NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Annual Report and Accounts

2020/21

Contents

Foreword

Welcome to NHS Herefordshire and Worcestershire Clinical Commissioning Group's Annual Report and Accounts for 2020/21.

What a year it has been since the Clinical Commissioning Group's (CCG) merger took effect on 1 April 2020, amid the unfolding COVID-19 pandemic and shortly after the implementation of the first national lockdown. A real team effort has been needed to plan and deliver health and care services for the people, patients, and carers across the two counties. The past year has brought to the forefront the CCG's focus as health system leaders and partners. There has been ever closer working with provider colleagues, local authority in the broadest sense including public health, both Healthwatch organisations in Herefordshire and Worcestershire, the emergency services, the voluntary sector and the independent sector to enable joined up care which has been much valued. CCG executives and staff have shown remarkable professionalism, dedication, and flexibility as they have grappled with the complexity and implications of the COVID-19 illness, organising the largest population vaccination programme in history, as well as maintaining existing services albeit with a prioritised focus. All of this has been done while mainly working from home, often juggling family and caring responsibilities, as well as testing computer platforms and broadband internet speeds to and, at times, beyond their capabilities.

We fully realise the difficulties this has created for all of you as users when new ways of contacting and dealing with services have come in to play, often at short notice, to safely balance access, quality and effectiveness. It has also highlighted where there are inequalities across our two counties, which we are determined to make progress be they cultural, geographical, technological etc.

My overwhelming feeling is one of enormous thanks to all of you who are reading this for playing your various parts in a myriad of different ways, enabling us to make progress in these most difficult of times. What it has clearly shown is that by working together we can achieve much more in tackling shared problems and issues rather than solely trying to deal with this individually. This bodes well as we go forward into a world where we are required to work as a system.

I hope that you enjoy reading this Annual Report. If you have any questions or comments on the information contained within, please contact our Communications Team at hw.comms@nhs.net.

I look forward to continuing to work with you in my role as Chair of Herefordshire and Worcestershire CCG.

Dr Ian Tait
Chairman
NHS Herefordshire and Worcestershire CCG

Annual Summary 2020/21

Key highlights and challenges

COVID-19 Pandemic

- Working with partners across Herefordshire and Worcestershire, co-ordinating and organisation COVID-19 response across system partners.
- Transformations and adaptations of services has been required including utilising digital and virtual consultations.
- Increased demand and pressure on the NHS leading to increased waiting times for elective procedures, diagnostics and outpatient appointments.

COVID-19 Vaccination Programme

- Enormous efforts have gone into the planning and mobilisation of the vaccination programme in Herefordshire and Worcestershire, working closely with partners and member practices.
- Extensive work has been undertaken to support population groups at risk of low COVID-19 vaccine uptake.

Integrated Care System (ICS)

- Herefordshire and Worcestershire was formally designated and will be recognised at an Integrated Care System from 1 April 2021.

Winter Pressures

- Once again, a tremendously difficult winter with challenges in respect of the management of COVID-19 positive patients.

Financial Climate

- The CCG developed a financial savings plan for 2020/21 however in direct response to COVID-19 the CCG was placed into a nationally led financial regime.

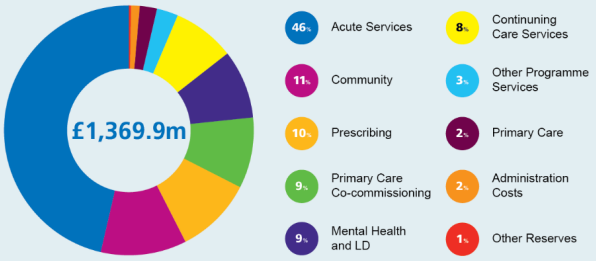
Annual expenditure

Total allocation in 2020/21 was **£1,369,858k**

Total Running Cost allocation was **£15,179k**

Total Expenditure was **£1,369,223k**

Delivered Saving of **£635k**



Looking ahead to 2021/22

Reset and recovery

- Working with system partners to address challenges in restoring NHS services across Herefordshire and Worcestershire.
- The Digital Strategy will play an important role in the reset and recovery work including the potential to deliver services online.

COVID-19 vaccination programme

- The COVID-19 vaccination programme will continue to be a priority as we move to vaccinate the younger population in the coming months.

Integrated Care System (ICS)

- Work to develop the Integrated Care System across Herefordshire and Worcestershire will continue as legislation, parliamentary approval and more information is received. The CCG will formally closedown in April 2022 and work will be undertaken to prepare for this.

Financial climate

- Attention has been turned to reducing system cost and programmes being implemented to ensure that system partners contribute to reduce expenditure and improve productivity.

Performance Report

Simon Trickett
Accountable Officer
NHS Herefordshire and Worcestershire CCG
11 June 2021

Performance overview

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 2020/21.

Key highlights and challenges this year

COVID-19 Pandemic (Coronavirus)

Managing the COVID-19 pandemic in Herefordshire and Worcestershire has been a monumental task across all parts of the health and care sector. Credit and gratitude are due to the thousands of health and care staff who have provided support to patients and service users who have adapted ways of working to ensure some continuity of essential services. All staff have been part of this effort.

The main role for the CCG has been one of co-ordination and organisation across system partners, although many members of CCG staff have also taken on new roles, temporarily supporting front line service delivery or co-ordinating system efforts and the distribution of Personal Protective Equipment (PPE), digital and IT resources and the swabbing and testing regimes. Particular credit is also due to the Primary Care Network (PCN) Clinical Directors who have played a crucial role in organising the efforts of the 81 GP practices across the two counties and have reorganised service delivery around ‘Hubs’, as well as taking full advantage of the available technology to convert a huge majority of patient contacts to being via the telephone or video consultations. This transformation has been rapid and hugely significant and the evaluation of this, and a lot of the other adaptations that were made across other parts of the health and care support offer, will be a key component of preparations for the next phases of this work.

Impact on services

The impact of the pandemic on the whole health care system has been significant and Herefordshire and Worcestershire Integrated Care System (ICS) is in active planning for recovery of its healthcare services. The COVID-19 pandemic was declared as a ‘level 4 incident’ nationally and as such, a range of more directive command and control structures have been operating using the national and regional NHS England and NHS Improvement teams working with local systems.

Senior leaders have been working collaboratively across the system to ensure that the required changes to operational delivery, business intelligence, finance and workforce are implemented in a way that maximises capacity and access for patients. The key focus of work, and the most obvious risk, relates to restoring outpatient appointments (both face to face and virtual), diagnostics requirements, elective procedures and long waiters, and ensuring that essential cancer services are maintained. Progress is being made across each area of focus, with detailed intervention plans in place to ensure every opportunity is explored and implemented to support the recovery of these services that were compromised during the first wave of COVID-19.

Expected demand for the service varies but the planning assumption is for 2% of the diagnosed population to need some additional support.

Discussions are progressing with local partners to finalise the design of a pathway, building on the national guidance. The local proposal is to utilise and then increase capacity of some of the existing service infrastructure, specifically the COVID-19 Management Services in both counties, current Multidisciplinary Team meetings, Respiratory Clinical Nurse Specialists and psychological and cognitive assessment services.

Safe restoration of services

Community transmission rates and subsequent demand for hospitalisation and in particular intensive care facilities have all fallen considerably since the further peak in demand that occurred during January and February 2021. The opportunity to reset service delivery aiming to deliver the NHS Long Term Plan ambitions and embed the positive changes made during the pandemic is a fundamental part of the recovery programme. There are two specific challenges facing the system. Firstly, the impact on elective waiting lists. As a result of the inability to undertake usual numbers of outpatients, diagnostics, and elective procedures during the height of COVID-19, there are significant numbers of individuals waiting for extended periods. The system now has a detailed recovery plan which includes clinical prioritisation, extended use of the independent sector for NHS procedures, Vanguard theatres and the implementation of three GIRFT pathways (getting it right first time) in the high volume specialties. The system partners are also working collaboratively to use capacity across acute hospital sites within Herefordshire and Worcestershire. In addition, a communications framework for patients, public, staff and stakeholders is near completion to provide clarity of waiting times.

The second challenge relates to the system workforce. Following the demands of the past year, workforce wellbeing and preparedness for reset and recovery are crucial. The People Board of the Integrated Care System (ICS) is leading the wellbeing and workforce planning agenda and as the system needs to be ambitious in its approach to reset and recovery, the board have also been requested to lead the organisational development required. Detailed timelines are being agreed alongside the actions required and will provide an ability to forecast how long recovery will take. The focus on the delivery of our system wide Clinical Prioritisation framework provides assurance. The operational focus locally is now on the ‘reset and recovery’ work which will be so important throughout 2021/22

Vaccination programme

From December 2020, the Government asked the NHS to deliver a vaccination programme for England. The CCG led on developing plans for Herefordshire and Worcestershire, building on the expertise and strong track record the NHS already has in delivering immunisations like the annual flu vaccination programme and routine immunisations for children and pregnant women. The delivery of these plans has primarily been led by local GPs and community pharmacies, however for the COVID-19 vaccine the CCG has also worked with local councils and social care providers to expand on this, as well as setting up roving vaccine delivery services in people’s homes or care homes.

Enormous efforts have also gone into the planning and mobilisation of the vaccination programme, which has had an excellent start with Herefordshire and Worcestershire being a leading local system nationally in terms of progress, in delivering vaccinations to the priority cohorts and to a higher proportion of the local population than any other area. Herefordshire and Worcestershire continues to perform very well in almost every indicator and assessment of progress relating to the vaccination programme. The local system has consistently

achieved excellent levels of vaccine delivery and take-up across all parts of the local population.

As has been widely reported nationally, vaccine supply has been more constrained since the end of March 2021 and the focus has been on delivery of second doses of vaccines, largely to those who received their first dose during December 2020 and January 2021. There has been limited opportunity to increase the numbers of first doses delivered, although every chance is taken to receive additional vaccine supply where it becomes available nationally. Primary Care Networks (PCNs) have been the main delivery vehicle for the second doses compared with Vaccination Centres. In late April 2021, it is anticipated more supply will become available and national permission is expected to move through to offering vaccinations to the Joint Committee for Vaccination and Immunisation (JCVI) cohorts 10-12 covering the remainder of the adult population.

Extensive work has also been undertaken through the Vaccine Inequalities Programme (VIP), which aims to support population groups at risk of low COVID-19 vaccine uptake. This is to ensure every eligible person living in Herefordshire and Worcestershire has the opportunity to receive the vaccination in a timely manner, within the national Joint Committee on Vaccination and Immunisation (JCVI) guidance. The CCG has worked closely with health and care partners and the programme continues to deliver some excellent examples of collaboration across local organisations, particularly in relation to outreach clinics offering vaccines to the homeless communities and in some local areas, such as Redditch with ethnic minority and harder to reach groups. Figures for the take-up of the vaccine in these groups in Herefordshire and Worcestershire compare well nationally. Work will continue to take place in 2021/22 to bridge vaccine uptake inequalities and to ensure that no one is left behind.

Integrated Care System (ICS)

Following a detailed planning and application process, Herefordshire and Worcestershire was formally designated and recognised by NHS England as an Integrated Care System (ICS) from 1 April 2021. This was confirmed following on from the development and submission of an ICS Development Plan and a review of this and other relevant documents, as well as progress across a range of key areas, at regional and national level. The approval was also granted without any ‘conditions’, unlike lots of other emerging Integrated Care Systems and is a significant vote of confidence in the local work.

Work has now started in response to the White Paper proposals and planning how a transition might operate, both in developing the current system working, but also in managing the transition to the new NHS statutory body, subject to approval by Parliament. A capability mapping process is underway, and work is progressing to further develop the place-based leadership and governance arrangements, supported by a series of workshops that are being independently facilitated.

A draft national timetable has been developed that outlines the various necessary steps to be taken, including the appointment of key roles. Most of these types of steps aren’t due until the second half of 2021/22 and do rely on the parliamentary approval process proceeding as planned. Legislation enabling the establishment of Integrated Care System statutory NHS bodies is expected to be first presented to Parliament in May 2021. This work will continue to progress throughout 2021/22.

Winter Pressures

We have once again seen a tremendously difficult winter. Overall, activity for winter 2020/21 was down due to the COVID-19 pandemic, however this presented challenges in respect of the management of COVID-19 positive patients. These challenges were felt significantly in the acute settings during the peak in COVID-19 inpatients across the country.

The performance of Wye Valley NHS Trust and Worcestershire Acute Hospitals NHS Trust during this period was admirable, especially Worcestershire who saw significant improvements in the Emergency Access Standard (as a result of transformation programmes being delivered). Both trusts improved internal hospital flow and achieved significant improvements in relation to discharge, in particular the significant increase in patients returning to their usual place of residence. This resulted in far fewer delays for patients and much improved ambulance handover indicators which is viewed as a key safety metric. These improvements were recognised formally by West Midlands Ambulance Service.

Performance against targets

Throughout 2020/21 service delivery has been significantly impacted by COVID-19, with services needing to adapt to meet new infection control process and capacity fluctuation. This has resulted in some increased waits for treatment and deteriorated performance, particularly in elective care. Services were particularly impacted during the main COVID-19 wave in the spring of 2020 and winter 2020/21. During this time, all urgent and emergency services continued to deliver effectively. As we exit the second wave of COVID-19, we are focused on restoring all services and meeting the needs of those on waiting lists where increased waits are seen, with those with the highest level of clinical need prioritised. Given this challenging position, performance has deteriorated across 20/21 within planned care. However, urgent and emergency care performance has maintained and, in some measures, improved through the implementation of new ways of working.

We continue to monitor COVID-19 and non-COVID-19 activity to support services to plan and recover activity lost over 2020/21

Financial climate

The CCG developed a financial savings plan to support achieving financial balance in the financial year 2020/21. However, in direct response to COVID-19 the CCG was placed into a nationally led financial regime which suspended the normal planning process negating the requirement to make formal QIPP savings, the national regime funding system costs incurred to enable a breakeven position to be reported, thus ensuring that finance was not an obstacle to service delivery. The finance regime was in place for the full year but operated under two separate models. From April 2020 to September 2020 the CCG was under a full cost reimbursement model. The model in place covering the period October 2020 to March 2021 was that of a system financial envelope being made available, based on costs in the first half of the year with a requirement to breakeven across the system, this was managed by all partners and the CCG recorded £1.7m of QIPP savings being achieved through prescribing initiatives.

For 2021/22 attention has now turned to reducing system cost and a Use of Resources programme has been put in place with all system partners contributing to reduce expenditure and improving productivity to improve the overall system financial position.

Looking ahead

While much of this last year has seen us responding to the pandemic, we look ahead to next year with a clear focus on what we need to achieve.

I am particularly focused on creating a strong reset and recovery plan for Herefordshire and Worcestershire. There is a lot of work involved in this and it will involve and system partners and us working together to address some of the challenges we currently face. Unfortunately, many patients have had to endure long waits for non-urgent treatment during our response to the pandemic, and it is crucial that we have a clear plan in place to ensure these patients receive the treatment they need. Our digital strategy will play a key part of the reset and recovery plan, ensuring that health and care records are shared across the system as well as providing alternatives such as online appointments via video and telephone consultations.

The pandemic has, however, accelerated a journey that was already underway across Herefordshire and Worcestershire, one that was set out in the NHS Long Term Plan and which placed the NHS, local authority and other partners on the pathway to more integrated ways of delivering care. This has led to innovation across Herefordshire and Worcestershire which we want to harness this coming year and expand to provide new ways of delivering services and accessing care.

Leadership of the COVID-19 vaccination programme will also continue to be a priority as we continue the rollout of the vaccine across our local population. It has been a hugely successful programme and it is critical that we continue this momentum and build upon this success as we work through the remaining eligible cohorts in Herefordshire and Worcestershire.

We will also need to spend time this year preparing for the closedown of the CCG by 1 April 2022, as we move towards becoming an Integrated Care System and a new statutory body. Organisational change can often mean uncertain times for staff, and we need to make sure that we support our staff as best as we can throughout this transition.

There is no doubt about the significant scale of challenge in front of us in 2021/22, however we remain confident that we can build on the momentum we have created this year to drive the much needed system leadership and transformational change.

Simon Trickett
Accountable Officer

About us

NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG) was established on 1 April 2020 following a merger of NHS Herefordshire CCG, NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG.

We are formed of 81 member GP practices and we are responsible for buying health services for 807,412 people across Herefordshire and Worcestershire. Specifically, this means we are responsible for:

- Planning health services based on assessing local needs.
- Paying for services that meet the needs of our patients (also known as 'commissioning').
- Monitoring the quality of the services and care provided to our patients.

Our vision for the population of Herefordshire and Worcestershire is that, through an integrated care model:

- 'Local people will live well in a supportive community with joined up care, underpinned by specialist expertise and delivered in the best place by the most appropriate people'.

This vision is underpinned by:

- The views of our patients and the public.
- Our understanding of our population's needs.
- Our need to address the quality, performance and financial challenges across Herefordshire and Worcestershire.

We developed this vision in collaboration with our local partners, meaning that it is central not only to what we do, but also to all other health and care organisations across Herefordshire and Worcestershire. It focuses us all on a shift towards more joined up, preventative and anticipatory care, with integration across health and social care providers providing seamless pathways across organisational boundaries.

Together we commission services from several 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.
- Herefordshire and Worcestershire Health and Care NHS Trust **–** Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) is the main provider of community and mental health services across Herefordshire and 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.

- The main local providers of secondary services in Herefordshire are Wye Valley NHS Trust (WVT). The Trust provides a full range of acute and emergency hospital-based services from Hereford County Hospital. It also runs services at community hospitals around the county; Ross-on-Wye, Leominster and Bromyard.

We also commission services from providers outside of Herefordshire and Worcestershire including:

- Gloucestershire Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust

The population we serve

We serve patients registered with general practices located across Herefordshire and Worcestershire. As of 1 April 2021, 807,412 patients were registered with Herefordshire and Worcestershire GPs.

In line with our statutory duties we have contributed to the development of the Herefordshire Joint Strategic Needs Assessment (JSNA) with our partners from Herefordshire Council and 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 wellbeing matters at all levels in each county. Originally introduced to inform decisions of each county's Health and Wellbeing Board; we consider the remit of the JSNAs to be much wider than that, providing a first port-of-call for health and wellbeing related evidence in Herefordshire and Worcestershire.

Herefordshire JSNA

- **Population** (mid-2018): 192,100.
- **Herefordshire's land classification**: 95% of land classified as 'rural'. Over half of the population live in rural areas.
- **Distribution of population** (mid-2017): Just under a third of the population lives in Hereford city (61,400 people), and just under a fifth in one of the three largest market towns of Leominster (12,200), Ross (11,400) and Ledbury (10,100).
- **Population aged 65 years or above** (mid-2018): 24% (Herefordshire); 18% (nationally)
- **Households in fuel poverty** (in 2015): 17% (Herefordshire); 13.5% (West Midlands); 11% (England).
- **Housing affordability**: Herefordshire is the worst area within the West Midlands region for housing affordability. House prices at the lower end of the housing market are 8.6 times higher than lower quartile annual earnings.
- **Earnings** in Herefordshire are consistently significantly lower than the average in England and the West Midlands. In 2018 the median weekly earnings for people who work in Herefordshire were £461.10, compared to £536.60 in the West Midlands and £574.90 in England.
- **Geographical Barriers to Services** is one of the domains that make up the Index of Multiple Deprivation (IMD). In 2015, almost half (55) of Herefordshire Lower Super Output Areas (LSOAs)[1] were among the 10% most deprived in England. In contrast there were just eight LSOAs among the 25% least deprived in England.

Source: https://understanding.herefordshire.gov.uk/quick-facts/

Worcestershire JSNA

Population

- Worcestershire's population was approximately 596,000 in 2019.
- 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 aged 65+ (33% increase between 2020 and 2036) and in particular in the very oldest age groups (75% increase between 2020 and 2036).

- By area, Worcestershire is mostly rural. By population, in mid-2019, almost three quarters (73.6%) of Worcestershire residents lived in areas classed as urban. Most of these were in areas classified as “urban city and town” (Worcester City, Redditch, Kidderminster, Bromsgrove, Malvern, Evesham and Droitwich).

Overarching indicators

- Life expectancy for males and females is 80 and 83.9 years respectively. This is higher than the national average which is 79.6 for males and 83.2 for females.
- Healthy life expectancy is 65.6 years for males and 65.2 years for females. This is higher than the national average of 63.4 for males and similar to the national average of 63.9 for females.

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

Please note that the information above mostly relates to a time before the onset COVID-19 and the full effects of the pandemic are not yet reflected in the data.

Our behavioural framework

We have developed a Behavioural Framework which indicated the key values that are important to the organisation, as well as explicitly setting out the behaviours that are expected by all members of staff.

The key values set out in our framework are:

Leadership and management

We will develop effective management and leadership structures that will deliver the vision of the organisation, building on good working relationships on the basis of trust, responsibility, openness, honesty and respect.

Wellbeing

We will promote a healthy and enjoyable working environment and support staff in developing a healthy work life balance.

Communication and contribution

We will be open and transparent in our communication and encourage contributions to support the development of the CCG

Learning and improvement

We will realise our full potential and embrace learning and improvement into our culture.

Equality and diversity

We will realise our full potential and embrace learning and improvement into our culture.

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 wellbeing, care and quality, and finance and efficiency.

Health and Wellbeing

- 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 wellbeing
- 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 through the CQC special measures improvement plan, which was lifted in September 2020.
- 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 2021/22
- 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 five 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.

Herefordshire Health and Wellbeing Strategy

Herefordshire Health and Wellbeing Board (HWB) bring together key health and care organisations to improve the health of local people and ensure fair access to services. It is managed by Herefordshire Council and the CCG has a leadership role in supporting the HWB and driving forward integrated care strategies and plans. The board will continue to deliver its statutory accountabilities, including the development and review of the county's Joint Strategic Needs Assessment ('Understanding Herefordshire') and its Joint Health and Wellbeing Strategy. It will also remain a key forum in which the leaders of the health and care bodies, including Healthwatch Herefordshire, will collaborate and ensure all partners are focused on delivering improved outcomes jointly for Herefordshire residents.

Herefordshire Health and Wellbeing Strategy aims to make Herefordshire a vibrant county where good health and wellbeing is matched with a strong and growing economy. The strategy has seven agreed priorities including mental health and wellbeing including the development of resilience in children, young people and adults which has been a key factor during the pandemic.

More information on Herefordshire Health and Wellbeing Strategy can be found on Herefordshire Council's website at:
https://www.herefordshire.gov.uk/downloads/download/419/health_and_wellbeing_strategy

Worcestershire Joint Health and Wellbeing Strategy 2016/21

The Worcestershire Health and Wellbeing Board brings together relevant stakeholders from the health and social care sectors. Key members of the Health and Wellbeing Board include Worcestershire County Council, local district authorities and voluntary sector organisations. The CCG is actively involved in the Health and Wellbeing Board and help to produce coordinated strategies in response to local needs.

The Worcestershire Joint Health and Wellbeing Strategy (2016/21) sets out the Health and Wellbeing Board's vision and priorities for 2016 to 2021. The CCG was actively involved in the production and 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 continues to support the three overarching priorities identified in the Joint Health and Wellbeing Strategy:

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

The strategy highlights the importance of partnership working to aid prevention and the rising tide in avoidable ill-health. The CCG's local commissioning plans are influenced and produced within the context of this document and the strategy looks to integrate commissioning plans and pool budgets across partners wherever possible.

For more information the Worcestershire Joint Health and Wellbeing Strategy can be found on Worcestershire County Council's website at: https://www.worcestershire.gov.uk/download/downloads/id/7051/joint_health_and_wellbeing_strategy_2016_to_2021.pdf

Herefordshire and Worcestershire Operational Plan (2020/21)

Traditional NHS annual planning for 2020/2021 was stood-down in April 2020 due to the COVID-19 pandemic. In its place, a number of COVID-19 planning phases were developed in-line with national requirements. The different phases are summarised in the table below:

RESPONSE TO COVID-19 – PHASES 1/2 Spring / Summer 2020	**RESTORATION – PHASE 3 September 2020 to March 2021**	**RE-SET RECOVERY – PHASE 4 April 2021 – March 2022**
• Phase 1 – NHS preparation and response to COVID-19 • Phase 2: ➢ stocktake of the system's health service landscape and a comprehensive record of the material service changes in each area ➢ restoration of essential services but also the planning for wider service restoration and recovery	• National requirement to start the restoration of all non-essential services and preparedness for further COVID-19 outbreaks • Included: ➢ Preparedness for further COVID-19 outbreaks ➢ Addressing inequalities and protecting the most vulnerable ➢ Restoring 'non-essential' services e.g. elective care, mental health, children & young people, primary care etc. ➢ Preparing for winter	• National guidance on 21/22 planning released late March 2021 • Recognised the need to have an agreed approach to recovery across Herefordshire and Worcestershire • Worked with system partners to develop the approach and framework

Throughout 2020/21 we have continued to update our Long Term Plan commitments to ensure we capture and embed the learning from our system response to the Coronavirus COVID-19 pandemic.

Better Care Fund – Herefordshire and Worcestershire

The Better Care Fund (BCF) is a mechanism for us to create a pooled budget with both Herefordshire and Worcestershire County Councils 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 both Herefordshire and Worcestershire's Joint Health and Wellbeing Strategies 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 both counties Health and Wellbeing Board in line with specific national conditions.

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.

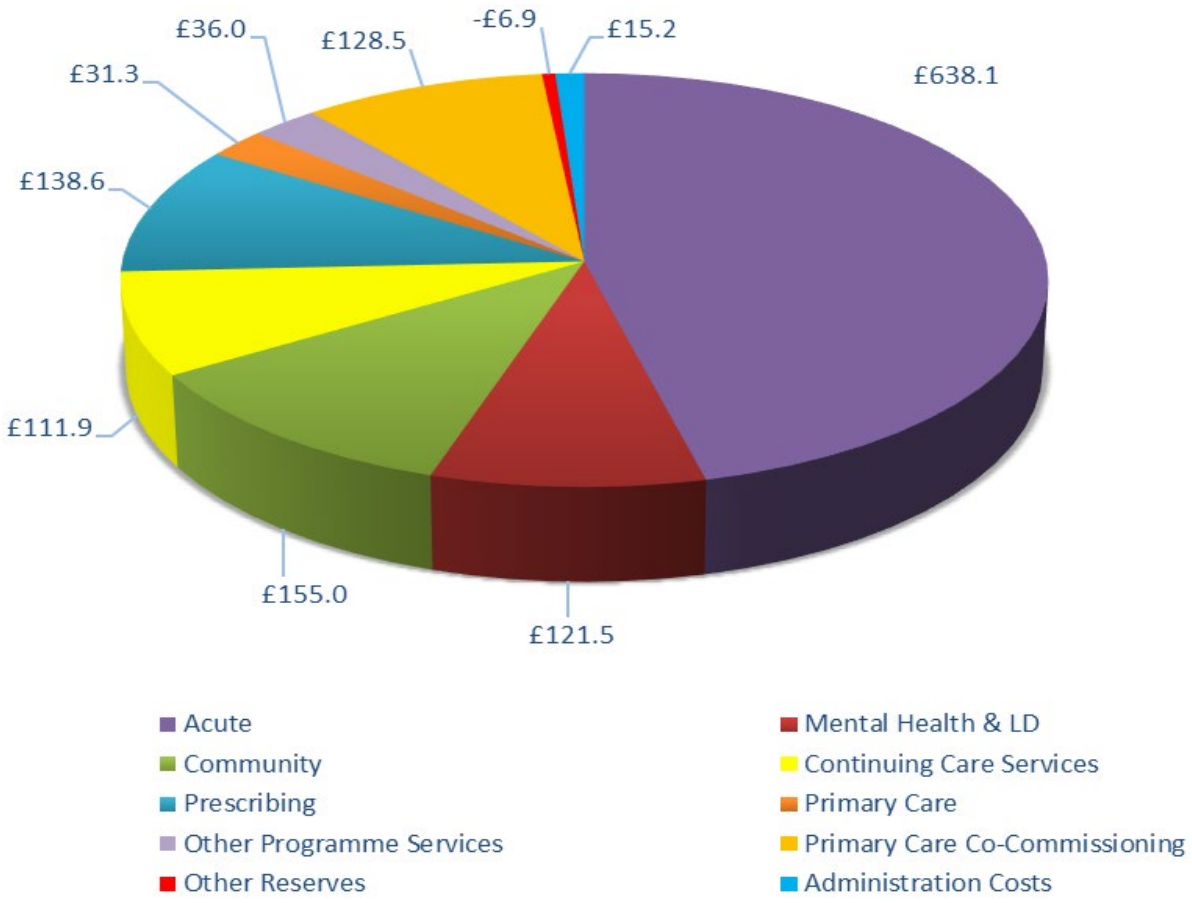
Within Worcestershire, the BCF for 2020/21 is £48.1m of which the CCG has contributed a nationally mandated £39.6 million – the balance of which is made up of the Disabled Facilities Grant of £6.1m and the Improved Better Care Fund grant of £2.4m made to Worcestershire County Council.

Within Herefordshire, the BCF for 2020/21 is £59.8m of which the CCG has contributed a nationally mandated £13.6m – the balance of which is made up by of the Disabled Facilities Grant of £2.3m, Improved Better Care Fund of £6.5m and two additional contributions from the CCG and Council of £10.7m and £26.7m to support care home placements.

Finance summary

Where the money was spent in 2020/21

NHS Herefordshire & Worcestershire CCG 2020/21
Expenditure by Category (£M)



Delivering our Financial Plan

We have delivered against both our Financial Plan for 2020/21 and the Mental Health Investment Standard. The total CCG deficit carried forward is £7.188m, an in-year improvement of £0.635m from the combined £7.823m bought forwards from the four legacy CCGs (Herefordshire CCG, Bromsgrove and Redditch CCG, South Worcestershire CCG and Wyre Forest CCG).

Following the outbreak of the COVID-19 pandemic the NHS suspended formal planning and implemented a centrally led financial regime which introduced new funding arrangements, whereby the CCG was reimbursed for all cost incurred during April 2020 to September 2020, allowing a breakeven position to be reported. During the second half of the year, covering the period October 2020 to March 2021, the CCG was allocated a system financial envelope in line with spend incurred in the first half of the year.

The Net Operating Expenditure for the financial year 2020/21 totalled £1.369bn, the largest area of committed spend was incurred through NHS contracts, these contracts cover Acute,

Community and Mental Health Services, a total of £854.9m. Under the national financial regime, the CCG were provided contract values which were nationally calculated based on actual spend in the previous financial year, as such this part of the financial portfolio was fixed. The next largest area of spend was recorded against Primary Care covering Co-Commissioning where the CCG has been delegated responsibility of local GP services from NHS England, and other Primary Care services covering more localised services outside of the national General Medical Services (GMS) contract, a total of £159.8m.

There were several areas of spend which were outside of this envelope, the largest covering the Hospital Discharge Programme which the CCG recorded £39.969m of spend against during 2020/21, in total Herefordshire and Worcestershire CCG recorded £69.451m of spend against COVID-19 during 2020/21, £18m of this through its NHS block contracts with its in system providers to support their COVID-19 related costs during the second half of the financial year.

The CCG experienced significant volatility in Continuing Healthcare (CHC) during 2020/21. On average costs of packages in CHC have risen by over 10% between 2019/20 and 2020/21, this as a result of increased personal protective equipment requirements and enhanced infection prevention and control at provider premises and the need for social distancing decreasing available care space. The CCG spent £111.9m during 2020/21 on Continuing Healthcare services which included the spend on the Hospital Discharge Programme, this compared with £68.5m during 2019/20 across the legacy four CCGs. These additional costs have been funded during 2020/21 under the Hospital Discharge Programme and government commitment to support organisations to breakeven, however the recurrent impact of these costs will require management moving into 2021/22. This required in year management and the recurrent impact of these price increases seen as a result of managing in the COVID-19 environment will need to be managed moving forwards.

In addition to the volatility in CHC the CCG also experienced volatility in its prescribing costs, which included dispensing fees. During the financial year the CCG has seen its cost growth exceed national cost growth by over 2.2%. At the outset of the pandemic costs seen for March 2020 were 22% higher than in March 2019, with cost in April 17% higher than recorded the previous year, this volatility has remained all year with rises in dispensing fees also being a major contributing factor. The CCG spent £138.6m during 2020/21 on prescribing, this compared with £123.5m during 2019/20, again, these additional costs have been funded during 2020/21 under the government's commitment to support organisations to breakeven, however the recurrent impact of these costs will require management moving into 2021/22.

COVID-19 Expenditure

COVID-19 expenditure was treated in two separate ways under the Financial Regime in place during 2020/21. For the first half of the year covering the period April 2020 to September 2020, all spend was reimbursed to systems to allow a breakeven position to be reported. Spend during the first half of the year was mainly aligned to the Hospital Discharge Programme, in addition to this the system incurred expenditure on remote management of patients, support for home working, personal and protective equipment (PPE), swabbing services, decontamination and segregation of patient pathways.

During the second half of the year the spend on the Hospital Discharge continued through until March 2021 and reimbursement made based on the guidance in place. For the second half of the year the system was given a system COVID-19 top-up to manage expenditure in all of the other areas at a system level, this covering all in scope spend, the Hospital Discharge scheme remaining out of scope and funded separately. In total the CCG has

incurred a total of £69.451m against COVID-19 during 2020/21 of which the CCG has spent £39.9m under the Hospital Discharge Programme.
All unused COVID-19 funding was returned as part of the CCG''s surplus.

Financial Allocation for 2021/22

The national financial regime in place during October 2020 to March 2021 has been rolled forwards into the first half of 2021/22, entitled H1, allocations have been released and a requirement in place for the system to breakeven. The finance regime for the second half of 2021/22 is unknown at present but planning has been undertaken across the system based on the system returning to published allocations in a move back to the Long Term Plan outlined by the NHS during 2019, whereby allocations were published covering the five year period 2019-2024.

As part of this plan the CCG is required to demonstrate an increase in spend on mental health services in line with the overall programme allocation growth as a minimum, and to hold an unallocated contingency reserve of up to 0.5% to manage any additional costs in-year as part of our agreed financial plans.

System Planning

System planning now turns to restoration and how we get back to business as usual, the national pandemic has meant elective care services have been affected and waiting list numbers have increased nationally. The CCG is working with system partners and is exploring all opportunities to improve the waiting list times and numbers waiting and aims to access additional funding through the Elective Recovery Fund to support this.

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 2020/21 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 that was on-going throughout the financial period brings a new set of circumstances for the CCG around recovery and restoration of services.

The Government has pledged to support the NHS financially as such we believe that this situation does not therefore lead to material uncertainty about the going concern of the CCG.

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

Performance analysis

Development and performance during 2020/21

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 2020/21 based on the following areas of work:

1. Improving care and quality

Ensuring the commissioning of high quality, safe, effective and sustainable primary and secondary health care through the achievement of constitutional standards/local improvement targets and delivery of key outcomes across challenged specialties

2. Delivery of GP Forward View and Integrated Care Plan

Developing a new model of care and delivery plan that supports sustainable primary care, delivery of the GP Forward View and the effective integration between primary, secondary, community and social care services consistent with integrated care principles and the Long Term Plan (LTP).

3. Financial Recovery and Sustainability

Sustaining financial recovery by the delivery of the Financial Recovery Plan, facilitating long term financial sustainability.

Sustainable development

For the NHS, the challenge is to deliver high quality care and continually improve health and wellbeing for present and future generations, all within the available social, financial and environmental resources. Sustainable development therefore promotes the idea that social, environmental and economic progress are all attainable within the limits of our earth's natural resources.

Sustainability has been recognised at a national level as an integral part of delivering high quality healthcare efficiently. The contribution the NHS can make to the sustainability agenda has been clearly set out in the Long Term Plan, the campaign for a Greener NHS which was launched in January 2020, and more recently the Delivering a 'Net Zero' National Health Service report published in October 2020.

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 through the implementation of our newly adopted Green Plan.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the national ambition which is to improve healthcare while reducing harmful carbon emissions, and investing in efforts that remove greenhouse gases from the atmosphere.

With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act (Delivering a 'Net Zero' National Health Service).

Two clear and feasible targets are outlined in the Delivering a 'Net Zero' National Health Service report:

- The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040

- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

The Greener NHS National Programme exists to drive this transformation while delivering against our broader environmental health priorities. Laid out in the NHS Long Term Plan, these extended sustainability commitments range from reducing single-use plastics and water consumption, through to improving air quality.

Policies

To embed sustainability within our business it is important to explain where in the CCG's processes and procedures sustainability features. This includes:

- Our Governing Body has recently adopted our first Green Plan (2021-2022)
- Signed up to the NHS Plastics Pledge to reduce single use plastic
- The CCG already considers sustainability at both selection stage, such as the Pre-Qualification (PQQ) stage and award tender stage for commissioning activities in response to The Social Value (Public Services) Act 2012
- Appointment of a Director of Digital Health and Infrastructure to support the digital transformation agenda and to drive down residual emissions from digital services
- First NHS Body in Herefordshire and Worcestershire to have Microsoft Teams technology available to support its staff and GPs in working from home since the COVID-19 pandemic began
- The CCG Chair has the Governing Body level statutory role for the sustainability / net zero agenda
- The CCG's Associate Director of Corporate Services is the Executive Lead and ICS/STP Lead for this area of work
- The internal staff Health and Wellbeing Group continues to raise awareness and further employee's understanding about 'green' issues through a range of delivery tools.

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 must be provided in part through contracting mechanisms as described above, and through their Annual Sustainability Reports. On a quarterly basis the CCG brings together the Sustainability Leads from our three main NHS Trust providers so that we can start to consider the priorities for an ICS Green Plan and support each other with the delivery of our own organisational Green / Sustainability Plans through the sharing of best practice and learning.

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 (CO_2e) 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 an effective commissioning body. During 2020/21 the continued contribution of the Quality Team ensured that each commissioning decision was subject to a robust Quality Assurance process, and where required informed by a Quality Impact Assessment process.

We work in close partnership with our commissioning and provider partners to ensure that all aspects of quality across the health economy in Herefordshire and Worcestershire has appropriate oversight and leadership to work toward solutions. 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 for Herefordshire and Worcestershire, and with the CCG Governing Body, in public. During 2020/21 we have worked in an increasingly integrated manner with partners across the system, to respond to the demands of the COVID-19 pandemic and the needs of our local population.

The use of patient narrative and experience continues to support the system 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 across Herefordshire and 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 2020/21 include:

- We received national recognition by NHS England within the 2021/22 Planning Guidance, of the coproduction collaborative work undertaken during 2020/21 to develop resources to support Primary Care Networks to deliver Annual Health Checks for people with Learning Disability. This contributed to an uptake rate of 85% across Herefordshire and Worcestershire, with several practices delivering Annual Health Checks to over 90% of people on their Learning Disability Register.
- Continued to strengthen working partnerships across Herefordshire and Worcestershire, including experts by experience and family carers, to ensure that learning emerging from the Learning Disability Mortality Review programme (known as LeDeR) influences local practice. During 2020/21 this included focused work on enabling COVID-19 vaccine uptake, achieving over 90%. To achieve this we worked collectively to consult and understand the barriers, using existing networks including the Staying Healthy Sub Group of the Learning Disability Partnership Board in Worcestershire and the Learning Disability Partnership Board in Herefordshire, to communicate facts in a way that all partners could understand and to unblock any challenges. Taking learning from local and national reports about LeDeR COVID-19 Rapid Reviews, we sought Ethics Forum support and Clinical Commissioning Executive Committee approval to offer vaccination for people with learning disability in care settings alongside JCVI 1. We were able to support earlier vaccination for many of our local Learning Disability population and they subsequently experienced a significantly reduced death rate in wave two of the UK COVID-19 pandemic.

- We provided the necessary leadership to coordinate a system approach to quality assurance for the system COVID-19 vaccination programme. By promoting, supporting review methodology, collating and sharing learning identified when inadvertent adverse or unexpected outcomes were realised, we supported system wide safety improvement and narrowed or closed the gaps in vaccine equity for many otherwise marginalised groups.
- Confirmed a Registered Patient Safety Specialist for the CCG in line with the national NHS Patient Safety Strategy. This individual is part of Patient Safety Specialist Network that will be key to galvanising the formation of effective local networks and support of delivery of the Strategy. Initially the key focus of the role is to support development of the patient safety syllabus and patient safety education and training.
- Maintained close working relationships with providers during the period of the pandemic to ensure there was a proportionate response to reported potential and actual adverse events so that all opportunities for learning were exploited and change implemented.
- Worked collaboratively with partners across the health and social care system to offer an integrated approach to supporting care settings through the COVID-19 pandemic. This included building additional resource onto the existing CCG Infection Prevention and Control Team, with the CCG hosting a COVID-19 Infection Prevention and Control Team to work alongside local authority and Public Health partners. Additional Quality Team support was provided into this dedicated 'cell' to ensure care settings were supported in a timely way.
- Provided expert Infection Prevention and Control advice and support to Primary Care to enable the safe re-introduction of face to face clinic facilities as soon as they were able during wave one of the COVID-19 pandemic.
- The CCG led a systemwide learning and sharing meeting fortnightly with infection prevention and control provider lead to promote systemwide sharing and learning from the COVID-19 pandemic.
- Launched an STP Personalised Palliative and End of Life Care Strategy incorporating the shared objectives for all partners involved in the patient pathway.
- Brought together stakeholders to ensure a system wide response to ensure the needs of those at the end of life were appropriately met during the COVID-19 pandemic, including publishing local guidance and information to consistently promote good practice based on evidence.
- Set up a system wide Bereavement Services Group to share best practice, better understand current provision and map future need.
- Commissioned additional bereavement services from Herefordshire and Worcestershire hospice providers to widen access to specialist provision during the pandemic.
- Worked with a wide range of partners to ensure that the ReSPECT process continued to be embedded, enabling an effective and shared approach to advance care planning.
- Worked closely with partners to develop integration of end of life care services in Herefordshire and Worcestershire to ensure joined up provision for patients.
- COVID-19 has impacted on the safeguarding system. The CCG, as system leads worked with partners in the Safeguarding Children Partnerships and Safeguarding Adult Boards and focused on our wider partnership response to the impact of COVID-19 restrictions on the safety and wellbeing of children and young people; and adults (with care and support needs) across Herefordshire and Worcestershire. We have recognised that the scale of this 'hidden harm' is yet to be fully understood. The ability of our multi-agency child safeguarding arrangements and our multi-agency

safeguarding adult arrangements to respond to this remains a priority for the safeguarding system.

- The CCG as one of the three Safeguarding Partners, alongside the Local Authority and Police, under the statutory guidance of 'Working Together to Safeguard Children' July 2018, have equal and joint responsibility for the effectiveness of local safeguarding children arrangements in Herefordshire, (Herefordshire Safeguarding Children Partnership-HSCP) as well as Worcestershire, (Worcestershire Safeguarding Children Partnership -WSCP). We have worked together to implement, embed and review the Safeguarding Children Partnership arrangements in each area; working with relevant agencies to improve safeguarding practice across the multi-agency system and respond to the needs of children in the area.
- The CCG's Safeguarding Team established a Herefordshire and Worcestershire Safeguarding Leads Forum where good practice is shared. Safeguarding Leads across the system worked together to improve the effectiveness of the safeguarding system.
- The CCG has supported shared learning and joint workstreams between both Safeguarding Adult Boards.
- The CCG worked in close partnership with the Local Authority (Public Health), in their role as Child Death Review (CDR) Partner for Herefordshire and Worcestershire. A joint Child Death Overview Panel which reviews all child deaths in both areas was established and an Independent Chair appointed. Thematic reviews with the wider West Mercia region are planned for the coming year.

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.

Complaints

In 2020/21 we received 218 complaints about services that we commission. The complaints are categorised as follows:

Subject	Number of complaints
Commissioning - CHC	49
Commissioning - other	39
Provider - Acute	47
Provider - Community	33
Provider - NHS111	2
Provider - Independent Sector	10
Provider - Ambulance	1
Provider - Nursing Homes (Infection Control)	1
Provider – GP practices	21
COVID-19 vaccination related complaints	15
Total	**218**

The key themes of the complaints received during 2020/21 were:

- **Access to GPs through the COVID-19 lockdowns** – complaints from individuals and via MPs
- **CHC complaints** – issues regarding communications, length of time taken to resolve issues with outcome letters being sent following appeals and backlog of payments due to clients/families
- **Mental health services** – access and issues relating to increased need during lockdowns
- **MP complaints** – relating to GP access and service provision as well as complaints associated to the COVID-19 vaccination programme, particularly in the early stages of rollout
- **Commissioning complaints** – relating to ear syringing and Long Covid services

Complaints to the Parliamentary and Health Service Ombudsman

Three CHC related complaints were reported on by the Parliamentary and Health Service Ombudsman during 2020/21. Two were not upheld, and one is awaiting an Independent Review Panel before further action can be taken.

No recommendations were made to the CCG by the Parliamentary and Health Service Ombudsman in 2020/21.

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, to enable us to engage with 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 incorporates:

- Patient and Public (PPI) Lay Representative on the Governing Body – presents the Communications and Engagement Highlight Report.
- Herefordshire and Worcestershire Involvement Network (HWIN) – regular updates and opportunities to be involved.
- Patient Participation Groups (PPGs) and their virtual network – regular updates, opportunities to be involved, engagement tools and sharing best practice.
- Partners across the Integrated Care System (ICS) including local Councils, Health Providers, Healthwatch and Voluntary and Community Sector (VCS) organisations
- Communications and Engagement team and working across the STP – fortnightly meetings with colleagues
- Engagement Manager Network – an informal network to support and share engagement and experience knowledge across the STP.

The pandemic has caused challenges and changes that has meant how we engage has had to be adapted. It is now more important than ever before to guarantee we are always on top of our engagement work and can adapt and change our engagement practices. 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 help to identify when engagement work needs to be carried out. Having this overarching system makes sure nothing is missed. Software such as Survey Monkey, Microsoft Teams and Outlook, have enabled us to continue our engagement virtually, in keeping with the government's social distancing guidelines.

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 2020/21 patient stories have focused upon a range of agreed themes, such as: examples of care being delivered within an acute setting during the COVID-19 pandemic; the potential impact of missed Annual Health Checks for individuals with learning disabilities; patient experience of elective care during the pandemic. Since the beginning of 2021, focus has been on patient's experience of booking and receiving COVID-19 vaccinations.

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.

The CCG ran a patient experience survey in the summer asking for feedback on experience of services since the pandemic began. This gave such insight and depth of information we now have an ongoing Patient Experience Feedback survey open that we review every two months. The key themes and trends emerging from this are shared with the Quality Team and other relevant CCG teams, as well as our colleagues in provider trusts.

Key highlights

Our major achievements this year have included:

Continuous engagement
We have recognised the importance and need for proactive and continuous engagement with patients and members of the public during the pandemic period. Continuous engagement ensures that patients across Herefordshire and Worcestershire can share their voice and views without having to wait to be called to engage. In line with the government guidelines, the engagement team has explored ways to make engagement as accessible as possible by offering an alternative to in-person sessions. The engagement team have sought to seek new and innovative ways to engage with the digitally excluded and the seldom heard. We have put together a continuous engagement plan to enable the CCG to maintain an ongoing active listening process with the public and stakeholders.

Digital Inclusion Advisory Group (DIAG)
We established the Digital Inclusion Advisory Group (DIAG) with advocate organisations, the voluntary and community sector, statutory partners and charities, who represent those who are digitally excluded. DIAG's purpose has been to explore new ways of delivering health and care and the barriers around this, during the pandemic. This work has particularly highlighted areas of support for those who are seldom heard or 'hard to reach' by traditional means.

Vaccine Inequalities Programme (VIP)
The engagement team have been part of the Vaccine Inequalities Programme (VIP). The aim of the programme is to ensure that all members of the population have access to and take the opportunity of having the COVID-19 vaccine. In particular, we have provided engagement support to population groups at risk of low COVID-19 vaccine uptake. This is to ensure that every eligible person living in Herefordshire and Worcestershire has the opportunity to receive the vaccination in a timely manner, within the national Joint Committee on Vaccination and Immunisation (JCVI) guidance. This is a very important programme of work which will contribute significantly to reducing health inequalities across Herefordshire and Worcestershire.

Staff engagement training
To ensure that the patient voice is at the centre of all work the CCG undertakes, we have provided engagement training sessions and tools for all CCG staff. The training sessions expand on the CCG's legal duty to engage, the types of engagement and experience methods available, where staff need to report any engagement they do themselves and information on the volunteer policies. We think is essential to raise awareness to all CCG staff about the legal duties the CCG has to undertake engagement, and to ensure that all staff are clear with what processes and actions they are required to take.

Seeking representative views

Due to the pandemic, we have been unable to engage by our usual methods. This has forced us to reassess and change to way that we engage with our population. We have sought out seldom heard groups, communities and members of the public by incorporating a mix of traditional and newer engagement methods. We appreciate everyone has different engagement needs that go beyond the routine engagement methods and have worked hard to ensure everyone's voice is heard. This work includes:

- Engagement with people and groups with protected characteristics – We have set up a database of voluntary and community sector organisation and charities who support those from protected characteristics, to enable engagement with targeted groups / communities
- Young People - through our regular activities and links with the Youth Engagement Network Group (YENG)
- Older people – the End of Life Programme has patient experience feedback agenda item at every meeting
- Working with the Voluntary and Community Sector (VCS) to support engagement with seldom heard groups such as carers, vaccine inequalities and the digitally excluded.
- Local engagement with GP practice populations – we send regular communications with Patient Participation Group (PPG) representatives and by asking for their feedback on topics such as virtual engagement and the Shared Care Record (previously known as the Integrated Care and Wellbeing Record (ICWR)). Our contact with PPG representatives has been instrumental in gathering local views and for engagement with the seldom heard or 'hard to reach' by traditional means.
- Through the Vaccine Inequality Programme we, and our partners, have engaged with the following groups; rough sleepers, the learning disabled and their carers, and faith communities particularly Mosques.

Looking ahead to 2021/22

From April 2021, the engagement team will continue to be part of the Vaccine Inequalities Programme, planning to ensure that all members of the population have access to, and take the opportunity of having the COVID-19 vaccine. This is a very important programme of work which will contribute significantly to reducing health inequalities across Herefordshire and Worcestershire. We will be focusing on priority groups, which will include Eastern European communities and urban deprived areas.

We shall maintain our engagement support on the Herefordshire and Worcestershire Shared Care Record. This will include coproducing the ‘Care Portal’ element to the Shared Care Record and engaging on the plan to implement a new system to enable health and care organisations to better integrate patient records.

We will support the ‘recovery’ programme to ensure that the patient’s view and opinions are represented in the plans to restore services.

The Personalised Care agenda will continue to be a priority and the engagement team will ensure that this is included in all the conversations we have with patients and the public.

The formation of the ICS will require communications and engagement with partners, stakeholders and the public. We shared the consultation with our networks and will continue to work with them to develop the new ways of working.

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 the two counties. 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/ICS 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 one 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 the local authorities, Public Health teams, our member GP practices, the Voluntary and Community Sector and patients themselves through co-production. Partners meet monthly at the ICS Health Inequalities and Prevention Collaborative which is chaired by the CCG Accountable Officer. Focus over the last year has included the eight urgent actions for tackling health inequalities set out by the NHSEI guidance as part of its phase 3 response to the COVID-19 pandemic. The actions have been further distilled into 5 priority areas our local high level plan is structured around. We recognise that to turn the tide on reducing health inequalities we need the right infrastructure, principles and framework in place across the system. Our plan includes creating awareness and building capability to embed reducing health inequalities in everything we do. We know to do this effectively we must meaningful engage with our local communities through our voluntary and community sector, working with trusted voices to understand the challenges they face without fear or recourse, and take a multi-agency approach that can genuinely address the causes of the causes to reduce the gap between those best and worst off in our communities.

We have continued to embed the Learning Disabilities Mortality Review (LeDeR) programme across Herefordshire and Worcestershire. Strong foundations have been further cemented by the introduction of the Learning Into Action meeting that promotes the sharing of learning and the co-production of proposed solutions with partners. The steering group oversees this work and ensures progress in the five key Priority Action groups in areas of concern that will improve health outcomes and reduce premature death amenable to quality healthcare.

The CCG has led the Vaccine Inequality Programme (VIP). The aim of the programme is to ensure that all members of the population have access to, and take the opportunity of having the COVID-19 vaccine. This is to ensure that every eligible person living in Herefordshire and Worcestershire has the opportunity to receive the vaccination in a timely manner, within the national Joint Committee on Vaccination and Immunisation (JCVI) guidance. The programme has used data and intelligence from past vaccination campaigns to focus work on targeted population groups, for example; Black and Asian minority groups, those in urban deprived areas, rough sleepers, the learning disabled, those in rural areas, seasonal workers and eastern European communities. The programme has also had a district focus,

responding to current data on COVID-19 prevalence and vaccine uptake. For example, supporting the Redditch area particularly in increasing their vaccine uptake, which has included close working with local council, faith and voluntary sector partners. Various communications and delivery interventions have been initiated in response to the community's needs. For example, drop-in clinics ran for local rough sleepers who were identified and invited to attend by the organisations who supported them.

Digital exclusion has been a key issue this year and much of our work has had to be conducted virtually. Various projects have been implemented to expand our understanding of this issue including the digital inclusion workstream which is part of the Digital First Primary Care Accelerator Programme. This work has highlighted who is digitally excluded in Herefordshire and Worcestershire (older people and those in social housing, which is concentrated in our urban centres but also scattered rurally) and the impact of this on access to services. This intelligence has been shared with CCG teams and our provider colleagues. For example, the Continuing Healthcare Team (CHC) shaped their review meetings with information and 'top tips' gathered during these projects. The Digital Inclusion Advisory Group (DIAG) was formed in response to these projects and will continue to inform the digital exclusion agenda in the coming year.

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 CCG has been demonstrating 'due regard' to the Public Sector 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.
The past year has been difficult and challenging for the NHS due to the national pandemic and the disproportionate impact COVID-19 has had on Ethnically Diverse Communities (EDS) and vulnerable groups. In response to the regional and national findings on the disproportionate impact on protected groups, we developed an Ethnically Diverse (previously referred to as BAME) action plan, to address the impacts both for staff and service users. We have made progress against the action plan, some of which we will report below whilst the full progress report can be found on our Equality and Inclusion web page when it is published in 2021.

We are committed to ensuring that equality, inclusion and human rights are 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

Herefordshire and Worcestershire CCG has 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 2020/21 as well as group session via Microsoft teams. Further training will be scheduled throughout 2021/22 so all of our staff has the opportunity to complete

Equality Impact Assessment (EIA) Process

The EIA toolkit has been developed to help us to identify potential and actual inequalities, thus enabling the proposed service 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 EIAs at the time of developing and reviewing policies and redesign of services. To equip staff with the necessary skills in undertaking the EIAs, 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 Commissioning

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 EIA process. The Equality and Inclusion Business Partner quality reviews the equality analysis and provides support, advice, and guidance as necessary.

The STP/ICS Equality Group brought together commissioning organisations and providers in Herefordshire and Worcestershire. The group is comprised of all key stakeholders and has meet regularly in the past year to find ways of bringing our work projects together. The ICS/STP Equality Group has been striving to work on joint approaches on key areas around equality and inclusion.

Equality Strategy 2020-2024 and Equality Objectives

In 2020, we developed our four-year Equality Strategy and established the Equality Objectives. We have been making progress on the Equality Objectives. 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	*Ensure all policies, strategies, service specifications, business plans, and commissioning/decommissioning projects undertake an Equality Impact and Risk Analysis*
Equality Objective 3	*Put in place an action plan which looks at the Governing Board membership and seek to make it representative of the BAME workforce/population, whichever is the highest.*
Equality Objective 4	*Implementation of the 'Beyond the data' recommendations due to the disproportionate impact and high number of deaths in the BAME community.*

Our Equality Impact Analysis (EIA) process has key questions around engagement and consultation in respect of commissioning/decommissioning services in respect of **Equality Objective 1.** As part of the EIA 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,** training has been delivered to relevant staff on the importance of completing the EIA forms on all projects in the summer of 2020. All the projects and proposals on the CCGs' online Verto system now direct commissioning staff to complete the EIA paperwork before the project can be approved. More work needs to be undertaken to ensure that all committees are checking for EIA 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.

For **Equality Objective 3 and 4**, we have developed an action plan to address the disproportionate impact of COVID-19 on vulnerable groups of which the ethnically diverse/BAME category has had specific actions to address the high impact and deaths in these communities. We continue to work with and understand these communities and have put in place actions from where progress can be measured to address the disproportionate impact. There will be annual report which will detail the progress made in 2021/2022

Equality Delivery System 2 (EDS2)

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.

With approval of NHS England and Improvement, the CCG, as part of the STP/ICS 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 2021/22. 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 2021/22 contract. Due to COVID-19, some elements of the contract were suspended last year and we will continue to work with providers to gain the assurance that we need that all contractual requirements are being met going forward.

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 Ethnically Diverse/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 2021/22 and beyond

The following list describes the areas which the CCG will prioritise, and will form part of the work plan for 2021/22:

1. Continued progress on the Equality Strategy and Equality Objectives for Herefordshire and Worcestershire CCG (HWCCG)
2. Development of the equality and inclusion action plan for HWCCG.
3. Development and delivery of Board development training for HWCCG.
4. Annual Review of Equality Objectives 2020-2024
5. Continued work on NHSEI standards and requirements
6. Work in partnership with colleagues across the ICS 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 reports on equality
13. Continued work within the procurement process on equality evaluation.

Our performance

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

Our performance is monitored using a number of different approaches including statistical process control which can be used to identify variation. Where variation is identified, a full review takes place as part of the Quality, Performance and Resources (QPR) committee which enables triangulation between finance, quality and performance. The annual review process brings together the outcomes of service changes with strategic goals, aims and financial spend.

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 2020/21 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 of 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%	82.259%
	Trolley waits in A&E < 12 hours	0	109
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	92%	56.23%
	Number of 52 week waiters on an incomplete pathway	0	7,665

Indicator		Target	Achieved
Cancer - 2-Week Waits	Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	85.54%
	Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	58.54%
Cancer Waits - 31-Days	Maximum one month (31 day) wait from diagnosis to first definite treatment for all cancers	96%	94.17%
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	81.12%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%	99.36%
	Maximum 31 day wait for subsequent treatment where that treatment is a course of Radiotherapy	94%	97.97%
Cancer Waits - 62-Days	Maximum two months (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	70.87%
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	79.88%
	Maximum 62 day wait for first definitive treatment following a consultant decision to upgrade the priority of the patient (all cancers)	94%	89.09%
Diagnostic Test Waiting Times	Patients waiting for a diagnostic test should have been waiting less than six weeks	99%	49.55%

Indicator		Target	Achieved
Category A ambulance calls	Red performance – response average within 7 minutes	00:07:00 hh:mm:ss	Redditch & Bromsgrove – 00:06:58 South Worcestershire – 00:08:24 Wyre Forest – 00:09:10 Herefordshire – 00:10:54 hh:mm:ss
	Ambulance handover times - % < 30 minutes (Worcestershire Acute position)	85%	Worcestershire Acute Hospitals NHS Trust: 91.4% Wye Valley NHS Trust: 88.16%
Mixed Sex Accommodation Breaches	Minimise breaches	0	Collection suspended since Feb 2020
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%	Collection suspended since Feb 2020
	IAPT - % of patients with depression and/or anxiety disorders who receive psychological therapies	22% by Mar 20	17.6%
	IAPT recovery - % of patients who have completed treatment who are moving to recovery	50%	50.81%
	% 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%	85.9%
	% 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%	98.72%
	% 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%	61%

Indicator		Target	Achieved
	% 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%	99.23%
	Estimated diagnosis rate for people with dementia for those patients aged 65+	67%	50.04%
Health Care infections	Incidence of healthcare associated infections - MRSA	0	4
	Incidence of healthcare associated infections – C Difficile	Not set	2016

Improving Performance

The achievement of constitutional standards and key performance measures has been significantly impacted throughout 2020/21 due to the impact of COVID-19 on both clinical and operational capacity. Monitoring of waiting lists, performance and activity has been maintained and is integral to recovery plans. As we move into 2021/22 waiting list recovery, supporting access to core services and maintaining delivery to support COVID-19 care are core and critical elements of the strategy.

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 and analysis of trends (SPC) at all levels in the system. 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 between all system partners. 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. As we move into 2021/22 these structures will evolve as the ICS delivery model moves into operational delivery.

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. The CCG also attend provider Trust Quality Governance Committee where we support, review, and challenge, care quality and performance factors 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. Delivery and reporting has again been significantly impacted due to the COVID-19 response, with a range of measures stood down during the year as service capacity switched to support treatment of patients with COVID-19 needs. As we move into 2021/22 new monitoring framework, taking a view on ICS development, system delivery is expected to be reintroduced and will form the basis of system assessment and improvement focus.

The latest published annual rating for the CCG was 'Good'. This relates to the 2019/20 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 Herefordshire and Worcestershire CCG
11 June 2021

Corporate Governance Report

Directors' Report

Our GP membership

There are 81 GP member practices which form NHS Herefordshire and Worcestershire CCG. They are as follows:

Abbey Medical Practice, Abbey Lane, Evesham, Worcestershire, WR11 4BS
Abbottswood Medical Centre, Defford Road, Pershore, Worcestershire, WR10 1HZ
Albany House Surgery, Albany Terrace, Worcester, Worcestershire, WR1 3DU
Alton Street Surgery, Alton Street, Ross-on-Wye, Herefordshire, HR9 5AB
Aylmer Lodge Cookley Partnership, Hume Street Medical Centre, Kidderminster, Worcestershire, DY11 6SF
Barbourne Health Centre, 44 Droitwich Road, Worcester, Worcestershire, WR3 7LH
Barn Close Surgery, 38 - 40 High Street, Broadway, Worcestershire, WR12 7DT
Barnt Green Surgery, 82 Hewell Road, Barnt Green, Birmingham, West Midlands, B45 8NF
Belmont Medical Centre, Eastholme Avenue, Belmont, Herefordshire, HR2 7XT
Bewdley Medical Centre, Dog Lane, Bewdley, Worcestershire, DY12 2EF
Bredon Hill Surgery, Main Road, Bredon, Tewkesbury, GL20 7QN
Cantilupe Surgery, 51 St Owen Steet, Hereford, Herefordshire, HR1 2JB
Catshill Village Surgery, 36 Woodrow Lane, Catshill, Bromsgrove, Worcestershire, B61 0PU
Chaddesley Corbett Surgery, Hemming Way, Chaddesley Corbett, Kidderminster, Worcestershire, DY10 4SF
Church Street Surgery, David Corbet House, Callows Lane, Kidderminster, Worcestershire, DY10 2JG
Churchfields Surgery, BHI Parkside, Stourbridge Road, Bromsgrove, Worcestershire, B61 0AZ
Colwall Surgery, Stone Drive, Colwall, Malvern, Worcestershire, WR13 6QJ
Cornhill Surgery, 65 New Road, Rubery, Birmingham, West Midlands, B45 9JT
Crabbs Cross Medical Centre, 39 Kenilworth Close, Crabbs Cross, Redditch, Worcestershire, B97 5JX
Crabbs Cross Surgery, 1 Kenilworth Close, Crabbs Cross, Redditch, Worcestershire, B97 5JX
Cradley Surgery, Bosbury Road, Cradley, Malvern, Worcestershire, WR13 5LT
Davenal House Surgery, 28 Birmingham Road, Bromsgrove, Worcestershire, B61 0DD
DeMontfort Medical Centre, Burford Road, Evesham, Worcestershire, WR11 3HD
Elbury Moor Medical Centre, Fairfield Close, Worcester, Worcestershire, WR4 9TX
Elgar House Surgery, Church Road, Redditch, Worcestershire, B97 4AB
Farrier House Surgery, Farrier House, Farrier Street, Worcester, WR1 3BH
Fownhope Surgery, Common Hill Lane, Fownhope, Herefordshire, HR1 4PZ
Golden Valley Practice, Temple Terrace, Ewyas Harold, Herefordshire, HR2 0EU
Great Witley Surgery, Worcester Road, Great Witley, Nr Worcester, WR6 6HR
Grey Gable Surgery, High Street, Inkberrow, Worcestershire, WR7 4BW

Hagley Surgery, 1 Victoria Passage, Hagley, Stourbridge, West Midlands, DY9 0NH
Haresfield Surgery, Turnpike House Medical Centre, 37 Newtown Road, Worcester, WR5 1HG
Hereford Medical Group, Station Medical Centre, Station Approach, Herefordshire, HR1 1BB
Hillview Medical Centre, 60 Bromsgrove Road, Redditch, Worcestershire, B97 4RN
Hollyoaks Medical Centre, 229 Station Road, Wythall, Birmingham, West Midlands, B47 6ET
Hollywood Medical Practice, Beaudesert Road, Hollywood, Birmingham, West Midlands, B47 5DP
Kidderminster Health Centre, Waterloo Street, Kidderminster, Worcestershire, DY10 2BG
Kingstone Surgery, The Surgery, Kingstone, Herefordshire, HR2 9HN
Kington Surgery, Eardisley Road, Kington, Herefordshire, HR5 3EA
Knightwick Surgery, Bromyard Road, Knightwick, Worcester, WR6 5PH
Ledbury Health Partnership, Market Street, Ledbury, Herefordshire, HR8 2AQ
Malvern Health Centre, 300 Pickersleigh Road, Malvern, Worcestershire, WR14 2GP
Merstow Green Medical Practice, Abbey Lane, Evesham, Worcestershire, WR11 4BS
Mortimer Medical Practice, Kingsland, Leominster, Herefordshire, HR6 9QL
Much Birch Surgery, Much Birch, Hereford, Herefordshire, HR2 8HT
New Court Surgery, Prospect View, 300 Pickersleigh Road, Malvern, Worcestershire, WR14 2GP
New Road Surgery, 104-106 New Road, Rubery, Birmingham, West Midlands, B45 9HY
New Road Surgery, 46 New Road, Bromsgrove, Worcestershire, B60 2JS
Northumberland House Surgery, Hume Street Medical Centre, Kidderminster, Worcestershire, DY11 6SF
Nunwell Surgery, 10 Pump Street, Bromyard, Herefordshire, HR7 4BZ
Ombersley Medical Centre, Main Road, Ombersley, Worcester, WR9 0EL
Pendeen Surgery, Kent Avenue, Ross-on-Wye, Herefordshire, HR9 5AH
Pershore Medical Practice, Queen Elizabeth House, Queen Elizabeth Drive, Pershore, Worcestershire, WR10 1PX
Riverside Surgery, Waterside, Evesham, Worcestershire, WR11 1JP
Salters Medical Practice, Droitwich Medical Centre, Droitwich, Worcestershire, WR9 8RD
Severn Valley Medical Practice, Henwick Halt Medical Centre, 1 Ingles Drive, St John's, Worcester, WR2 5HL
Spa Medical Practice, Droitwich Medical Centre, Ombersley Street East, Droitwich Spa, Worcestershire, WR9 8RD
Spring Gardens Group Medical Practice, Spring Gardens, Worcester, Worcestershire, WR1 2BS
St John's House Surgery, 229 Bromyard Road, Worcester, Worcestershire, WR2 5FB
St Johns Surgery, BHI Parkside, Stourbridge Road, Bromsgrove, Worcestershire, B61 0AZ
St Martin's Gate Surgery, Turnpike House Medical Centre, 37 Newtown Road, Worcester, WR5 1EZ
St Saviours Surgery, Merick Road, Malvern Link, Worcestershire, WR14 1DD
St Stephens Medical Partnership, Adelaide Street, Redditch, Worcestershire, B97 4AL
Stanmore House, Linden Avenue, Kidderminster, Worcestershire, DY10 3AA
Stourport Health Centre, Worcester Street, Stourport-on-Severn, Worcestershire, DY13 8EH
Tenbury Wells Surgery, 34 Teme Street, Tenbury Wells, Worcestershire, WR15 8AA

The Bridge Surgery, 8 Evesham Road, Headless Cross, Redditch, Worcestershire, B97 4LA
The Corbett Medical Practice, 36 Corbett Avenue, Droitwich Spa, Worcestershire, WR9 7BE
The Dow Surgery, William Street, Redditch, Worcestershire, B97 4AJ
The Glebeland Surgery, The Glebe , Belbroughton, Stourbridge, West Midlands, DY9 9TH
The Marches Surgery, Westfield Walk, Leominster, Herefordshire, HR6 8HD
The Ridgway Surgery, 6 - 8 Feckenham Road, Astwood Bank, Redditch, Worcestershire, B96 6DS
Thorneloe Lodge Surgery, 29 Barbourne Road, Worcester, Worcestershire, WR1 1RU
Upton Surgery, Tunnel Hill, Upton Upon Severn, Worcestershire, WR8 0QL
Wargrave House Surgery, 23 St Owen Street, Hereford, Herefordshire, HR1 2JB
Weobley Surgery, The Surgery, Weobley, Herefordshire, HR4 8SN
Westfield Surgery, Westfield Walk, Leominster, Herefordshire, HR6 8HD
Whiteacres Medical Centre, Maple Road, Malvern, Worcestershire, WR14 1GQ
Winyates Health Centre, Winyates Way, Redditch, Worcestershire, B98 0NR
Wolverley Surgery, Wolverley, Kidderminster, Worcestershire, DY11 5TH
York House Medical Centre, York Street, Stourport-on-Severn, Worcestershire, DY13 9EH

Our Governing Body

Our Governing Body is clinically-led, with roles that include a clinical chair, four elected GPs, two Medical Directors and clinically qualified executives. This enables the CCG to have a comprehensive knowledge of the health needs of the Herefordshire and Worcestershire population.

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 the 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 strategic direction of the CCG.

Our Governing Body meets in formal public sessions six times a year, however due to the pandemic, all 2020/21 meetings took place virtually. 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 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 and Appointments 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 and Gifts and Hospitality Policy in place, publicly available Register of Interests and Register of Procurement Decisions. All of these can be found on our website at
https://herefordshireandworcestershireccg.nhs.uk/about-us/corporate/conflicts-of-interest
https://herefordshireandworcestershireccg.nhs.uk/about-us/corporate/procurement

Personal data related incidents

No personal data related incidents were reported to the Information Commissioner's Office during 2020/21 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. A Core Standards return is normally undertaken annually. This year the process changed due to COVID-19 pressures and assurance was provided including winter pressure and COVID-19 management integration, but the work plan for Core Standards delivery for the HWCCG continued.

The CCG's Governing Body received the minutes from the Clinical Commissioning and Executive Committee on 11 November 2020 containing an updated report on Emergency Planning and the Core Standards assurance process in October 2020. HWCCG has maintained 'Substantially Compliant' rating during 2020. The CCG also works with its key providers to support and monitor their compliance with the Core Standards.

The CCG has in place an 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 an EPRR Policy, EPRR on call policy and Business Continuity Plan. The Business Continuity plan ensures that in the event of a significant incident threatening personnel, buildings or operational structure, its critical activities can still be delivered.

The incident management plan was activated in March 2020 for COVID-19. Policies and plans are being reviewed and learnings shared with multi-agency partners to enhance our response capability and knowledge.

The CCG EPRR are active members of the Local Health Resilience Partnership (LHRP) and represents the local health economy at both the Worcestershire and Herefordshire Tactical Coordinating Groups (TCGs) in the event that an incident requires multi-agency command and control arrangements to be instigated at a county level. Following NHS EPPR command and control protocol, the 'Silver health partnership TCG' in addition was activated in both Herefordshire and Worcestershire.

The CCG has a team of senior managers providing on call cover 24 hours a day, 7 days a week, who undertook refreshed training in 2020 in line with National Occupational Standards and have actively participated in the live pandemic and emergency planning response during 2020. They will be offered further training opportunities to attend events in the future.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Directors' 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 Herefordshire and Worcestershire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2020 is published on our website at https://herefordshireandworcestershireccg.nhs.uk/policies/safeguarding-1/303-modern-slavery-statement-1/file

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 Herefordshire and Worcestershire CCG.

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

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

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the 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.
- Confirm that the Annual Report and Accounts, as a whole, is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts

and the judgements required for determining that it is fair, balanced and understandable.

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

Simon Trickett
Accountable Officer
NHS Herefordshire and Worcestershire CCG
11 June 2021

Governance Statement

Introduction and context

NHS Herefordshire and Worcestershire CCG is a corporate body established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended).

The clinical commissioning group'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 of 1 April 2020, the clinical commissioning group 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.

When the members of the CCG meet to conduct business as the group, through attendance of the Member Practice Representatives, this will be known as the Clinical Commissioning Group Practice Forum. The Clinical Commissioning Group Practice Forum will be established as a membership group of the Herefordshire and Worcestershire Clinical Commissioning Group. The Practice Forum may meet as a single group or as separate counties or localities either face to face or virtually using digital technology. The Clinical Commissioning Group Practice Forum delegates all decision making to the Clinical Commissioning Group Governing Body with these exceptions; -

a) Agreement to make material changes to the CCG's constitution, in line with section 1.4.2. Examples of material changes may include, but is not limited to: dissolution, mergers, changes to the exercise of joint / delegated commissioning functions.
b) Approve the vision, values and overall strategic direction of the CCG
c) Approval of applications to be a member of the CCG, subject to NHSEI approval process
d) Ratify the appointment of elected members of the Clinical Commissioning Group Governing Body
e) Approve the removal of elected members of the Clinical Commissioning Group Governing Body

The group remains accountable for all 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 2020/21 and attendance rates were as follows:

Name	Role	In office during 2020/21	Attendance
Dr Ian Tait	Chair	1 April 2020 – 31 March 2021	6/6
Dr Ian Roper	Elected Governing Body GP (Herefordshire)	1 April 2020 – 31 March 2021	5/6
Dr Richard Davies	Elected Governing Body GP (Redditch & Bromsgrove)	1 April 2020 – 31 March 2021	6/6
Dr Louise Bramble	Elected Governing Body GP (Wyre Forest)	1 April 2020 – 31 March 2021	5/6
Dr George Henry	Elected Governing Body GP (South Worcestershire)	1 April 2020 – 31 March 2021	6/6
Dr Martin Lee	Secondary Care Doctor	1 April 2020 – 31 March 2021	6/6
Prof. Tamar Thompson OBE	Deputy Chair and Lay Member for Patient and	1 April 2020 – 31 March 2021	6/6

	Public Involvement and Quality		
Graham Hotchen	Lay Member for Audit and Governance	1 April 2020 – 31 March 2021	6/6
Rob Parker	Lay Member for Finance	1 April 2020 – 31 March 2021	6/6
Trish Calvert	Lay Member for Primary Care	1 April 2020 – 31 March 2021	6/6
Simon Trickett	Chief Executive/STP ICS Lead	1 April 2020 – 31 March 2021	6/6
Mari Gay	Managing Director (Worcestershire)	1 April 2020 – 31 March 2021	5/6
Lisa Levy	Chief Nursing Officer and Director of Quality	1 April 2020 – 31 March 2021	5/6
Mark Dutton	Chief Finance Officer	1 April 2020 – 31 March 2021	6/6
Dr Carl Ellson	Medical Director for Strategy and Transformation	1 April 2020 – 31 March 2021	6/6
Dr Clare Marley	Medical Director for Quality and Assurance	1 April 2020 – 31 March 2021	2/6

The CCG Governing Body may regularly invite the following individuals to attend any or all of its meetings as attendees:

Name	**Role**
Hana Taylor	Associate Director of Corporate Services
Mike Emery	Director of Digital Strategy and Infrastructure
Lynda Dando	Director of Primary Care
David Mehaffey	Director of ICS
Scott Parker	Director of Performance
Ruth Lemiech	Director of Strategy, Commissioning and Transformation

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 2020/21 and the effectiveness of the Governing Body and committees is reviewed annually. NHS England reviews the performance of the CCG. The CCG has maintained the nationally required Governing Body composition and membership through 2020/21.

Meetings of the Governing Body

The Governing Body met six times during 2020/21 and held all meetings virtually, in view of the COVID-19 pandemic. 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 welcomes 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, which are facilitating the transition to ICS operating models
- Review and oversight of the CCG's response to managing the COVID-19 pandemic and subsequent delivery of restoration plans
- Review of performance against constitutional targets and trajectories, as well as across the full range of challenged/priority clinical specialties
- Review of quality across primary, secondary and tertiary care, including the independent sector commissioned by the CCG for its total population
- Review of the CCG's financial position and sustainability programme, including oversight of the financial regime in place during COVID-19
- 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 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 the Governing Body 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 2020/21 the key areas of work of the committees were:

- Integrated governance, risk management and internal control
- Seeking assurance in respect of the adequacy of financial, governance and corporate systems and processes that have been employed in response to the COVID-19 pandemic
- Approving internal and external audit plans, reviewing progress against these and receiving assurance on actions taken following audits
- Reviewing the 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
- Reviewing systems for financial reporting to the CCG, including those of budgetary control.

The membership of the committee in 2020/21 was as follows:

Name	Role	Membership of the committee during 2020/21
Graham Hotchen (Chair)	Lay Member for Audit and Governance	1 April 2020 – 31 March 2021
Rob Parker	Lay Member for Finance	1 April 2020 – 31 March 2021
Trish Calvert	Lay Member for Primary Care	1 April 2020 – 31 March 2021

Remuneration and Appointments Committee

The statutory role of the Remuneration and Appointments Committee is to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for all 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. In addition, the Governing Body has delegated to the Committee all functions related to the appointment and removal of

Governing Body members, with the exception of Lay Members. The Committee does not have a decision-making responsibility in relation to determinations about remuneration arrangements and makes recommendations to the Governing Body.

During 2020/21 the key areas of work of the committee were:

Remuneration

- Terms and conditions of employment for all employees of the CCG and other individuals providing services to it, including pensions, remuneration, fees, and travelling or other allowances payable to employees and to other persons providing services to the CCG. This does not include Lay Members.
- Performance review framework and pay strategy for staff on VSM contracts;
- Salaries and, if appropriate, performance related awards for the Chief Executive and other staff on VSM contracts in line with the agreed pay strategy and performance review framework;

Appointments

- Decisions about Governing Body and VSM appointments
- Considering succession planning for directors and other senior executives in the course of its work, taking into account the challenges and opportunities facing the CCG, the diversity of the Governing Body and the skills and expertise needed on the Governing Body in the future;
- Keeping under review the leadership needs of the organisation, both executive and non-executive, with a view to ensuring the continued ability of the organisation to deliver its stated aims;
- Approving local role description and person specifications for elected and appointed Governing Body members in line with the CCG's Standing Orders;

The membership of the committee in 2020/21 was as follows:

Name	Role	Membership of the committee during 2020/21
Rob Parker (Chair)	Lay Member for Finance	1 April 2020 – 31 March 2021
Trish Calvert	Lay Member for Primary Care	1 April 2020 – 31 March 2021
Dr Martin Lee	Secondary Care Doctor	1 April 2020 – 31 March 2021
Prof. Tamar Thompson OBE	Lay Member for Patient and Public Involvement and Quality	1 April 2020 – 31 March 2021
Dr Ian Tait	CCG Chair	1 April 2020 – 31 March 2021

Lay Member Remuneration and Appointments Panel

The purpose of the panel is to make decisions about the appointment, removal, remuneration, fees and other allowances for Lay Members of the Governing Body.

The Committee did not meet during 2020/21.

The membership of the committee in 2020/21 was as follows:

Name	Role	Membership of the committee during 2020/21
Dr Martin Lee (Chair)	Secondary Care Doctor	1 April 2020 – 31 March 2021
Dr Ian Tait	CCG Chair	1 April 2020 – 31 March 2021
Dr Louise Bramble	Elected Governing Body GP	1 April 2020 – 31 March 2021
Dr Ian Roper	Elected Governing Body GP	1 April 2020 – 31 March 2021

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 of 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 2020/21:

- Oversight of service recovery and restoration planning across primary care, that supports the wider system restoration, including consideration of how aspects of good practice could be implemented as part of future operating models
- Support primary care integration across the ICS, enabling PCNs to fulfil their national and local potential with strong clinical leadership, exhibiting the characteristics of a Supercharged PCN working as part of a wider District Collaborative
- Continued implementation and delivery of the of the COVID-19 Vaccination Programme
- Contractual management of 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 breach / remedial notices, and removing a contract)
- Implementation and delivery of the PCN Directed Enhanced Service including in year service specifications
- Commissioning and implementation of a new 2021/22 Reducing Variation Improving Outcomes local contract
- Commissioning and implementation of the 2021/22 Local Enhanced Services Contracts approach and the overarching aims relating to delivery of outcomes at place, including equity of approach across Herefordshire and Worcestershire
- Oversight and delivery of improved and extended primary care access programmes, including consideration of contract extensions that may be required in view of the COVID-19 pandemic and the revised Enhanced Access service specification due to be implemented April 2022
- Oversight and delivery of initiatives that have been taken to support general practice in terms of resilience, GP recruitment and retention.

The membership of the committee in 2020/21 was as follows:

Name	Role	Membership of the committee during 2020/21	Attendance
Trish Calvert (Chair)	Lay Member for Primary Care	1 April 2020 – 31 March 2021	5/5
Prof. Tamar Thompson OBE (Vice Chair)	Lay Member for Patient and Public Involvement and Quality	1 April 2020 – 31 March 2021	5/5
Lynda Dando	Director of Primary Care	1 April 2020 – 31 March 2021	5/5
Simon Trickett	Chief Executive	1 April 2020 – 31 March 2021	4/5
Mark Dutton	Chief Finance Officer	1 April 2020 – 31 March 2021	5/5
Dr Clare Marley	Medical Director (Quality & Assurance)	1 April 2020 – 31 March 2021	2/5

Quality, Performance and Resources (QPR) Committee

This committee provides assurance in respect of the quality and safety of all services (primary, secondary and tertiary care, including the independent sector) commissioned by the CCG for its total population. During 2020/21 the key areas of work of this committee was:

- 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.
- Seek assurance that the CCG's Restoration Programme workstream is operating effectively and is on course to successfully implement and mobilise healthcare services delivery across the Herefordshire and Worcestershire healthcare system, in line with nationally mandated priority actions.
- 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 and resources.

The membership of the committee in 2020/21 was as follows:

Name	Role	Membership of the committee during 2019/20
Dr Martin Lee (Chair)	Secondary Care Doctor	1 April 2020 – 31 March 2021
Prof. Tamar Thompson OBE (Vice Chair)	Lay Member for Patient and Public Involvement and Quality	1 April 2020 – 31 March 2021

Rob Parker	Lay Member for Finance	1 April 2020 – 31 March 2021
Trish Calvert	Lay Member for Primary Care	1 April 2020 – 31 March 2021
Dr Ian Tait	CCG Chair	1 April 2020 – 31 March 2021
Dr George Henry	Elected Governing Body GP	1 April 2020 – 31 March 2021
Dr Ian Roper	Elected Governing Body GP	1 April 2020 – 31 March 2021
Dr Richard Davies	Elected Governing Body GP	1 April 2020 – 31 March 2021
Simon Trickett	Chief Executive	1 April 2020 – 31 March 2021
Mark Dutton	Chief Finance Officer	1 April 2020 – 31 March 2021
Mari Gay	Managing Director	1 April 2020 – 31 March 2021
Lisa Levy	Chief Nursing Officer and Director of Quality	1 April 2020 – 31 March 2021
Scott Parker	Director of Performance	1 April 2020 – 31 March 2021
Dr Clare Marley	Medical Director (Quality & Assurance)	1 April 2020 – 31 March 2021
Dr Carl Ellson	Medical Director (Strategy & Transformation)	1 April 2020 – 31 March 2021
Emily Godfrey	Associate Director of Programme Management	1 April 2020 – 31 March 2021
Christine Price	Healthwatch Herefordshire Representative	1 April 2020 – 31 March 2021
Jo Ringshall	Healthwatch Worcestershire Representative	1 April 2020 – 31 March 2021

Clinical Commissioning and Executive Committee

This committee has a delegated responsibility for oversight and decision making about commissioning of clinical services, service transformation and oversight of corporate policies and matters. The committee played a vital role in providing a rapid decision-making function

in respect of COVID-19 clinical policies and guidance. In addition, it focused on the following key areas of work during 2020/21:

- Overseeing the CCG's clinical commissioning and transformation agenda, the implementation of the CCG Clinical Commissioning Strategy and provide assurance to the Governing Body that there is appropriate clinical input into the CCG's decision making;
- Ensuring that the CCG commissioning policies, decisions and transformation plans are consistent with the strategies of the CCG Governing Body, within the strategic context of the Herefordshire and Worcestershire STP;
- Overseeing ICS development, the CCG's transition to a Strategic Commissioner, and providing Strategic Commissioner decision making for the implementation of STP programmes;
- Receiving and approving outline business cases for proposed developments and service changes, service specifications, ensuring appropriate clinical, financial and quality input and challenge have been part of the process;
- Overseeing the CCG's corporate agenda; and
- Overseeing joint commissioning arrangements with local authorities – through S75, Better Care Fund (BCF) and other joint commissioning arrangements.

The membership of the committee in 2020/21 was as follows:

Name	Role	Membership of the committee during 2020/21
Simon Trickett (Chair)	Chief Executive	1 April 2020 – 31 March 2021
Dr Louise Bramble	Elected Governing Body GP	1 April 2020 – 31 March 2021
Dr Richard Davies	Elected Governing Body GP	1 April 2020 – 31 March 2021
Mark Dutton	Chief Finance Officer	1 April 2020 – 31 March 2021
Dr Martin Lee	Secondary Care Doctor	1 April 2020 – 31 March 2021
Dr Carl Ellson	Medical Director (Strategy & Transformation)	1 April 2020 – 31 March 2021
Dr Ian Tait	CCG Chair	1 April 2020 – 31 March 2021
Prof. Tamar Thompson OBE	Lay Member for Patient and Public Involvement and Quality	1 April 2020 – 31 March 2021

Lisa Levy	Chief Nursing Officer and Director of Quality	1 April 2020 – 31 March 2021
Clare Marley	Medical Director (Quality & Assurance)	1 April 2020 – 31 March 2021
Mari Gay	Managing Director	1 April 2020 – 31 March 2021
Ruth Lemiech	Director of Strategy and Transformation	1 April 2020 – 31 March 2021
Dr George Henry	Elected Governing Body GP	1 April 2020 – 31 March 2021
Dr Ian Roper	Elected Governing Body GP	1 April 2020 – 31 March 2021
Jo-Anne Alner	Managing Director (Herefordshire)	1 April 2020 – 31 December 2021
Alison Talbot-Smith	Director of Integration	1 April 2020 – 30 November 2021

Financial Sustainability Committee

The committee focused on the following key areas of work during 2020/21:

- Development and approval of a robust Financial Sustainability Plan
- Ensure that the actions contained within the plan are delivered, and report to the Governing Body on progress
- Oversee the in-year financial plan and financial position to ensure this remains in line with the signed off financial plan for the CCG
- Seek assurance regarding the CCG's response to the NHSEI financial framework, the deployment of financial spend associated with urgent COVID-19 approvals and consideration of financial recovery / sustainability associated with restoration workstreams
- Oversee the development of the LTFM (Long Term Financial Model) and financial plan for 2020/21, including planning assumptions and alignment to the overall CCG strategy
- Oversee how the CCG's financial position aligns and interfaces with the overall ICS position, as the CCG progresses towards its role as strategic commissioner within the ICS
- Seek assurance, via reporting from the Associate Director of PMO (Programme Management Office), that Senior Responsible Owner (SROs) have a robust Financial Sustainability Programme is in place as the prime means for securing a sustainable financial position, effective management of risks and assurance around programme delivery on an in year and recurrent basis

- Provide assurance to the Governing Body 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 Body of any additional actions that may be necessary
- Take decisions on actions necessary to support delivery of the Financial Sustainability Plan, within approved delegated limits.

The membership of the committee in 2020/21 was as follows:

Name	Role	Membership of the committee during 2020/21
Rob Parker (Chair)	Lay Member for Finance	1 April 2020 – 31 March 2021
Graham Hotchen (Vice Chair)	Lay Member for Audit and Governance	1 April 2020 – 31 March 2021
Trish Calvert	Lay Member for Primary Care	1 April 2020 – 31 March 2021
Dr Ian Tait	CCG Chair	1 April 2020 – 31 March 2021
Dr Ian Roper	Elected Governing Body GP	1 April 2020 – 31 March 2021
Dr Richard Davies	Elected Governing Body GP	1 April 2020 – 31 March 2021
Dr Carl Ellson	Medical Director (Strategy & Transformation)	1 April 2020 – 31 March 2021
Simon Trickett	Chief Executive	1 April 2020 – 31 March 2021
Mark Dutton	Chief Finance Officer	1 April 2020 – 31 March 2021
Tim Tebbs	Financial Sustainability Director	1 April 2020 – 31 August 2020

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 encourages 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 key mechanisms through which risk management is captured are:

- Risk Management and Assurance Strategy
- Organisational Wide Risk Register
- The Governing Body Assurance Framework also details any areas where a lack of assurance may exist against the achievement of strategic objectives, along with mitigations.

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 Herefordshire and Worcestershire CCG 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 CCG's 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 CCG also received substantial assurance from its internal auditors in respect of the Governing Body Assurance Framework (GBAF) and Risk Management Audit, which evidenced that a sound system of internal control is in place.

The strategy defines the risk scoring matrix which is used for all risks, both clinical and non-clinical, incidents and complaints within the organisation. New risks identified for inclusion on

the risk register are assessed for likelihood and severity using a 5 x 5 risk matrix in accordance with the Risk Management and Assurance 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 scores 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 and 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.

Risks are recorded on the 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 risks which fall within its remit.

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 providers. 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.

Risk Assessment

The key strategic risks to delivery of the strategic objectives for the CCG during 2020/21 were:

Key strategic risks	Key mitigations
DUE to the impact of COVID-19 **THEN** there is a risk that the Quality, Improvement, Productivity and Prevention (QIPP) Programme will fail to deliver the target savings of £36m **RESULTING** in an impact on the delivery of the advised control total.	NHSEI financial regime in place throughout 2020/21 meant that the CCG received sufficient reimbursement to cover QIPP opportunities which could not be implemented.
DUE to additional direct commissioning responsibilities for primary care arising from the ICS (Dental, Ophthalmic and Pharmacy) **THEN** there is a risk to primary care team capacity **RESULTING** in a potential inability to deliver the primary care delegated statutory functions.	Monthly meetings with NHSEI to share information regarding functions, capacity, finances and risks. Skills gap analysis to be undertaken locally.
DUE to provider capacity to deliver required activity and significantly increasing waiting lists due to COVID-19 (inability to complete work as efficiently and patient declining / delaying procedure) **THEN** there is a risk that patients are waiting too long for diagnosis and treatment in line with their rights as specified by the NHS Constitution (18 weeks / 52 weeks) **RESULTING** in the risk that they may come to harm during the waiting period or require more extensive / invasive treatment due to disease progression.	Harm review processes are in place across all provider organisations. These will be reported through STEIS (Strategic Executive Information System) if moderate or severe harm has been caused. Any minor harms are reported through the respective trusts' divisional governance teams. All providers also have harm review oversight meetings chaired by executives to identify any themes, trends and learning that require escalation to inform the clinical prioritisation agenda. Weekly system restoration oversight meeting chaired by CCG with regular review of Referral to Treatment (RTT) position and actions to address long waiters. ICS has purchased additional vanguard capacity to enable increased throughput. Use of independent sector to support long-waiters.

Key strategic risks	Key mitigations
	Full system engagement with GIRFT (Getting it Right First Time) which has supported identification of efficiency gains which will support increased throughput across the system. Patients being offered out of county offer where appropriate / available. Full waiting list reviews in place to ensure safety and appropriate clinical prioritisation of waiting list.
DUE to the continued circulation of COVID-19, presenting in waves of increasing and decreasing case rates **THEN** there is a high risk to the elderly and vulnerable (those with co-morbidities) population and to the capacity and resilience of the Health Service **RESULTING** in expected patient harm and the enactment of emergency planning processes, such as business continuity and following assessment, diagnosis treatment national guidance / requirements.	Development and delivery of a single flu and COVID-19 plan to support phase 3 delivery from September 2020. System approach to vaccination which has been extremely successful, with a high proportion of the eligible population having received at least 1 dose (ahead of schedule). Vaccination, working in partnership with councils, focused work in areas of deprivation, hard to reach groups and communities where uptake is lower. Use of system wide early warning triggers (including forward projection of cases) enabling early preparation and response to future waves.
DUE to potential legal and legislative barriers **THEN** this could constrain STP / ICS actions and decisions **RESULTING** in preventing the delivery of new care models and planning arrangements across the footprint.	Publication of a white paper providing an indication of new legislation – allowing the ICS to develop models in line with this. Place development programme – developing place operating models within current legislation.
DUE to insufficiently robust programme management processes **THEN** there is potential for non-delivery or poor delivery of priorities **RESULTING** in change and associated planned benefits for H&W	ICS PMO leading strategic approach to system planning which includes a system approach to financial sustainability and use of consistent project management processes and reporting. This also includes review of monthly highlight reports which encompass

Key strategic risks	Key mitigations
CCG not being delivered in terms of financial savings and service improvements.	programme achievements, risks and escalations which are subsequently reported to relevant ICS and CCG committees – Good engagement from provider partners.
DUE to the impacts of COVID-19 response / restoration **THEN** there is inadequate capacity and capability to deliver transformation change **RESULTING** in non-delivery of quintuple aims and a sustainable health and care system.	Strategic approach to restoration and recovery – Weekly meetings with provider Chief Operating Officer's, financial leads, Business Intelligence leads and clinicians. Formal reset and recovery board being implemented, focused on system-wide solution i.e. Vanguard theatres on both provider sites for high volume, low complexity specialties. Active engagement in the Regional Elective Delivery Programme and GIRFT (Getting it Right First time) approach across Herefordshire and Worcestershire providers, with a focus on improving productivity and increasing capacity. Mutual aid across providers to support areas of greatest need. Exploring digital solutions to support waiting list management, which in turn will release capacity.
DUE to the challenges and capacity as a result of the COVID-19 pandemic **THEN** there has been an impact on the CHC review process **RESULTING** in the risk of additional costs to the CCG.	National CHC guidance for restoration released. Additional resource requirements have been identified and liaison with the regional team has taken place. System has been awarded a financial envelope and discussion with partners has taken place to agree how to best utilise this resource to ensure maximum benefit in undertaking the required assessments.
DUE to current operational demands **THEN** the CCG cash demand could exceed that which is allowed by the Annual Cash Drawdown Requirement (ACDR) **RESULTING** in significant financial risk to the CCG.	National finance regime in place throughout 2020/2021 was cash backed to ensure sufficient cash to ensure operational efficiency could be maintained and suppliers could be paid within 7 days as required nationally.

Key strategic risks	Key mitigations
DUE to a new GP Payment system being introduced to manage GP payments online through CAPITA **THEN** this will become responsibility of the CCG and require the implementation of processes previously undertaken by NHSEI **RESULTING** in a potentially resource intensive process that will need to be completed to ensure no gaps in payments occur.	Implementation of the system from June 2021. NHSEI are working with CCGs to manage the transition, prioritisation of resource will occur when responsibility is transferred.
DUE to the inability to recruit an appropriately skilled workforce **THEN** GP practices may not be able to continue to deliver high quality services **RESULTING** in the potential for compromised patient care or access to services.	Significant Workforce Transformation plan in place across Herefordshire and Worcestershire focussing on recruitment and retention of staff. Engagement with the workforce to understand how to improve working conditions and support for the existing and future workforce have been undertaken. Annual Workforce trajectories in place at system level to model supply and demand of workforce. This includes GPs, Nurses, Direct Patient Care and Administration staff. Herefordshire and Worcestershire Workforce Strategy in place since 2018. Workforce reporting locally on a quarterly basis at practice level, PCN level and is reported through the workforce governance structure - Workforce Implementation Group, GP Transformation Board, ICS workforce groups and via the national workforce reporting system. Work with wider partners to review future workforce needs across the STP and joined up approaches to ensure economies of scale.
DUE to lack of a sustainable consultant workforce model **THEN** there is a risk that the CCG are unable to commission a sustainable and safe service that enables people displaying symptoms of a stroke or TIA do not receive timely treatment or interventions	Exploration of opportunities for Clinical Nurse Specialists to extend their skills and experience within a comprehensive stroke centre. Continuation of workforce development to explore opportunities for new roles such as Consultant Nurse Practitioners and optimisation of

Key strategic risks	Key mitigations
(against national best practice guidelines) **RESULTING** in the deterioration in outcomes for patients.	Senior Clinical Nurse Specialists (CNSs) to fulfil functions traditionally undertaken by stroke consultants. Exploration of opportunities for cross working between consultants across partner organisations. Development of joint consultant post(s) with flexibility to work across the ICS and future development of stroke / TIA services. Implementation of telemedicine solutions across providers.
DUE to insufficient capacity **THEN** diagnostic services, including endoscopy, may not be able to make timely diagnosis **RESULTING** in lack of assurance that commissioned services will avoid potential delays in treatment and adverse impact upon performance against cancer standards.	Restoration work initiated in preparation for Phase 3, which commenced in September 2020. This is being reviewed by both Trusts and the CCG to determine viability of any existing plans. Principal elements include: • Review of local independent sector provision and capacity requirements; • Trust waiting list initiatives in place; • System review of Primary Care diagnostic waiting list completed and shared with Trusts to assist with validation of waiting list; • Deep dive into diagnostic waiting list backlog as part of clinical prioritisation process. National Community Diagnostic Hub (CDH) workstream adopted, this will significantly increase diagnostic capacity across the ICS, if successful capital and revenue bids are awarded: • 5 year plan for up to 3 CDH across the ICS to separate routine from acute / emergency diagnostic capacity and demand.
DUE to provider capacity to deliver required activity and significantly increasing waiting list due to COVID-19 (inability to complete work as efficiently and patient declining / delaying procedure) **THEN** there is	Use of independent sector during the pandemic to maintain access to cancer surgery for pathway 2 patients.

Key strategic risks	Key mitigations
a risk that people are waiting too long for cancer diagnosis and treatment in line with their rights as specified by the NHS Constitution **RESULTING** in the risk that they may come to harm during the waiting period or require more extensive / invasive treatment due to disease progression.	Re-establishment of surgical capacity at main hospital sites. Restoration and recovery plans for diagnostics. Development of bid for Early Adopter and Community Diagnostic Hubs. Use of Kidderminster Treatment Centre as a centralised site for outpatient appointments, diagnostics and some Oncology treatments (Worcestershire). Restoration and Recovery Forum in place across both providers to prioritise surgical capacity for Pathway 2 cancer patients. Weekly waiting list reviews of Pathway 2 patients. Ongoing monitoring of incidence and detection rates at specialty level to flag pathways with reduced referral levels and potentially target local communications.
DUE to lack of assurance that the commissioned service has an adequate IT system to reduce human factors a proportion of diagnostic results not being reviewed by a Trust Clinician (WAHT) **THEN** there is risk of delayed or missed diagnosis **RESULTING** in lack of assurance of the CCG's ability to commission a safe service that doesn't result in avoidable harm.	Action plan to address the concerns has been developed and is monitored via the Clinical Governance Committee which is attended by the CCG's Associate Director of Nursing and Quality. This area forms part of a standing agenda item at quarterly meetings between CCG Clinical Leads and Trust Chief Medical Officers.
DUE to the complexity of managing an individual complex case, whose care spans a number of partners **THEN** there is a risk to the reputation of the organisation if arrangements were challenged **RESULTING** in the individual seeking alternatives to NHS commissioned care which may pose a safeguarding risk.	One identified consultant based at the specialist Midlands NHS Trust has overall clinical control of this patient's care supported by six specialist Consultants for every clinical speciality. Multidisciplinary Team (MDT) continues to work together to ensure patient gets the right care. MDT plan remains in place.

Key strategic risks	Key mitigations
DUE to reports of medical staff in training, potentially not receiving adequate supervision **THEN** there is a lack of assurance that the CCG can commission a service that ensures this staff group are able to undertake their roles safely **RESULTING** in potentially unintended patient harm.	The risks relating to medical staff supervision continue to be monitored through Worcestershire Acute Hospitals Trust (WAHT) Clinical Governance Committee and the Trust's Quality Governance Committee. CCG representation is at both meetings. Any issues are escalated to the CCG QPR Committee.
DUE to lack of assurance that the services commissioned from WAHT includes a sufficiently robust process for reviewing hospital deaths **THEN** the capacity to identify and act on timely learning may not be in place **RESULTING** in a reduced ability to prevent future harm.	The risks relating to mortality reviews continue to be monitored through WAHT's Clinical Governance Committee and the Trust's Quality Governance Committee. CCG representation is at both meetings. In December 2021 the Trust confirmed that it had switched to a new advanced electronic system for monitoring the mortality review processes. The CCG awaits confirmation that the new electronic system is producing accurate data which demonstrated improved compliance.
DUE to medical clinicians not adhering to the scope of clinical practice and provider governance being insufficient to identify this in a timely manner in line with the Patterson Inquiry **THEN** there is potential that clinical interventions will not be carried out in line with national and local clinical guidelines **RESULTING** in poor outcomes and potential patient harm.	The risks relating to the findings from the Patterson Report continue to be monitored through the respective Trusts (Wye Valley and Worcestershire Acute Hospitals Trust) Governance Committee(s). CCG representation is at all these meetings. Any issues are escalated to the CCG QPR Committee.

For each risk, it is ensured that adequate controls, actions and assurances are in place to effectively mitigate the risks identified. The relevant risk register extracts are presented to the respective lead committees for review, in terms of the Quality, Performance and Resources Committee, Clinical Commissioning and Executive Committee, Primary Care Commissioning Committee and Financial Sustainability Committee. The Governing Body is provided with a link to the risk register as part of the GBAF report for assurance, which is submitted on a bi-monthly basis.

The Audit Committee reviews the adequacy of the Board Assurance Framework and Risk Register through receipt of bi-monthly reports.

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 CCG has been provided with substantial assurance and no material concerns were identified.

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 (IG)

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 (known as the Data Security and Protection Toolkit - DSPT) and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

Due to the COVID-19 outbreak the IG Toolkit submission was extended to 30 September 2020. However, an interim submission was required as of 31 March 2020, along with an agreed improvement plan. This was submitted for the legacy CCGs (NHS Herefordshire CCG, NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG) prior to the merged CCG coming into effect on 1 April 2020.

In accordance with the NHS Digital process, the CCG's IG Toolkit was submitted as 'standards not fully met' as of 31 March 2021. An improvement plan was agreed in line with a June 2021 submission date.

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 information governance processes and procedures in line with the DSPT. 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 and Assurance 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 2020/21.

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, 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 CCG operates 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 2020/21, 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:

As part of the CCG's COVID-19 response, focus is places upon ensuring that the CCG's restoration plan can continue to be progressed as appropriate and that service delivery and quality outcomes across high risk areas such as cancer, elective care and diagnostics are not adversely impacted.

- During June and July 2020, STP programme leads developed their detailed phase 3 restoration delivery plans in preparation for NHSEI regional submission in September 2020. Plans were summarised and submitted alongside the phase 3 technical requirements (activity, performance, finance and workforce) on 21 September 2020.
- Each month programme leads report progress against the phase 3 restoration delivery plans, with a focus on key milestones, risks and issues. These reports are submitted to the Herefordshire and Worcestershire PMO for scrutiny against the phase 3 requirements. Areas will be RAG rated and it will be indicated whether there has been favourable, adverse or no movement compared to the last reporting period.
- The STP Phase 3 Restoration Task and Finish Group was established in early September 2020 to oversee development of the STP Phase 3 Restoration Plan. The core membership of this group consists of operational, clinical, business intelligence, finance and workforce leads, with PMO oversight. This group continues to meet on a weekly basis to review progress against the plan, with a focus on delivery against each activity requirement. Each week the group undertakes a deep-dive into a specific area which is off trajectory or at risk.
- ICS / STP Programme Boards continue to provide oversight of the restoration programme, escalating issues through programme highlight reports to the PMO.
- A fortnightly STP Cancer Planning group has also been established to focus on the specific cancer risks in relation to the restoration of services. Any escalations are then raised at the weekly STP Phase 3 Restoration meeting.
- The ICS Ethics Committee plays a critical role in the over-sight and ratification of decisions with regards to the best use of finite elective capacity and resources.
- Prior to November 2020, the Herefordshire and Worcestershire phase 3 restoration programme reported progress to the CCG's Financial Sustainability Committee (FSC). In recognition of the impact on quality and performance, it was agreed that oversight of the restoration work will report into the CCG's Quality, Performance and Resources Committee from November; the detailed financial aspect will remain as part of the FSC agenda.

Managing the impact of COVID-19 upon the CCG's underlying financial position, with particular focus on managing the resulting cost pressures within areas such as prescribing and CHC.

- The CCG has a large backlog of unassessed cases and routine reviews resulting from compliance with COVID-19 guidance on agreeing cases without review. The CHC restoration process began on the 1 September 2020, the finance team are

working closely with the CHC team to understand the longer term financial implication of the COVID packages issued during the course of the year.

- Liaison with partner organisations is underway to understand how to best to deploy funding to support the CHC restoration and recovery process across the system in line with the NHSEI long stop date of 31 March 2021.
- In line with updated guidance, CCG to resumed CHC assessments from the 1 September 2020 and all placements from the 19 March to the 31 August 2020 needed to have been assessed and transferred to core arrangements; whether it was NHS, Social Care or Self-funded.
- Ongoing oversight of COVID-19 resurgence, potential impact on hospital admissions and the CHC discharges that may result. Reviewing flow through local discharge pathways 3 and 4, in particular.
- CHC brokerage team continue to ensure value for money (VFM) through new commissioning arrangements.
- Future End of Life (EOL) domiciliary contract procurement to build on changes through the recent COVID-19 emergency period and to address move back towards pre COVID-19 rates.
- Ongoing weekly meetings with Herefordshire and Worcestershire County Councils to ensure disputes are kept to a minimum and resolved as quickly as possible.
- As of March 2020, IPP (Itemised Prescribing Payment) expenditure was significantly higher than previous months in 2019/20 and this was raised with NHS England as a brought forward cost pressure. March costs were 13% above the 2019/20 average IPP £ per dispensing day. Similarly, April 2020 actuals (received in June) were 18% higher than the 2019/20 average. May to August 2020 actuals showed a decrease which brought the overall annual forecast spend more in line with 2019/20 levels, however September 2020's actuals received in November have shown another increase and resulted in a £0.90m cost pressure. If the costs increase again over the winter period 2021/22, this could result in further cost pressures to the CCG which are not currently mitigated.

Due to the COVID-19 pandemic, it has created a backlog of secondary care activity, particularly electives, which is subject to review and management in order to avoid protracted delays in accessing treatment and adverse impact on patient outcomes.

- Patient Treatment List Tracker subject to regular oversight by the CCG, with detailed process and reporting protocols for 70+ week waiters.
- Use of the independent sector in the second wave of the pandemic to enable continuation of some urgent surgery. Diagnostics outsourcing to the independent sector and third party providers and increasing throughput using waiting list initiatives and outsourcing.
- Quality Impact Assessments (QIAs) undertaken for the independent sector, commissioned by local providers, and overseen by the CCG.
- Clinical review of the identification of harm and harm processes commenced and were active during 2020/21. These reviews are at individual patient level to provide assurance of levels of harm.
- Collaborative clinical prioritisation framework is in development to ensure those with greatest clinical need are prioritised.

- Both WAHT (Worcestershire Acute Hospitals Trust) and WVT (Wye Valley Trust) are in the process of implementing e-Reviews, which will support validating current waiting lists.
- Demand management initiatives identified and ReVIvO contract support established from 1 November 2020.
- Implementation of a Standard Operating Procedure for Primary Care Access to Elective Care Services.
- Development of Advice and Guidance and Referral Assessment Service Dashboard which, to date, demonstrates a 56% increase in advice and guidance / conversion to first attendance, which is low at 20%.
- Demand and capacity modelling were finalised, but this may be further impacted by any subsequent wave of the pandemic.
- Workforce task and finish groups were established to develop appropriate solutions. NHSEI confirmation that the development of specific diagnostic service academies is ongoing and are designed to improve standardisation of training and to increase recruitment where possible.
- Continuation of work with clinical leads to understand their requirements in order to enable multidisciplinary team working to address the backlog.

Stroke and TIA

- STP Stroke Programme Board is in place to review and redesign longer term sustainable solutions for stroke care across the STP.
- Monitoring of performance and quality metrics to understand the level of risk and need for intervention, i.e. mortality and SSNAP (Sentinel Stroke National Audit Programme).
- In September 2020, the Quarter 1 (April 20 – June 20) SSNAP results were published. WVT remained at a grade B for the sixth consecutive quarter, whilst WAHT moved from a C to a B.
- National funding for the Regional Integrated Stroke Delivery Networks (ISDN) has been confirmed and actions are being taken to recruit to the clinical and management roles. Herefordshire and Worcestershire ICS is part of the West Midlands ISDN. There has been successful recruitment to the Acute Clinical Leads and Rehabilitation Clinical Lead posts. Regional Stroke Delivery Board brings together the Clinical Policy Unit, GIRFT, Clinical Leads and ICS representatives to develop the strategic objectives for stroke and TIA at ISDN and regional level.
- Collaborative working across the STP in support of seven day consultant access in advance of a longer term new clinical model.
- Ongoing recruitment plans in place at provider level - Discussions ongoing regarding joint appointments (consultant workforce).
- Implementation of telemedicine solution - Work continues to support system remote working.
- TIA clinics continue five days per week. Sustainable seven day solution to be identified. Use of remote consultations is potentially facilitating delivery of a seven day service, but timely access to MRI is a key requirement. Diagnostics will form part of the first iteration of the Community Diagnostic Hub.

- Wye Valley Trust has been part of South West Clinical Network since November 2019, to ensure 24-7 access to thrombolysis decision making.

Diagnostics Capacity and Systems

- Service concerns portal enables oversight of GP feedback regarding examples of diagnostic delays. Serious incident framework enables the CCG to have oversight of diagnostic delays that result in harm, providing detail of the root causes and remedial actions being taken.
- WAHT have moved to an option for in-sourcing additional capacity to strengthen governance and reduce impact on patients.
- Implementation of an electronic reporting system for diagnostics in the Emergency Department (ED).
- The CCG has collated a report that analysed serious incidents with the category of 'delayed diagnosis' and identified an increased trend in reporting. The report was shared with the WAHT Chief Nurse and was discussed at the Trust CQR meetings (Clinical Quality Review), with learning from Significant Incidents (SIs) strengthened through the Serious Incidents Review and Learning Group.
- Further discussion with WAHT Acting Chief Medical Officer has confirmed that there are ongoing issues with the radiology and pathology electronic requesting software (ICE) and Bluespier IT processes. CCG were informed that a three year IT strategy was put in place to replace the current systems and to ensure interoperability.
- An action plan to address IT concerns was developed and is monitored via the Clinical Governance Committee, which is attended by CCG's Associate Director of Nursing and Quality.
- Plans continue to be underway to recruit nurse endoscopists to address capacity gaps.
- WAHT is working to train nurse practitioners to improve access to key diagnostics and is developing a business case to support an upgrade of the endoscopy suite.
- Outsourcing to the independent sector and third party providers and increasing throughput using waiting list initiatives and outsourcing.

Cancer Standards

- The Restoration and Recovery Programme is in place. The Cancer Alliance has overarching responsibility for developing the plan.
- Robust monitoring arrangements are in place to oversee performance for the two week wait, 41 day and 62 day standards and 104 day breaches, with active CCG involvement in the WAHT Cancer Board.
- CCG has active sight of harm review outcomes for 63-103 day and 104-day breaches.
- CCG raised 104-day breaches with the Cancer Alliance, particularly those that were attributed to local patients who have been referred to tertiary services.
- CCG has put advice and guidance in place for primary care GPs in respect of the two week wait referrals.

- Waiting lists and backlogs were reviewed on a regular basis across providers and at system level to unblock challenges to care.
- Independent sector provision supporting cancer surgery, along with tertiary arrangements were assessed, to support best outcomes for patients.
- Herefordshire and Worcestershire STP localised the national urology campaign, urging people to come forward if they were experiencing symptoms.

Review of economy, efficiency and 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 CCG receives an annual, third party assurance report from which it can gain assurance that the finance and accounting services delivered by NHS SBS are robust.

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 the 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 CCG continues to be committed to the elimination of any form of fraud, bribery or corruption, and from 1 April 2021 now adhere to the Government Functional standard 013: Counter Fraud, which replaces the previous NHS CFA Standards for Commissioners. The Chief Finance Officer (CFO) maintains responsibility for overseeing counter fraud work. The CCG 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 the identified risks, which also includes raising awareness, promoting the counter fraud, bribery and corruption culture and investigation of allegations.

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

The CCG is committed to ensuring NHS resources are appropriately protected from fraud, bribery and corruption and follows the national NHS counter fraud strategy and the series of standards for commissioners of NHS services. As an NHS commissioner the CCG ensures that NHS funds and resources are safeguarded against those minded to commit fraud, bribery or corruption. Failure to do so may impact on a commissioner's ability to invest in provider services, as NHS funds and resources would be wrongfully diverted from patient care.

To reduce economic crime against the NHS, it is necessary to take a multi-faceted approach that is both proactive and reactive. Throughout the year, the CCG's CFS follows the four key principles and Standards for Commissioners. These are designed to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit crime. The four key principles are:

A. **Strategic Governance** - this sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation. The Chief Finance Officer is the nominated individual at the CCG to oversee and provide strategic management and support for all anti-fraud, bribery and corruption work within the organisation. An accredited counter fraud specialist is contracted via CW Audit to undertake counter fraud work proportionate to identified risks. The counter fraud specialist attends the Audit and Governance Committee on a regular basis to provide updates on the work plan, highlight any relevant guidance and to give assurance of any investigations.

B. **Inform and involve** those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face counter fraud presentations, public awareness campaigns and media management. The CFS provides counter fraud material to CCG staff, including new starters. Working relationships with stakeholders are strengthened and maintained through active engagement.

C. **Prevent and deter** economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during counter fraud presentations and using other media opportunities so that the risk and consequences of detection are clear to potential offenders. Those individuals who

are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards and guidance.

D. **Hold to account** those who have committed economic crime against the NHS. The CCG's CFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the CCG, the CFS must ensure that investigations are undertaken to satisfy national legislation. The CCG encourages the prosecution of offenders, and where appropriate, refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate, and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally. The CFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution.

This has been an unprecedented year, but the CFS has continued to raise staff awareness on fraud, bribery and corruption through regular communication to both CCG staff and GP practice managers and staff. 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.

Throughout 2020/21, the CCG has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. The risk analysis was undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Measures to mitigate the identified risks are included in the CFS's work plan, progress against which will be reported to the Audit Committee. The CFS considers risks identified from historical work, national cases and NHS CFA data, in dialogue with the CCG. Risks will be recorded in line with the CCG's Risk Management and Assurance Strategy and included on the Risk Register.

Raising Concerns / Whistleblowing

The CCG has a Raising Concerns (Whistleblowing) Policy in place, which is supported and complemented by the following suite of policies:

- Management of Conflict of Interests and Gifts and Hospitality
- Fraud, Bribery and Corruption Policy
- Sanctions and Redress Policy

Through implementing and embedding the principles of these policies, it builds trust with staff and encourages them to raise all concerns. This helps ensure that concerns are reported, even if they do not require further investigation or pertain to any counter fraud related matters. This will help both the CFS and CCG to improve and make processes more robust.

Staff can report any whistleblowing concerns through the following mechanisms:

- Counter Fraud Specialist
- Chief Finance Officer
- Fraud Champion

- National Fraud and Corruption reporting line on 0800 028 40 60
- Online at: https://cfa.nhs.uk/reportfraud
- Nominated CCG Speak Up Guardians

In previous years staff surveys had been undertaken, but it was not possible this year due to the COVID-19 pandemic. However, the previous staff survey indicated that 100% staff were aware of the CCG's Whistleblowing Policy.

For any whistleblowing claims where fraud is suspected, investigations may be initiated. Progress on any such fraud investigations are reported to the CCG Audit Committee. The CFS attends each meeting and is available to directly answer questions that the Audit Committee have regarding fraud risks. The Audit Committee also review breaches of internal control that are brought to its attention. Internal Audit provides regular updates against their programme of work and would highlight any breaches of internal control.

Any other whistleblowing claims will be taken forward by the CCG HR Team and managed in line with relevant policies.

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 draft conclusion was that:

> *"The organisation has an adequate and effective framework for risk management, governance and internal control."*

During the year, the Internal Audit issued the following audit reports:

Area of audit	**Level of assurance given**
Primary Care – GP claims for additional expenditure in response to COVID-19	Substantial Assurance
Payments to GP Practices	Substantial Assurance
Financial Management	Substantial Assurance
Governing Body Assurance Framework and Risk Management Culture	Substantial Assurance
Governance arrangements	Reasonable Assurance
Key Financial Controls	Substantial Assurance
Post COVID-19 Recovery Strategy	Reasonable Assurance
Continuing Healthcare / Personal Health Budgets	Reasonable Assurance
Conflicts of Interest	Substantial Assurance
The following areas were also reviewed in an advisory capacity	
Digitisation and IT Plans	Advisory
Financial Governance and Resilience	Advisory

Factors and Findings Which Have Informed the Opinion

Whilst opportunities for some enhancements to the control environment were identified, we have based the annual opinion assessment on the areas of audit highlighted above.

Of the eleven final reports issued to date, we have issued nine positive (either a substantial or reasonable) assurance opinions. The remaining two reports were issued as advisory which do not include an opinion, but identified some enhancements to the control framework.

We have not issued any 'no assurance' or 'partial' opinion reports in 2020/21, to date. In the audits shown as providing Reasonable and Substantial assurance we have identified some areas where enhancements are required and in each of these cases management actions have been agreed, the implementation of which will improve the control environment.

Based on the work we have undertaken to date on the CCG's systems on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS).

Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- Internal audit has not reviewed all risks and assurances relating to the organisation; the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS).
- The opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management.
- Where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance.
- Due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention.
- Our internal audit work for 2020/21 has been undertaken through the substantial operational disruptions caused by the COVID-19 pandemic. In undertaking our audit work, we recognise that there has been a significant impact on both the operations of the organisation and its risk profile, and our annual opinion should be read in this context.

Acceptance of internal audit management actions

Management have agreed actions to address all the findings reported by the internal audit service during 2020/21.

Implementation of internal audit management actions

Where actions have been agreed by management, these have been monitored via the action tracking process in place, which is managed and reported by the CCG's internal auditors, RSM UK. Throughout the year, progress was reported to the Audit Committee. When management provide updates to us, evidence is requested to validate high and medium priority actions that have been addressed and can be closed off.

Our action tracking work throughout the year has highlighted good progress by CCG management in promptly addressing the issues and the actions raised.

Working with other assurance providers

In forming our opinion, we have not placed any direct reliance on other assurance providers.

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.

The Governing Body has oversight of the control framework and the Audit Committee provides assurance to the Governing Body that the organisation's overall internal control and governance system operates in an adequate and effective way. The committee's work focuses not only on financial controls, but also risk management and quality governance controls. The Audit Committee has provided assurance to the Governing Body on the effectiveness of the internal control framework and has generally concluded that it is effective. There were no serious lapses in internal control (including Information Governance breaches).

The recorded opinion of internal audit against each review areas for 2020/21 have reaffirmed the assurance the CCG can take from its governance, risk management and internal control.

Conclusion

There have been no significant control issues identified in 2020/21. There have been no serious lapses in internal control including information governance or conflict of interest breaches.

Simon Trickett

Accountable Officer
NHS Herefordshire and Worcestershire CCG
11 June 2021

Remuneration Report

Remuneration Policy

We have established a Remuneration and Appointments Committee in line with our constitution, standing orders and scheme of delegation. The statutory role of the Remuneration and Appointments Committee is to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for all 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. In addition, the Governing Body has delegated to the Committee all functions related to the appointment and removal of Governing Body members, with the exception of Lay Members. The Committee does not have a decision-making responsibility in relation to determinations about remuneration arrangements and makes recommendations to the Governing Body.

The following Governing Body members are members of the committee:

- Rob Parker | Lay Member for Finance (Chair)
- Trish Calvert | Lay Member for Primary Care
- Dr Martin Lee | Secondary Care Doctor
- Prof. Tamar Thompson OBE | Lay Member for Patient and Public Involvement and Quality
- Dr Ian Tait | CCG Chair

The main responsibilities of the Remuneration and Appointments Committee are:

Remuneration

- Terms and conditions of employment for all employees of the CCG and other individuals providing services to it, including pensions, remuneration, fees, and travelling or other allowances payable to employees and to other persons providing services to the CCG. This does not include Lay Members.
- Performance review framework and pay strategy for staff on VSM contracts.
- Salaries and, if appropriate, performance related awards for the Chief Executive and other staff on VSM contracts in line with the agreed pay strategy and performance review framework.
- 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.
- Considerations of the severance payments of the Chief Executive 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).

Appointments

- Make decisions about appointments to and, when necessary, removal of individuals from the Governing Body.
- Where applicable, determine terms of office of Governing Body members.

- Regularly evaluate the balance of skills, experience, independence, diversity and knowledge of the CCG Governing Body and make recommendations to the Governing Body with regard to any changes.
- Give full consideration to succession planning for directors and other senior executives in the course of its work, taking into account the challenges and opportunities facing the CCG, the diversity of the Governing Body and the skills and expertise needed on the Governing Body in the future.
- Keep under review the leadership needs of the organisation, both executive and non-executive, with a view to ensuring the continued ability of the organisation to deliver its stated aims.
- As and when vacancies arise on the Governing Body, evaluate the balance of skills knowledge, experience and diversity on the Governing Body, and, in the light of this evaluation, advise on the role and capabilities required for particular appointments.
- Approve local role description and person specifications for elected and appointed Governing Body members in line with the CCG's Standing Orders.
- In respect of Governing Body members (apart from Lay Members) and other senior executives, the Committee shall ensure that appropriate recruitment processes are agreed and adhered to which comply with the relevant legislation and best practice.

Other

- Determine appropriate disciplinary arrangements for employees, including the Chief Executive, (where they are an employee and / or member of the Clinical Commissioning Group, and for other persons working on behalf of the Group).

Senior manager remuneration

The tables on the following pages set out the remuneration and pension benefits for our senior managers in 2020/21 and are subject to audit.

Salaries and allowances (2020/21)
The below salaries and allowances information is 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)
	£'000	£'00	£'000	£'000	£'000	£'000
Jo-Anne Alner* (finished 31 Jan 21)	95-100	-	-	-	0-2.5	95-100
Louise Bramble	65-70	-	-	-	-	65-70
Hazel Braund*	105-110	-	-	-	17.5-20	120-125

Trish Calvert/Haines	15-20	-	-	-	-	15-20
Lynda Dando*	95-100	65	5-10	-	12.5-15	120-125
Richard Davies	35-40	-	-	-	-	35-40
Mark Dutton	115-120	82	5-10	-	17.5-20	150-155
Carl Ellson	135-140	10	-	-	-	135-140
Mike Emery*	95-100	-	-	-	22.5-25	115-120
Mari Gay	120-125	-	0-5	-	15-17.5	140-145
George Henry	70-75	-	-	-	-	70-75
Graham Hotchen	15-20	-	-	-	-	15-20
Martin Lee	35-40	-	-	-	-	35-40
Ruth Lemiech*	95-100	-	-	-	22-27.5	120-125
Lisa Levy	95-100	66	0-5	-	32.5-35	140-145
Clare Marley	80-85	15	-	-	20-22.5	105-110
David Mehaffey* (started 1 Jan 21)	25-30	-	-	-	7.5-10	35-40
Rob Parker	20-25	-	-	-	-	20-25
Scott Parker*	95-100	-	-	-	22.5-25	115-120
Ian Roper	65-70	-	-	-	-	65-70
Ian Tait	70-75	-	-	-	-	70-75
Alison Talbot-Smith* (finished 30 Sept 20)	50-55	-	-	-	5-7.5	55-60
Prof. Tamar Thompson	15-20	-	-	-	-	15-20
Simon Trickett	145-150	96	5-10	-	42.5-45	205-210

No prior year comparative information is available for 2019/20 as the CCG was created on 1 April 2020.

*As regular attendees at Governing Body meetings the CCG considers these staff to be senior managers.

Pension benefits (2020/21)

The below pension benefits information is 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 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash equivalent transfer value at 31 March 2021	Cash equivalent transfer value at 1 April 2020	Real increase in cash equivalent transfer value
	£000	£000	£000	£000	£000	£000	£000
Jo-Anne Alner (left Jan 21)	0-2.5	0-2.5	35-40	70-75	687	759	0
Hazel Braund	0-2.5	0-2.5	40-45	105-110	951	895	27
Lynda Dando	0-2.5	2.5-5	30-35	90-95	0	0	0
Mark Dutton	0-2.5	0-2.5	35-40	70-75	530	496	12
Mike Emery	0-2.5	*	15-20	*	225	197	12
Mari Gay	2.5-5	2.5-5	50-55	160-165	1,199	1,121	42
Ruth Lemiech	0-2.5	0-2.5	25-30	45-50	390	354	17
Lisa Levy	0-2.5	5-7.5	35-40	115-120	850	775	49
Clare Marley	0-2.5	0-2.5	15-20	30-35	223	198	10
David Mehaffey (started Jan 21)	0-2.5	*	15-20	*	202	187	8
Scott Parker	0-2.5	*	10-15	*	105	83	8
Alison Talbot-Smith (left Sept 20)	0-2.5	0-2.5	30-35	60-65	581	547	9
Simon Trickett	2.5-5	*	50-55	*	670	608	32

*No lump sum applicable as Section 2008 Member.

No prior year comparative information is available for 2019/20 as the CCG was created on 1 April 2020.

For senior managers listed in the 'salaries and allowances' table but not the pension benefits' table, no pension contributions are payable by the CCG in respect of these.

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 A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (or other allowable

beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Losses and special payments

There was one loss and no special payment cases in 2020/21, these are subject to audit.

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
	2020-21	2020-21
	Number	£'000
Administrative write-offs	2	1
Fruitless payments	-	-
Store losses	-	-
Book Keeping Losses	-	-
Constructive loss	-	-
Cash losses	-	-
Claims abandoned	-	
Total	2	1

No prior year comparative information for 2019/20 is provided, as the CCG was created on 1 April 2020.

Pay multiples

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, subject to audit:

	2020-21
Banded remuneration range of the highest paid member	£150,000 - £155,000
Mid-point of the banded annualised remuneration of the highest paid member	152,500
Median of the annualised remuneration of workforce	38,890
Pay multiple (ratio of highest paid member to median workforce)	3.92
Range of annualised staff remuneration excluding the highest paid member	£5,288 - £135,134

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 Herefordshire and Worcestershire CCG in the financial year 2020/21 was £150,000 - £155,000. This was 3.92 times the median remuneration of the workforce, which was £38,890.

In 2020/21 no employee received remuneration in excess of the highest paid director/member.

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

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

Non-disclosure of information

No disclosures have been omitted under GDPR Article 21.

Staff Report

Staff numbers and costs

Staff composition (2020/21)

The total breakdown of people employed by NHS Herefordshire and Worcestershire CCG (based on 31 March 2021) is as follows and is subject to audit:

Staff Grouping	Female		Male		Total
	Headcount	%	Headcount	%	
Governing Body	3	30.0%	7	70.0%	**10**
Other Senior Management (Band 8C+)	36	60.0%	24	40.0%	**60**
All Other Employees	204	83.3%	41	16.7%	**245**
Total	**243**	**77.14%**	**72**	**22.86%**	**315**

The workforce analysis by Band (based on 31 March 2021) is as follows:

Pay Band	Headcount	Pay Band	Headcount
Apprentice	0	Band 8A	49
Band 1	0	Band 8B	28
Band 2	4	Band 8C	11
Band 3	18	Band 8D	4
Band 4	27	Band 9	0
Band 5	21	Medical	25
Band 6	53	VSM	20
Band 7	45	Gov Body	10

The workforce analysis by Function (based on 31 March 2021) is as follows:

Staff category	Permanent Staff	Other Staff	Total Staff
Additional Professional – Scientific and Technical	14	-	14
Administrative and Clerical	171	27	168
Allied Health Professionals	1	-	1
Medical and Dental	3	28	31
Nursing and Midwifery Registered	58	13	71
Total	**247**	**68**	**315**

The CCG actively participates in the collection of Workforce Race Equality Data (WRES) which tells us as an organisation what the breakdown of our staff is in respect of diversity and representation at different pay bands. We have used the information gathered as part of the WRES data to develop recruitment policies and practices. As an organisation, we are presently working through the NHS Model Employer goals, have set an action plan to over-haul our recruitment practices, and are in the process of developing a reverse mentoring scheme for BAME staff. The WRES data also highlighted several areas where we need to increase the diversity of staff and we are actively working to address this with colleagues

and partners across the ICS. The action plan has been developed in response to the data we have collected and there are practical actions that have been put in place to increase the diversity of staff across the organisation, including at Governing Board level. We are also in the process of establishing a staff inclusion network for the organisation so we can better understand staff concerns and help us develop our policies and procedures.

Staff costs (2020/21)

Staff costs for 2020/21, highlighted below, are subject to audit:

Employee Benefits	Permanent employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	11,215	516	11,731
Social security costs	1,221	1	1,222
Employer contributions to the NHS Pension Scheme	2,140	0	2,140
Apprenticeship Levy	36	0	39
Termination benefits	2	0	2
Gross employee benefits expenditure	**14,617**	**517**	**15,134**
Total – Net admin employee benefits including capitalised costs	**14,284**	**517**	**14,801**
New employee benefits excluding capitalised costs	**14,284**	**517**	**14,801**

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 20.68%, In 2020/21 the increase of £620k was paid for by NHS England within the CCG's net parliamentary funding.

Staff redeployments (2020/21)

Sixteen members of CCG staff have been redeployed to other organisations during 2020/21 to support the emergency response to COVID-19 as well as the COVID-19 vaccination programme. The average length of a redeployment was 14 weeks.

55 CCG employees joined a system vaccination redeployment process, making themselves available for last minute ad hoc support to vaccination sites. In addition, over 40 members of CCG staff have been redeployed internally, both full time and part time, to support the emergency response to the pandemic.

Staff turnover (2020/21)

CCG Staff Turnover 2020/21	2020/21 Number
Average FTE Employed 2020/21	269.04
Total FTE Leavers 2020/21	31.73
Turnover Rate	11.79%

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

Sickness absence data

Proxy Working Days version (as per new guidance)		
FTE-Days Available	**FTE-Days Lost to Sickness Absence**	**Average working days lost**
53162.39	729.17	3.04

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 2020/21	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 2020/21 the following was spent on consultancy fees and is subject to audit:

	2020/21
	£'000
Consultancy expenditure	5
Contingent labour expenditure	517

No prior year comparative information for 2019/20 is provided, as the CCG was created on 1 April 2020.

Off-payroll engagements (non-payroll expenditure)

Table 1: All off-payroll engagements as of 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	4
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	1

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 2020 and 31 March 20, 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 2020 and 31 March 2021	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3 - Off-payroll engagements of Governing Body members and / or senior officers with significant financial responsibility, between 1 April 2020 and 31 March 2021.

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

Listed below are the exit packages agreed in 2020/21 which as subject to audit.

	Compulsory redundancies	
	Number	**Bands of £5k**
Less than £10,000	1	0-5

Parliamentary Accountability and Audit Report

NHS Herefordshire and Worcestershire CCG is not required to produce a Parliamentary Accountability and Audit Report.

The CCG operated in line with the prevailing national guidance in respect of gifts and hospitality throughout the COVID-19 pandemic. In particular, the guidance made it permissible for CCGs to accept gifts over normally prescribed values if it would support the COVID-19 response.

An audit certificate and report are also included in this Annual Report at page 88.

Independent auditor's report to the members of the Governing Body of NHS Herefordshire and Worcestershire CCG

In our auditor's report issued on 10 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the CCG for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had:

- Completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

and

- Completed the work necessary to issue our Whole of Government Accounts (WGA) Component Assurance statement for the year ended 31 March 2021. We have now completed this work.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 10 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

Under the Code of Audit Practice, we are required to report to you if, 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 2021.

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

Responsibilities of the Accountable Officer

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) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of NHS Herefordshire and Worcestershire CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Peter Barber

Peter Barber, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

17 August 2021

Grant Thornton

Our ref:
Your ref:

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Temple Quay
Bristol
BS2 0EL

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F +44 (0)117 955 4934

Members of the Audit Committee
Herefordshire and Worcestershire CCG

17 August 2021

Dear Members of the Audit Committee

Update on previous Value for Money reporting to the Audit Committee

Under the 2020 Code of Audit Practice, we are required to issue our Auditor's Annual Report for local NHS bodies at the same time as our opinion on the financial statements. As a result of the ongoing pandemic, and the impact it has had on both preparers and auditors of accounts to complete their work as quickly as would normally be expected, the National Audit Office updated its guidance to auditors to allow us to postpone completion of our work on arrangements to secure value for money and focus our resources firstly on the delivery of our opinions on the financial statements. This was intended to help ensure as many opinions as possible could be issued in line with national timetables and legislation. We are pleased to report that we issued our opinion on the financial statements on 10 June 2021 which was in line with the timetable set out by NHS England / NHS Improvement.

In our updated Audit Findings Report, which we issued to the Audit Committee on 8 June 2021, we reported the interim results of our value for money work. We also advised you that we expected to issue our draft Auditor's Annual Report, including our commentary on arrangements to secure value for money in July 2021. We have now completed our work on your value for money arrangements and issued our final Auditor's Annual Report on 19 July 2021, which is in line with the date we previously communicated to you. A summary of our findings is set out overleaf.

The results of our value for money work

We have completed our value for money work and our detailed commentary is set out in the separate Auditor's Annual Report, which is presented alongside this report.

As part of our work, we considered whether there were any risks of significant weakness in the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources. The risks we identified are detailed in the table overleaf, along with the further procedures we performed and our conclusions. We are therefore satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Risk of significant weakness (per plan)	Procedures undertaken	Conclusion
The CCG is forecasting a balanced position for the 2020/21 financial year. Whilst the CCG appears to have adequate arrangements in place there remain challenges to securing financial sustainability at both CCG and systems wide levels in the future. The CCG is currently operating in an uncertain planning environment due to Covid 19, however, there is a recognition that the delivery of meaningful (recurrent) CIP going forward will be challenging. There is also a recognition that whilst the CCG's financial performance is good there is a systems wide deficit to be addressed collectively as an Integrated Care System becomes the focus.	We have reviewed progress and further understand systems wide plans and governance and in particular the CCG's role in this.	We did not identify a significant weakness in the CCG's arrangements. We have raised two recommendations in the Auditors Annual Report for improvement in relation to financial sustainability. We recommended: -that the CCG draws up a medium term financial plan which sets out how to bring the Herefordshire and Worcestershire health community into balance whilst at the same time reducing the backlog of elective and other activity -that in relation to drawing up the medium term system financial plan for the Integrated Care System, the Finance Forum should consider; placing greater emphasis on scenario analysis to determine the potential range of future system deficits and direct the generation of further mitigation strategies. reviewing progress in drawing up a medium term financial strategy for the system, including the current view of the likely system deficit position; timeline/process for pulling together a plan, actions to date and plans to address the inevitable large holes.

The contents of this letter relate only to the matters which have come to our attention, which we believe need to be reported to you. It is not a comprehensive record of all the relevant matters, which may be subject to change, and, in particular, we cannot be held responsible to you for reporting all of the risks which may affect the CCG or all weaknesses in your internal controls. This letter has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting or refraining from acting on the basis of the content of this letter, as this letter was not prepared for, nor intended for, any other purpose.

Certificate

The completion of our value for money work now means we have completed our audit for 2020/21 and included in Appendix A is the wording for our Audit Certificate confirming completion. A separate signed version of this certificate dated 17 August has now been issued to the CCG.

Yours sincerely

Peter Barber

Director

Appendix A - Audit certificate

The audit certificate was delayed pending completion of our value for money work. As we have issued our Auditor's Annual Report, which includes our commentary on your value for money arrangements, we are able to issue the audit certificate. The wording of the audit certificate is set out below.

Independent auditor's report to the members of the Governing Body of NHS Herefordshire and Worcestershire CCG

In our auditor's report issued on 10 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the CCG for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had:

- Completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

and

- Completed the work necessary to issue our Whole of Government Accounts (WGA) Component Assurance statement for the year ended 31 March 2021. We have now completed this work.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 10 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

Under the Code of Audit Practice, we are required to report to you if, 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 2021.

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

Responsibilities of the Accountable Officer

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) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of NHS Herefordshire and Worcestershire CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Signature

Peter Barber, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

Date

Annual Accounts

Simon Trickett
Accountable Officer
NHS Herefordshire and Worcestershire CCG
11 June 2021

Data entered below will be used throughout the workbook:

Entity name:	NHS Herefordshire and Worcestershire CCG
This year	2020-21
Last year	2019-20
This year ended	31-March-2021
Last year ended	31-March-2020
This year commencing:	01-April-2020
Last year commencing:	01-April-2019

NHS Herefordshire and Worcestershire CCG - Annual Accounts 2020-21

The Primary Statements:

Notes to the Accounts

NHS Herefordshire and Worcestershire CCG - Annual Accounts 2020-21

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

	Note	2020-21 £'000
Income from sale of goods and services	2	(4,975)
Other operating income	2	(183)
Total operating income		**(5,158)**
Staff costs	4	15,134
Purchase of goods and services	5	1,357,656
Depreciation and impairment charges	5	520
Other Operating Expenditure	5	1,071
Total operating expenditure		**1,374,381**
Net Operating Expenditure		**1,369,223**
Net expenditure for the Year		**1,369,223**
Net (Gain)/Loss on Transfer by Absorption	7	47,996
Total Net Expenditure for the Financial Year		**1,417,219**
Comprehensive Expenditure for the year		**1,417,219**

Total net revenue expenditure for the year (before transfers) of £1,369.223m is funded by in-year revenue resource allocations from NHS England totalling £1,369.858m. The in-year under-spend for the financial year of £635k is reported in note 19 (financial performance targets).

The revenue resource allocation is accounted for by crediting the General Fund, but this funding is only drawn down from NHS England and accounted for, to meet payments as they fall due.

The total funding credited to the General Fund during the year was therefore less than the revenue resource allocation and totalled £1,344.256m (see Statement of Changes in Taxpayers Equity)

NHS Herefordshire and Worcestershire CCG - Annual Accounts 2020-21

Statement of Financial Position as at 31 March 2021

	Note	31 March 2021 £'000	01 April 2020 £'000
Non-current assets:			
Property, plant and equipment	9	1,222	1,641
Total non-current assets		1,222	1,641
Current assets:			
Inventories	10	687	946
Trade and other receivables	11	16,570	24,609
Cash and cash equivalents	12	36	1,214
Total current assets		17,293	26,769
Total assets		18,515	28,410
Current liabilities			
Trade and other payables	13	(91,478)	(76,406)
Total current liabilities		(91,478)	(76,406)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(72,963)**	(47,996)
Financed by Taxpayers' Equity			
General fund		(72,963)	(47,996)
Total taxpayers' equity:		**(72,963)**	(47,996)

The notes on pages 110 to 129 form part of this statement

The financial statements on pages 105 to 109 were approved by the Governing Body on 8th June 2021 and signed on its behalf by:

Chief Accountable Officer
Simon Trickett

NHS Herefordshire and Worcestershire CCG - Annual Accounts 2020-21

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	0	**0**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating expenditure for the financial year	(1,369,223)	**(1,369,223)**
Transfers by absorption to (from) other bodies	(47,996)	**(47,996)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(1,417,219)**	**(1,417,219)**
Net funding drawn down from NHS England	1,344,256	**1,344,256**
Balance at 31 March 2021	**(72,963)**	**(72,963)**

The notes on pages 110 to 129 form part of this statement

NHS Herefordshire and Worcestershire CCG - Annual Accounts 2020-21

Statement of Cash Flows for the year ended 31 March 2021

	Note	2020-21 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(1,369,223)
Depreciation and amortisation	5	520
(Increase)/decrease in inventories	10	259
(Increase)/decrease in trade & other receivables	11	8,039
Increase/(decrease) in trade & other payables	13	15,072
Net Cash Inflow (Outflow) from Operating Activities		**(1,345,333)**
Cash Flows from Investing Activities		
(Payments) for property, plant and equipment	9	(101)
Net Cash Inflow (Outflow) from Investing Activities		**(101)**
Net Cash Inflow (Outflow) before Financing		**(1,345,434)**
Cash Flows from Financing Activities		
Net funding drawn down from NHS England		1,344,256
Net Cash Inflow (Outflow) from Financing Activities		**1,344,256**
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(1,178)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**1,214**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**36**

The notes on pages 110 to 129 form part of this statement

NHS Herefordshire and Worcestershire CCG - Annual Accounts 2020-21

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the futures is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Covid**

The accounts have been prepared on a going concern basis and reflect additional spend incurred in response to the COVID-19 Pandemic which has impacted on the whole of the financial year 2020/21. NHS England took control nationally to support management of the pandemic financially and implemented a 2 part national financial regime covering all of England. The regime for the period April 2020 to September 2020 was covered by a system envelope approach, all NHS contracts were set nationally and additional resources were made available to support service provision during this time. Where contracts were not set nationally the government pledged to fund all additional costs incurred to enable systems to report a breakeven position. The biggest area of additional spend was incurred through the Hospital Discharge Programme, this programme was a full costs recovery programme in line with guidance where full costs under phase 1 were reimbursed to CCGs during the period April 2020 to September August 2020, phase 2 of the Hospital Discharge programme covered the period 1st September to March 20201, under phase 2 only the first 6 weeks of care was funded while services moved into restoration to allow time for assessment. The financial regime covering the second half of the year from October 2020 to March 2021 again utilised a system envelope approach, the envelope based on spend incurred during the first half of the year, however under the regime for the second half of the year systems were expected to return a breakeven or better financial position, the only additional support coming through the Hospital Discharge Programme and selected support for Personal Protective Equipment and maintaining GP services. In addition to its incurring its own spend the CCG was recharged by both Worcestershire County Council and Herefordshire County Council for packages of care, this policy change implemented by the Department of Health and Social Care, CCGs receiving additional system allocation to cover the costs incurred under HDP and Councils then invoicing the CCG for reimbursement. The CCG has incurred a total of £69.451m against COVID during 2020/21 of which the CCG has spent £39.9m under the Hospital Discharge Programme and has reported these costs within its financially position, over and above those costs it would incur during a normal financial year, this change in policy covered under NHS England financial reporting requirements in line with the Governments response to the COVID pandemic

1.3 **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.

1.4 **CCG Merger**

NHS Herefordshire and Worcestershire CCG was approved by NHS England to operate from 1 April 2020 and was created from the merger of NHS Herefordshire CCG, NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG. Closing balances from the predecessor CCGs were transferred to NHS Herefordshire and Worcestershire CCG at 1 April 2020. The transfer of balances is detailed in note 7. As a result of the merger, other than for the Statement of Financial Position and related notes, comparative figures for the previous financial year have not been provided as the CCG did not exist in 2019-20.

Transfers as part of reorganisation are accounted for by the use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury.

The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated.

Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

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

1.5 **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 CCG entered pooled budget arrangements with Herefordshire County Council for the Herefordshire Better Care Fund and with Worcestershire County Council for the Worcestershire Better Care Fund. Funds were pooled in accordance with section 75 of the NHS Act 2006 and note 16 to the accounts provides details of the income and expenditure relating to these arrangements.

1.6 **Revenue**

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

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

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
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.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **Other Expenses**

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.

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.9.2 **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.

1.9.3 **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.

1.10 **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.

1.10.1 **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.

1.11 **Inventories**

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

1.12 **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.

1.13 **Provisions**

The clinical commissioning group has no provisions as at 31 March 2021
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 former Herefordshire and Worcestershire Primary Care Trusts.

1.14 **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.

1.15 **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 CCGs contribute annually to a pooled fund, which is used to settle the claims.

1.16 **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.

1.16.1 **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.

1.17 **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.

1.18 **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.

1.19 **Third Party Assets**

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

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

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

1.20.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
As disclosed in note 16 to the financial statements, the CCG is party to a section 75 agreements in relation to the Better Care Fund (BCF) in Herefordshire and 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 note16, 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. The CCG amount for 2020/21 is £10.456m
- 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. The CCG amount for 2020/21 is £23.269m
- 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." The CCG amount for 2020/21 is £72.503m

As disclosed in note 16, 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.

1.20.2 **Sources of estimation uncertainty**

There are considered to be no sources of estimation uncertainty that pose significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Estimations have been made in respect of a number of accruals; these accruals have been calculated based on the best available information when preparing the financial statements, and on historic experience, principally in respect of certain elements of prescribing.

1.21 **Partially completed spells and maternity pathways**

In line with national CCG financial guidance for 2020/21 the CCG has moved away form the historic accounting treatment for both partially completed spells and maternity prepayments.

1.21.1 **Partially completed spells**

With the continuation of fixed payments for activity with no additional variability for the number of patients treated in the year there is no requirement to calculate accruals or carry forward opening accruals for partially completed spells of care. The CCG's 2020/21 payables totals, shown in note 13, reflects the change in accounting treatment through a cash payment to providers to negate this debt.

1.21.2 **Maternity Pathways**

A similar exercise has been undertaken with providers for the maternity prepayments as reflected in the CCG's 2020/21 receivables position shown in note 11.

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM

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

The impact of IFRS 16 may result in leases being recognised as a non-current asset in the statement of financial position and a corresponding lease liability. For existing leases, the cumulative impact of this charge to operating expenses will be adjusted to opening reserves. The current assessment is the annual impact on operation expenses is unlikely to be material.

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2 Other Operating Revenue

	2020-21 Total
	£'000
Income from sale of goods and services (contracts)	
Non-patient care services to other bodies	4,252
Other Contract income	390
Recoveries in respect of employee benefits	333
Total Income from sale of goods and services	**4,975**
Other operating income	
Charitable and other contributions to revenue expenditure: non-NHS	43
Other non contract revenue	140
Total Other operating income	**183**
Total Operating Income	**5,158**

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

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

	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000
Source of Revenue			
NHS	1,747	-	153
Non NHS	2,505	390	180
Total	**4,252**	**390**	**333**

	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000
Timing of Revenue			
Point in time	4,252	390	333
Total	**4,252**	**390**	**333**

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4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	11,215	516	11,731
Social security costs	1,221	1	1,222
Employer Contributions to NHS Pension scheme	2,140	-	2,140
Apprenticeship Levy	39	-	39
Termination benefits	2	-	2
Gross employee benefits expenditure	**14,617**	**517**	**15,134**
Less recoveries in respect of employee benefits (note 4.1.2)	(333)	-	(333)
Total - Net admin employee benefits including capitalised costs	**14,284**	**517**	**14,801**
Net employee benefits excluding capitalised costs	**14,284**	**517**	**14,801**

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 20.68%, In 2020/21 the increase of £620k was paid for by NHS England within the CCG's net parliamentary funding.

4.1.2 Recoveries in respect of employee benefits

			2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(257)	-	(257)
Social security costs	(34)	-	(34)
Employer contributions to the NHS Pension Scheme	(42)	-	(42)
Total recoveries in respect of employee benefits	**(333)**	**-**	**(333)**

4.2 Average number of people employed

	2020-21		
	Permanently employed	Other	Total
	Number	Number	Number
Total	242.97	9.32	252.29

4.3 Exit packages agreed in the financial year

	2020-21	
	Compulsory redundancies	
	Number	Bands of £5k
Less than £10,000	1	0-5

4.4 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.

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

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

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

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

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5. Operating expenses (excluding staff costs)

	2020-21 Total £'000
Purchase of goods and services	
Services from other CCGs and NHS England	7,713
Services from foundation trusts	107,497
Services from other NHS trusts	747,374
Purchase of healthcare from non-NHS bodies	205,547
Purchase of social care	1,028
Prescribing costs	138,834
Pharmaceutical services	2,170
General Ophthalmic services	209
GPMS and APMS	133,829
Supplies and services – clinical	465
Supplies and services – general	1,170
Consultancy services	5
Establishment	9,966
Premises	646
Audit fees *	114
Other non statutory audit expenditure	
· Other services **	48
Other professional fees	599
Legal fees	359
Education, training and conferences	83
Total Purchase of goods and services	**1,357,656**
Depreciation and impairment charges	
Depreciation	520
Total Depreciation and impairment charges	**520**
Other Operating Expenditure	
Chair and Non Executive Members	364
Expected credit loss on receivables	368
Inventories consumed	280
Other expenditure	59
Total Other Operating Expenditure	**1,071**
Total operating expenditure	**1,359,247**

* Audit fees shown are inclusive of VAT

** Other non statutory audit expenditure relates to a Mental Health Investment Statement

In accordance with SI 2008 no. 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 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.

6.1 Better Payment Practice Code

Measure of compliance	2020-21 Number	2020-21 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	31,211	357,241
Total Non-NHS Trade Invoices paid within target	30,257	350,951
Percentage of Non-NHS Trade invoices paid within target	**96.94%**	**98.24%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	3,039	859,106
Total NHS Trade Invoices Paid within target	2,777	853,020
Percentage of NHS Trade Invoices paid within target	**91.38%**	**99.29%**

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

Upon merger of the 4 predecessor CCGs to form Herefordshire and Worcestershire CCG responsibility for paying all outstanding payables transferred to the new statutory body. To facilitate this all outstanding invoices were removed from the predecessor financial ledgers and re-inputted on to the new Herefordshire and Worcestershire CCG's financial ledger. This process was completed by the end of April 2020 and consequently the first date available to pay NHS invoices was 1st May. This resulted in the payment of the majority of transferred invoices failing to be made within the 30 day target during April and May, leading to the CCG's 91.38% average annual compliance for the percentage of NHS trade invoices paid within target based on the number of invoices.

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 and non-cash costs of prescribing and system top-up payments made to providers by NHSE

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

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

The CCG received the following balances on 1 April 2020 from the 4 predecessor CCGs: Herefordshire CCG, Redditch and Bromsgrove CCG, South Worcestershire CCG and Wyre Forest CCG

	Herefordshire	Redditch and Bromsgrove	South Worcestershire	Wyre Forest	Total
	£'000	£'000	£'000	£'000	£'000
Transfer of property plant and equipment	652	64	896	29	1,641
Transfer of inventories	145	240	401	160	946
Transfer of cash and cash equivalents	93	504	79	538	1,214
Transfer of receivables	6,157	5,221	10,885	2,346	24,609
Transfer of payables	(19,198)	(12,279)	(36,322)	(8,607)	(76,406)
Net loss on transfers by absorption	**(12,151)**	**(6,250)**	**(24,061)**	**(5,534)**	**(47,996)**

8. Operating Leases

8.1.1 Payments recognised as an Expense

	Buildings	Other	2020-21 Total
	£'000	£'000	£'000
Payments recognised as an expense			
Minimum lease payments	346	5	**351**
Total	**346**	**5**	**351**

8.1.2 Future minimum lease payments

	Buildings	Other	2020-21 Total
	£'000	£'000	£'000
Payable:			
No later than one year	279	3	**282**
Between one and five years	361	3	**364**
After five years	38	-	**38**
Total	**678**	**6**	**684**

The buildings lease payments and future minimum lease payments disclosed above relates to:
The Coach House
St Owens Street
Acton House
Barnsley Hall and Barnsley Court

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9 Property, plant and equipment

2020-21	Buildings excluding dwellings £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2020	-	-	-	-
Transfer from other public sector body under absorption	288	2,579	76	2,943
Additions purchased	-	101	-	101
Cost/Valuation at 31 March 2021	**288**	**2,680**	**76**	**3,044**
Depreciation 01 April 2020	-	-	-	-
Transfer from other public sector body under absorption	63	1,193	46	1,302
Charged during the year	29	476	15	520
Depreciation at 31 March 2021	**92**	**1,669**	**61**	**1,822**
Net Book Value at 31 March 2021	**196**	**1,011**	**15**	**1,222**
Purchased	196	1,010	15	1,222
Total at 31 March 2021	**196**	**1,010**	**15**	**1,222**
Asset financing:				
Owned	196	1,010	15	1,222
Total at 31 March 2021	**196**	**1,010**	**15**	**1,222**

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	10
Information technology	0	5
Furniture & fittings	0	5

10 Inventories

	Drugs	Consumables	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2020	-	-	-	-	**-**
Transfer from other public sector body under absorption	6	801	6	133	**946**
Additions	-	-	21	-	**21**
Inventories recognised as an expense in the period	(6)	(209)	-	(65)	**(280)**
Transfer (to) from - Reclassification	-	(592)	-	592	**-**
Balance at 31 March 2021	**0**	**(0)**	**27**	**660**	**687**

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11.1 Trade and other receivables	Current 31 March 2021 £'000	Current 1 April 2020 £'000
NHS receivables: Revenue	7,684	6,077
NHS prepayments	-	5,836
NHS accrued income	-	2,086
Non-NHS and Other WGA receivables: Revenue	4,754	6176
Non-NHS and Other WGA prepayments	4,114	3,989
Non-NHS and Other WGA accrued income	-	379
Expected credit loss allowance-receivables	(518)	(151)
VAT	446	71
Other receivables and accruals	90	146
Total Trade & other receivables	**16,570**	**24,609**

The value of NHS prepayments and accrued income has reduced primarily due to the change in accounting treatment for maternity pathways.

11.2 Receivables past their due date but not impaired

	31 March 2021	
	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000
By up to three months	182	1,452
By three to six months	-	71
By more than six months	6	1,571
Total	**188**	**3,094**

11.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies
	£'000
Balance at 01 April 2020	(151)
Changes due to modifications that did not result in derecognition	(367)
Total	**(518)**

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12 Cash and cash equivalents

	2020-21 £'000
Balance at 01 April 2020	**-**
Transfer from other public sector body under absorption	1,214
Net change in year	(1,178)
Balance at 31 March 2021	**36**
Made up of:	
Cash with the Government Banking Service	36
Cash and cash equivalents as in statement of financial position	**36**
Balance at 31 March 2021	**36**

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13 Trade and other payables

	Current 31 March 2021 £'000	Current 1 April 2020 £'000
NHS payables: Revenue	3,746	9,750
NHS accruals	489	4,405
Non-NHS and Other WGA payables: Revenue	15,289	10,352
Non-NHS and Other WGA accruals	69,989	50,202
Non-NHS and Other WGA deferred income	-	31
Social security costs	186	187
Tax	168	172
Other payables and accruals	1,612	1,307
Total Trade & Other Payables	**91,479**	**76,406**

Other payables include £1,165k outstanding pension contributions at 31 March 2021

The value of NHS payables and accruals has reduced primarily due to the change in accounting treatment for partially completed spells of care

The value of Non-NHS and Other WGA payables and accruals had increased due to the additional Covid costs

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14 Financial instruments

14.1 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.

14.1.1 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.

14.1.2 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.

14.1.3 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.

14.1.4 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.

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14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2021 £'000
Trade and other receivables with NHSE bodies	5,911
Trade and other receivables with other DHSC group bodies	2,059
Trade and other receivables with external bodies	4,557
Cash and cash equivalents	36
Total at 31 March 2021	**12,563**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2021 £'000
Trade and other payables with NHSE bodies	902
Trade and other payables with other DHSC group bodies	3,506
Trade and other payables with external bodies	86,716
Total at 31 March 2021	**91,124**

15 Operating segments

The CCG considers that the only operating segment is the commissioning of healthcare services.
This has net expenditure of £1,369.223m in 2020-21 and net liabilities of £72.963m at 31 March 2021

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16 Joint arrangements

The CCG is party to a number of joint commissioning arrangements with Worcestershire County Council and Herefordshire County Council as part of a Section 75 Agreement (also see Accounting Policies 1.5 and 1.20.1).

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.

For Worcestershire services, 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.

For Herefordshire the process is managed through a joint post with decision taking held through Strategic executive discussions between organisational executives of both Herefordshire County Council and Herefordshire and Worcestershire CCG

NHS Herefordshire and Worcestershire Clinical Commissioning Group 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 and all costs are included in note 5 - operating expenses:

Schemes	CCG retained sole control £'000	Council acted as lead commissioner £'000	Jointly controlled £'000	Grand Total £'000
Better Care Fund	25,277	14,336		39,613
Wheelchairs Service	1,925			1,925
Integrated Community Equipment Service			1,216	1,216
Learning Disabilities	3,550	1,422		4,972
Mental Health	225	127	8,212	8,564
Funded Nursing Care	12,399			12,399
Children's Services (including CAMHS)	9,423	168		9,591
Other Community Services	1,230	447		1,677
Protection of Adult Social Care		5,854		5,854
Community Health Redesign	6,836			6,836
Intermediate Care	802			802
Falls reduction	123			123
Care Home Market	10,713			10,713
Safeguarding		91		91
Children's Commissioning Unit		40		40
Integrated Community Equipment			1,028	1,028
Children with Complex Needs		784		784
Total Agreement	**72,503**	**23,269**	**10,456**	**106,228**

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17 Related party transactions

Herefordshire and Worcestershire CCG have transactions with related parties in 2020-21.

GPs that are members of the CCG's Governing Body are not considered to have significant control within their GP practice, unless they are sole partners of that GP practice, which they are not in Herefordshire and Worcestershire CCG

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. There is no requirement to provide transactional information with these organisations but material transactions have taken place with the following NHS bodies

Worcestershire Acute NHS Trust
Wye Valley NHS Trust
Herefordshire and Worcestershire Health and Care Trust
West Midlands Ambulance Service NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Birmingham Women's and Children's NHS Foundation Trust
Royal Orthopaedic NHS Foundation Trust
Dudley Group NHS Foundation Trust
Sandwell and West Birmingham NHS Trust
South Warwickshire NHS Foundation Trust
Robert Jones and Agnes Hunt NHS Foundation Trust
University Hospitals Coventry and Warwick NHS Trust
NHS Sandwell & West Birmingham CCG
NHS England
NHS Midlands and Lancashire CSU

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Worcestershire County Council and Herefordshire County Council in respect of joint arrangements.

The CCG has not received revenue and capital payments from charitable funds.

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18 Third party assets

	2020-21 £'000
Third party assets held by NHS Herefordshire and Worcestershire CCG	35

19 Financial performance targets

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

	2020-21 Target £'000	2020-21 Performance £'000	Duty Achieved? Yes/No	Explanation
Expenditure not to exceed income	1,375,117	1,374,482	Yes	The CCG underspent its in-year 2020-21 revenue resource limit by £635k
Capital resource use does not exceed the amount specified in Directions	101	101	Yes	The CCG spent its capital resource limit
Revenue resource use does not exceed the amount specified in Directions	1,369,858	1,369,223	Yes	The CCG underspent its in-year 2020-21 revenue resource limit by £635k
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	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
Revenue administration resource use does not exceed the amount specified in Directions	15,179	15,167	Yes	The CCG underspent its 2020-21 administration revenue resource allocation by £12k