC group bodies	2,715	2,446
Trade and other payables with external bodies	9,475	9,048
Total at 31 March 2020	**17,292**	14,020

13 Operating Segments

The CCG consider that the only operating segment is the commissioning of healthcare services

14 Joint arrangements - interests in joint operations

The CCG is party to a number of joint commissioning arrangements with NHS South Worcestershire CCG , NHS Wyre Forest CCG and Worcestershire County Council as part of a Section 75 Agreement. Each partner reflects its share of the income, expenditure, assets and liabilities of the pool within their financial statements.

The Agreement enables alignment or pooling of funds that are used to commission a range of acute, community, mental health and Children's services and also incorporates the Better Care Fund.

The flow of funds included within the Agreement varies dependent upon the nature of the services, although the Council acts as 'banker' in the majority of cases with CCGs making monthly contributions to the council which are then passed onto providers in accordance with contractual arrangements.

Investment and disinvestment decisions are made jointly by the Partners to the Agreement through the Integrated Commissioning Executive Oversight Group (ICEOG), on which each partner is represented.

NHS Redditch and Bromsgrove CCG accounts for its share of the expenditure in these schemes as fully expensed in the year and in accordance with IFRS 11 the expenditure is treated as per the table below:

Schemes	CCG retained sole control £'000	Council acted as lead commissioner £'000	Council retained sole control £'000	Jointly controlled £'000	Grand Total £'000
BCF	7,493	1,447		3,012	11,952
Wheelchairs Service		556			556
Integrated Community Equipment Service				331	331
Learning Disabilities	59	1,307			1,367
Mental Health	17,915	159	1,924		19,997
Funded Nursing Care	3,585				3,585
Children's Services (including CAMHS)	97	5,161			5,258
Other Community Services	31	62	2		94
Total Agreement	**29,180**	**8,692**	**1,926**	**3,343**	**43,140**

15 Events after the reporting period

NHS Redditch and Bromsgrove CCG was dissolved on 31 March 2020 having joined with NHS South Worcestershire CCG, NHS Wyre Forest CCG and NHS Herefordshire CCG to establish NHS Herefordshire and Worcestershire CCG with effect from 1 April 2020. This followed approval of the application at the NHS England and Improvement Regional Support Group - Midlands Region on 14 October 2019 and again on 24 February 2020 to confirm that conditions had been met.
The details of the dissolving CCG balances & the newly established CCG balances are shown below:

	Closing Balances				Opening Balances
	Redditch & Bromsgrove CCG £'000	South Worcestershire CCG £'000	Wyre Forest CCG £'000	Herefordshire CCG £'000	Herefordshire & Worcestershire CCG £'000
Property, plant and equipment	64	895	29	652	1,640
Inventories	240	400	160	145	945
Trade and other receivables	10,785	16,581	3,775	7,227	24,609
Cash and cash equivalents	505	79	538	93	1,215
Trade and other payables	- 17,373	- 40,628	- 12,891	- 19,273	- 76,406
Net Assets/Liabilities	**- 5,779**	**- 22,673**	**- 8,389**	**- 11,156**	**- 47,997**

Note 16 Related party transactions

The Department of Health is regarded as a related party. During the year Redditch and Bromsgrove CCG has

Related Party	
Birmingham Women's & Children's NHS Foundation Trust	Purchase of Healthcare
Royal Orthopaedic NHS Foundation Trust	Purchase of Healthcare
Sandwell & West Birmingham Hospitals NHS Trust	Purchase of Healthcare
University Hospital Birmingham NHS Foundation Trust	Purchase of Healthcare
West Midlands Ambulance NHS Foundation Trust	Purchase of Healthcare
Worcestershire Acute NHS Trust	Purchase of Healthcare
Worcestershire Health & Care NHS Trust	Purchase of Healthcare

In addition, the CCG has had a number of material transactions with other government departments and other

Related Party	**Purpose of Transaction**
Worcestershire County Council	Purchase of Community Care
HM Revenue & Customs	Payment of Income Tax etc.
NHS Pensions Scheme	Payment of Superannuation

During the year the following Board Members or members of the key management staff or parties related to them have undertaken the following material transactions with Redditch and Bromsgrove CCG

GPs that are members of the governing body are not considered to have significant influence within the GP

Related Party	**Purpose of Transaction**
SW Healthcare (Various GPs shareholders)	Healthcare Contract

Prior Year Comparator

The Department of Health is regarded as a related party. During the year Redditch and Bromsgrove CCG has

Related Party	
Birmingham Women's & Children's NHS Foundation Trust	Purchase of Healthcare
Royal Orthopaedic NHS Foundation Trust	Purchase of Healthcare
University Hospital Birmingham NHS Foundation Trust	Purchase of Healthcare
Sandwell & West Birmingham Hospitals NHS Trust	Purchase of Healthcare
West Midlands Ambulance NHS Foundation Trust	Purchase of Healthcare
Worcestershire Acute NHS Trust	Purchase of Healthcare
Worcestershire Health & Care NHS Trust	Purchase of Healthcare

In addition, the CCG has had a number of material transactions with other government departments and other

Related Party	**Purpose of Transaction**
Worcestershire County Council	Purchase of Community Care
HM Revenue & Customs	Payment of Income Tax etc.
NHS Pensions Scheme	Payment of Superannuation

During the year the following Board Members or members of the key management staff or parties related to them have undertaken the following material transactions with Redditch and Bromsgrove CCG

GPs that are members of the governing body are not considered to have significant influence within the GP

None

17 Financial performance targets

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

	2019-20 Target £'000	**2019-20 Performance £'000**	**Duty Achieved Yes/No**	**Explanation**	2018-19 Target £'000	2018-19 Performance £'000
Expenditure not to exceed income	252,549	252,528	Yes	The CCG underspent its in-year 2019-20 revenue resource limit by £0.021m	238,318	238,312
Capital resource use does not exceed the amount specified in Directions	Not applicable	Not applicable	Not applicable	Not applicable	not applicable	not applicable
Revenue resource use does not exceed the amount specified in Directions	250,540	250,519	Yes	The CCG underspent its in-year 2019-20 revenue resource limit by £0.021m	237,204	237,198
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	Not applicable	Not applicable	Not applicable	Not applicable	not applicable	not applicable
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	Not applicable	Not applicable	Not applicable	Not applicable	not applicable	not applicable
Revenue administration resource use does not exceed the amount specified in Directions	3,891	3,575	Yes	The CCG underspent its 2019-20 administration revenue resource allocation by £0.316m	3,756	3,342

Independent auditor's report to the members of the Governing Body of NHS Herefordshire and Worcestershire Clinical Commissioning Group in respect of NHS Redditch and Bromsgrove Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Redditch and Bromsgrove CCG (the 'CCG') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accountable Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the CCG's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the CCG's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the CCG's financial statements shall be prepared on a going concern basis, we considered the risks associated with the CCG's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the CCG's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

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

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 15 to the financial statements, which indicates that NHS Redditch and Bromsgrove CCG merged with NHS Herefordshire CCG, NHS South Worcestershire and NHS Wyre Forest CCG to become NHS Herefordshire and Worcestershire CCG on 1st April 2020. NHS Herefordshire and Worcestershire CCG took over the services and functions of NHS Redditch and Bromsgrove CCG.

Other information

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

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

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the Health and Social Care Act 2012; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity required by the Code of Audit Practice

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

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

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

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 47 to 48, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

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

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Report on other legal and regulatory requirements – Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) 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 and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Redditch and Bromsgrove CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Peter Barber, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

25 June 2020