NHS
Redditch and Bromsgrove
Clinical Commissioning Group

Annual Report and Accounts

2018/19

Contents

Performance Report

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Foreword

Welcome to NHS Redditch and Bromsgrove Clinical Commissioning Group's Annual Report and Accounts for 2018/19.

This report is intended to highlight what has gone well, identify areas which need further work and look towards where the future may take us.

I would like to firstly thank healthcare staff, social care services, patients and local residents for their efforts to support the health services over the last 12 months. Preventing illness is so important, I would therefore like to acknowledge all patients for their efforts - where relevant- in having their flu vaccinations, stopping smoking, increasing exercise and maintaining a healthy weight. This all makes a huge difference. A word of thanks also has to go to everyone working in health and social care over the last year.

We continue to work with the three big healthcare providers, Worcestershire Acute Hospitals NHS Trust, Worcestershire Health and Care NHS Trust and General Practitioner services to ensure safe and sustainable services are available to all residents.

The Worcestershire Health and Care NHS Trust, which runs the community hospitals and provides community services such as district nurses and mental health services, continues to do well. Worcestershire Acute Hospital NHS Trust is continuing to show improvement in several areas, although further improvements are still required to bring the Trust out of Special Measures. We also commission General Practitioner services and there has been a new impetus to improve access for patients and new ways of working.

Over recent months we have continued to work collaboratively with partners including colleagues in Herefordshire, as we look at harmonising some specialist services and integrating care better between local providers as part of our Sustainability and Transformation Partnership (STP).

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

Dr Richard Davies

Chairman
NHS Redditch and Bromsgrove CCG

Performance overview

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

This overview is designed to provide you with enough information to understand a bit more about our organisation, our purpose, the key risks and challenges to the achievement of our objectives and how we have performed during 2018/19.

Key highlights this year

NHS Long-Term Plan and future CCG role

The new Long-Term Plan for the NHS was published at the beginning of January. The Plan takes forward a lot of the work that was described in the Five Year Forward View with the integration of services and of organisations being a key theme. The focus is around the following themes:

1. Enhancing ‘out of hospital’ care and dissolving the historic divide between primary and community health services
2. Redesigning and reducing pressure on emergency hospital services
3. Providing people with more control over their own health, and more personalised care when they need it
4. Moving towards more digitally-enabled primary and outpatient care
5. Focusing on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.

One of the key stipulations within the Long-Term Plan was that all parts of the country will be covered by Integrated Care Systems by 2021. To help support this the Plan also outlines an expectation that CCGs will need to merge to become larger and that there would typically be a single CCG for each Integrated Care System area by April 2021. Discussions this year have since taken place with Governing Bodies and stakeholders in Herefordshire and Worcestershire to determine how best to plan for and approach that locally.

Two retirements of current postholders have already enabled some management costs efficiencies to be made as well as ensuring further alignment of functions across the four CCGs in Herefordshire and Worcestershire in anticipation of becoming a single CCG in the future. Mark Dutton will be appointed as the Chief Finance Officer for Herefordshire CCG with effect from 1st April 2019 and will hold the role for all four CCGs. Lynda Dando similarly will be appointed as Director of Primary Care and will also work across all four CCGs with effect from 1st April 2019. Aligning resources and the development of joint posts across more specialised functions such as safeguarding and performance management is also being progressed and similar opportunities will be sought throughout 2019/20.

New national GP Contract

Towards the end of January also saw the publication of a new national GP contract that is designed to cover a five-year period and includes planned funding uplifts to the core contract each year to provide certainty for financial planning for Practices.

The document also proposes a new 'Directly Enhanced Service' (DES) that GP practices can choose to sign up to, the funding for which totals £4.6 billion over the five-year period. There are several areas of focus for the DES, initially this requires Practices to sign up to work in Primary Care Networks with neighbouring Practices and covering 30,000-50,000 patients and to operational from 1st July 2019.

The DES also provides additional funding for Networks to employ 20,000 additional staff over the five year period, with a focus on the use of Social Prescribers, Pharmacists, Physiotherapists, Community Paramedics and other staff that can provide an alternative to a GP and assist with workforce gaps but also to ensure GPs have more time to spend with complex patients with long term conditions. The DES also includes some national service specifications for services such as end of life care and mandatory use of initiatives like electronic prescribing.

Our local GP practices are in an advantageous position to be able to comply with many of the requirements of the new DES in 2019/20 because of the work that has already been done in the last few years. Primary Care Networks can almost exclusively evolve from the existing Promoting Clinical Excellence and Neighbourhood Team groupings and that way of working and those relationships are well established.

Neighbourhood Team plans implementation and ongoing review

On the subject of Neighbourhood Teams, this past year the Worcestershire Alliance Programme Board has continued to oversee the development of integrated care within Worcestershire and the development of the Alliance Board and Neighbourhood Team structures.

There are now 14 Neighbourhood Teams working across Worcestershire, all of which involve GP practices collaborating and working within a single team with input from community and mental health teams, and increasingly social work staff and partners from other agencies such as housing.

This year each Neighbourhood Team has submitted a plan that details their response to the Promoting Clinical Excellence (PCE) contract requirements, including how they will focus on further reducing emergency admissions and on continuing the work on reducing unwarranted variation in planned care referrals and prescribing. These plans are being monitored by our Financial Recovery Board, with the new Integrated Care Board and the three Alliance Boards also playing a role in ensuring delivery.

Our Sustainability and Transformation Partnership

We have continued to strengthen our relationships with partners across Herefordshire and Worcestershire as part of our Sustainability and Transformation Partnership (STP) Plan, which sets out the direction for local models of healthcare and support services. This is a long-term plan to address some of the local health and care inequalities we have, to improve health outcomes for people across the area, and to ensure we can continue to provide safe and sustainable care into the future.

A new Operating Model for the STP has been developed this year and is being discussed with partners. The key themes of this are how the local system can take more ownership of the STP and how this work can be much more aligned with the day to day working, rather than being seen as a parallel exercise.

Part of the transition to some of the new ways of working for Integrated Care Systems will be how to align governance, decision making and some of the assurance and regulation work, which increasingly will become a local activity as the role of NHS England and NHS Improvement evolves. The proposed Operating Model does include some shared forums overseeing system wide finance, quality and performance, as well as a stronger focus on a clinical strategy that would seek to address any shortfalls in those.

Leadership of these forums, and the wider STP executive and partnerships forums will need to be distributed amongst existing system non-executive, GPs and Lay Members and the plan is to phase in the new approach throughout 2019/20, subject to approval from NHS England and NHS improvement.

Urgent Care and Winter challenges

The Winter period has once again been challenging for the Worcestershire system, particularly in relation to performance with frequent high levels of escalation. There has been significant concern related to ambulance handover delays, increased corridor care and 12-hour breaches. Demand over the winter period for Accident and Emergency overall attendances at A&E have increased from last year by 3.7% for the period November 2018 to February 2019.

Worcestershire Acute Hospitals NHS Trust continues to be supported by both NHS Improvement and the national Emergency Care Intensive Support Team (ECIST) and we continue to provide system leadership support for both escalation and to promote implementation of the agreed plans that are overseen by the A&E Delivery Board. Delivery of the A&E Delivery Board Plan and the six priority areas with that plan remain the focus.

The priorities within the Plan include:

- Development and utilisation of additional bedded capacity and associated operational improvements. This has produced an extra 84 beds within the system this winter
- Sustained reduction in over ‘one’ hour ambulance delays and reducing reliance on ‘corridor care’
- Delivery of a front door streaming model in line with the national policy imperative for this. To support the implementation required the CCG has enhanced its specification for both front door streaming and GP streaming services and highlighted the requirements with the new Trust leadership team
- Increased activity through all of the Same Day Emergency Care (SDEC) services, specifically through the Ambulatory Emergency Care and Frailty Assessment unit pathways. Detailed and updated specifications are now in pace for these services;
- Acute trust patient flow program, including improving discharges processes, implementing ‘no delay’ across the Trust
- Enhanced site leadership across the Acute Trust. The Emergency Care Intensive Support Team (ECIST) have provided a programme director to support delivery of these final two priorities.

The Urgent Treatment Centre pilot of the Alexandra Hospital which is part of the Future of Acute Hospital Services in Worcestershire (FOAHSW) arrangements continues until the end of May 2019 and the evaluation of this pilot service is now underway.

Work to review stroke services

This year we have continued to develop plans to improve outcomes for stroke patients across Herefordshire and Worcestershire. The Stroke Programme Board has developed a number of different options for potential service delivery models and has sought feedback from clinicians and other key groups as it continues to refine those models. The Herefordshire and Worcestershire Stroke Programme Board includes representation from from clinical and operational staff from Worcestershire Acute Hospitals NHS Trust, Wye Valley NHS Trust and Worcestershire Health and Care NHS Trust, commissioners from the four CCGs and Powys Health Board, clinical and operational representatives from West Midlands Ambulance Service and the Welsh Ambulance Service, Public Health and the Stroke Association.

The options appraisal work included some analysis of future demand for stroke services and accurate bed and non-bed-based modelling, considering potential changes to the stroke pathway, achievement of key clinical and performance standards across 7 days and identification of the enablers that are required to deliver the models.

Further community engagement work is planned to continue in 2019/20 to identify patient's priorities for stroke services and that will be fed into the programme and overall options appraisal.

Transforming Care programme

There has been significant progress this year with the Transforming Care programme of work which aims to develop community capacity and reducing inappropriate hospital admissions and length of stay for people with learning disabilities.

All health economies have been working on nationally defined trajectories to reduce hospital placements and to make sure that more patients can be cared for in the community and at home. Worcestershire and South Yorkshire are the only two few areas that have remained on track with the trajectory and this is attracting national interest now as a best practice site.

Integrated Care of Older People in Worcestershire

This year we have developed a new strategy for Integrated Care of Older People (ICOPE) in Worcestershire. This is a joint document and is accompanied by a Memorandum of Understanding that will be signed by partners to govern how it is implemented.

The Worcestershire ICOPE programme is a joint initiative being developed collaboratively by the local NHS providers, Social Care, Public Health, Age UK Herefordshire and Worcestershire, Worcestershire Association of Carers as well as older people and public groups. Worcestershire partners need to work together to encourage the older population to stay healthy, active and independent whilst making the best use of available resources.

The programme aims to:

- Improve the experience of ageing for Older People
- Achieve the best possible outcomes for Older People living in Worcestershire
- Make most efficient use of resources
- Improve the experience of caring for Older People for professional and informal and formal care providers.

Integrated Clinical Assessments and Triage Service (ICATS) for Musculoskeletal conditions

We have been working with the other two CCGs this past year to implement a new countywide Integrated Clinical Assessments and Triage Service (ICATS) for Musculoskeletal conditions that will be in place from January 2019. This is in line with a national mandate from NHS England but is also with a view to standardising access across the county and to reduce demand on diagnostic services. The latter point is with a view to prioritising access to more specialist scans for patients in the highest need, particularly those on cancer pathways.

The new service is being implemented slightly differently in each of the three CCG areas, depending upon the capacity and experience available and the historical pathways for this service. The plan will be to standardise this over time into one model that can also deliver benefits of scale.

Extended access to primary care

This year has seen deliver the extended access to primary care programme. This means that wider access to primary care appointments has now been made available to 100% of our local population. Plans are now being prepared for the future alignment of these extended services with the primary care out of hours service, the contract for which expires in April 2020. Our Joint Commissioning Committee agreed that this would also be scoped and developed as a new service across Herefordshire and Worcestershire.

University of Worcester proposed Medical School

We have been an active participant in a new stakeholder group that has been established to support the University of Worcester develop their plans and formal application to open a Medical School.

Were the application to be successful this would be of enormous benefit to the local health economy, particularly in terms of attracting and hopefully retaining graduates in local roles. If successful the ‘Three Counties Medical School’ would receive its first admissions in September 2021 and the university are working with Swansea University as their ‘contingent partner’, with the course and curriculum aligning with that delivered in Swansea. One of the important roles for us to assist with next year is to help to shape the proposed local curriculum and to support engagement with local health organisations, particularly primary care and local GP Practices who will hopefully play an important role in offering training support and placements.

NHS 70

In July this year the NHS turned 70 and across Worcestershire we saw this as an opportunity to celebrate achievements and thank NHS staff for their contributions. It also presented us locally with the opportunity to talk about plans to address the pressures of a growing and aging population and to make sure that services are fit for the future.

Across the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP) a number of events and activities were held to look back and celebrate local success, as well as using the opportunity to have conversations about how services may need to change and how people may need to adapt their behaviour and expectations about how, where and when services should be accessed.

Key challenges this year

Winter pressures

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

Performance against targets

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

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

Financial climate

While delivery against our Financial Recovery Plan has been a notable success in 2018/19, I fear that our target for this forthcoming year will be equally – if not more – challenging. However, I remain confident in our ability to deliver the significant savings required while supporting the delivery of the best possible services for local residents.

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

Improving acute services

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

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

Since then the Trust has also been served a number of section 29A notices by the CQC, the most recent in July 2017, which set out requirements for significant improvement. This year the health watchdog’s latest report indicated that improvements continue to be made by the Trust and welcomed the increased stability, but demanded that more work still needs to be done in a number of areas.

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

Looking ahead to 2019/20

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

Much of what we are planning to do will build on what has been achieved in 2018/19. We will need to go further to reduce expenditure where we can without this impacting on the quality of care. We believe there is further to go to reduce prescribing expenditure – particularly around repeat prescribing - to ensure controls around expensive packages of care are working optimally. We also plan to better control our contractual expenditure, particularly with the independent sector and out of county acute hospitals.

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

There will also be much greater focus on single programmes of work across Herefordshire and Worcestershire this year as part of the Sustainability and Transformation Partnership, using it as a delivery tool for both continued financial recovery and transformation programmes. This will include focusing on our own organisational form across the two Counties as we potentially move from becoming four CCGs into a single CCG across the STP footprint. In doing so I would expect us to be able to remove a great deal of unnecessary duplication from across our system and increase the amount of resource that we can put into delivering frontline services.

There is no doubt about the significant scale of challenge in front of us in 2019/20. However, we remain confident that we can build on the momentum we have created this year to drive much needed transformational change to improve services for patients whilst achieving further cost efficiencies and better value for money.

Simon Trickett
Accountable Officer

About us

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

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

Serving a population of more than 178,000 people across Redditch and Bromsgrove, we are responsible for:

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

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

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

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

We also commission services from providers outside of Worcestershire including:

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

The population we serve

We serve patients registered with general practices located across Redditch and Bromsgrove. As at 1st January 2019, 178,390 patients were registered with Redditch and Bromsgrove GPs.

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

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

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

- Redditch and Bromsgrove has a wide socio-economic range, with some very affluent areas and some of the most deprived areas in the county. There is a clear link between deprivation and health outcomes such as premature mortality
- Redditch and Bromsgrove has a relatively youthful population with 22.8% of the registered population being aged 0-19
- Average life expectancy is 79.0 years for men and 83.3 years for women in Redditch, and 79.4 years for men, 83.7 years for women in Bromsgrove. These figures are very close to the national values. Mortality rates for major conditions also tend to be close to the national average, though circulatory disease mortality appears to have worsened a little relative to nationally in the last decade
- The proportion of children in year 6 who are overweight or obese in Bromsgrove and Redditch respectively is 27.6% and 34.4% compared with 34.2% nationally. The Bromsgrove value is statistically significantly lower than the national rate
- The proportion of children who at age 5 reach a good stage of development is 66.4% for Redditch and 75% for Bromsgrove. The rate for Redditch is statistically significantly lower, and statistically significantly higher for Bromsgrove than the national level of 69.3%
- Emergency admission rates for self-harm are not significantly different to the national average in Bromsgrove (171.3 per 100,000 compared to 196.5). Redditch is statistically significantly higher than the national level with a rate of 278.1 per 100,000 admissions
- Recorded unadjusted prevalence of asthma, chronic heart disease, diabetes, hypertension and stroke are all higher than the national average, although this could be partly explained by more effective local recording
- The teenage conception rate is significantly below the national level of 20.8% in Bromsgrove at 10.3%. The rate for Redditch is similar to the national average at 25.7%.

The JSNA can be found on our website at www.redditchandbromsgroveccg.nhs.uk/about-us/strategy/.

Our vision and values

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

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

- Fair, ethical and transparent
- Patient safety and experience

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

Key challenges

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

Health and Well-being

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

Care and quality

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

Finance and efficiency

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

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

Our strategic approach

Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP)

Across Herefordshire and Worcestershire, all health and care organisations are committed to always providing safe and effective services, but together we acknowledge that the way some services are run may need to change. This is because we have a growing population and rising demands on services, and we have to make sure we can do the best we can with the resources available.

The Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP) brings together local health and care organisations (including local authorities) across the two counties, supported by voluntary and community groups as well as patient and carer representatives.

It is a long-term plan to address some of the local health and care inequalities we have, to improve health outcomes for people across the area, and to ensure we continue to provide safe and sustainable care into the future.

This means maximising efficiency and effectiveness of what we do, putting prevention, self-care and promoting independence at the heart, developing out of hospital care, and providing clinically and financially sustainable services. We are also working on projects to support the changes we need to make, for example around workforce, organisational development, engagement, communications, digital and finance.

During 2018/19 the STP has continued to be a key area of focus for us. The programme workstreams are well developed and are progressing, with strong monitoring of progress from a central Programme Management Office (PMO) that is now being expanded to incorporate PMO resources from across the Worcestershire and Herefordshire CCGs and the central STP team. The Herefordshire and Worcestershire STP work continues to be highly regarded and is considered to be ahead of some other areas, particularly in terms of the strength of relationships between partners and the maturity of some of the joint working. Performance issues and financial sustainability of the systems continue to be the main areas of risk and concern.

The STP has agreed some priority headlines under which there are lots of different work-streams at different stages of development. There are four main areas of work which are described below:

1. Maximise efficiency and effectiveness

We intend to maximise efficiency and effectiveness across clinical, service and support functions to improve experience and reduce cost, through minimising unnecessary avoidable contacts, reducing variation and improving outcomes. As part of this work we are reviewing how digital and technological solutions could be better introduced across everything that we do and are aligning ourselves with other NHS organisations across Worcestershire, Herefordshire, Coventry and Warwickshire to give us greater purchasing power for things like clinical consumer items.

2. Prevention, Self-Care, Promoting Independence

We plan on reshaping our approach to prevention to create an environment where people stay healthy for longer. We intend on supporting resilient communities where self-care is the norm, digitally-enabled where possible and staff include prevention in all that they do. We see social prescribing is a way of enabling primary care services to refer patients with social, emotional or practical needs to a range of local non-clinical services. We are also reviewing the use of social media and technology to support prevention and self-care.

3. Integrated Primary and Community Care

We have continued to develop an improved out of hospital care model by investing in sustainable primary care which integrates with community based physical and mental health teams, working alongside social care to reduce reliance on hospital and social care beds through emphasising 'own bed instead'. We have set up local neighbourhood teams across the county where Community Nurses, Enhanced Care Teams, Promoting Independence, Community Therapists and other closely aligned services are working together in a much more collaborative way with social care and GP colleagues. These teams are wrapping around their patients who are vulnerable or at greater risk of hospital admission. By providing more proactive and responsive support the aim is to reduce reliance on hospital beds and keep people well at home for longer.

4. Establishing clinically and financially sustainable services

We continuing to design sustainable services through the development of the right networks and collaborations across and beyond Herefordshire and Worcestershire to improve urgent care, cancer care, elective care, maternity services, and specialist mental health and learning disability services. For example, the aligned STP Elective Care Transformation Group has been established as a dedicated clinically-led work programme within the STP, bringing together a range of partners to deliver this aim with a number of objectives including the delivery of the NHS constitutional 18-week referral to treatment standard. This workstream plans to explore how existing enhanced services can be maximised to meet some of the activity demands for instance diabetes and to further explore how other opportunities such as procedures undertaken as a day case, could potentially be delivered in outpatients. Progress also remains good with joint working on the Local Maternity System plan that was the only one within the West Midlands region to be fully assured.

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

Worcestershire Joint Health and Wellbeing Strategy 2016/21

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

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

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

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

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

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

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

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

Herefordshire and Worcestershire Operational Plan (2017 to 2019)

We have developed a single commissioner plan that covers the four CCGs in Herefordshire and Worcestershire in line with our Sustainability and Transformation Partnership footprint. The plan sets out each CCG's strategic aims and priorities, including key actions to support the delivery of the STP Plan, our aspirations for performance against the NHS constitutional standards and other performance requirements as well as the arrangements that we have in place for quality assurance.

For more information our Joint Operational Plan (2017/18 to 2018/19) can be found on our website at www.redditchandbromsgroveccg.nhs.uk/about-us/strategy/.

Better Care Fund

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

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

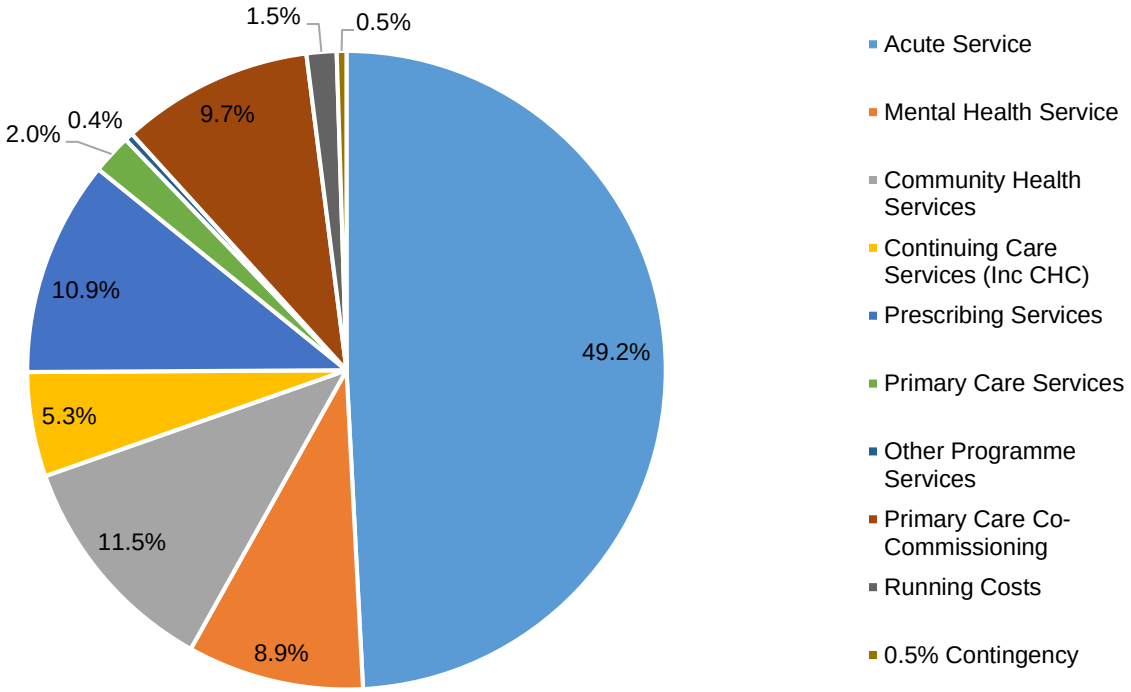
Although not ‘new’ money, the BCF sets an ambitious challenge to integrate health and social care. The scale and scope of the Better Care Fund is determined by the Worcestershire Health and Wellbeing Board in line with specific national conditions.

In Worcestershire the focus for intervention from the BCF is to support people who are currently, or who are at risk of becoming, heavily dependent on health and adult social care services to live their normal lives. Within Worcestershire the BCF for 2018/19 is £40.6 million, of which we have contributed £10.7 million, with the majority of the remainder coming from the other two Worcestershire CCGs.

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

Finance summary

Where the money was spent in 2018/19



Delivering our Financial Plan

We have delivered against our Financial Plan for 2018/19. The total CCG cumulative deficit is £8.293 million.

Adjusting for the in-year financial pressures around No Cheaper Stock Obtainable (NCSO) and contract activity pressures the CCG delivered a surplus of £6k compared to the approved financial plan for an in-year breakeven on the resources allocated. This ensured the CCG made a small improvement in reducing its cumulative deficit. The CCG plan for 2018/19 included £2.3m from the Commissioning Sustainability Funding (CSF), to support the CCG in-being able to deliver an in-year balanced position. The £2.3m CSF was non-recurrent and non-re-payable to NHS England.

The delivery of our Financial Plan for 2018/19 continues to be challenging and gets more difficult year on year. There continues to be the on-going requirement to deliver higher levels of cash-releasing efficiency savings against the increasing demand for services. The CCG has also had to manage the continued financial impact of the NCSO national drugs pressure and still managed to over achieve the savings plan in prescribing budgets. The CCG has also had to manage higher demand for acute activity than planned for across a number of hospital trusts.

During 2018/19 the CCG (in partnership with the other two CCGs in Worcestershire) continued its focus on on-going financial scrutiny, not only at a CCG level, but also in identifying system savings opportunities across the Worcestershire Health Economy. The

CCGs delivery was £28.6 million savings against a £31 million target across the Worcestershire CCGs. Overall, 2018/19 saw another increase in expenditure within Secondary Care across a number of our hospital trust contracts. We also saw increased expenditure against the 999 Ambulance contract and also increased expenditure due to Ambulance handover delays at the Alexandra Hospital. Prescribing pressures around NCSO drug availability also caused some financial pressure, however this was offset by increased savings within the prescribing portfolio. We also saw some financial pressure against the Continuing Healthcare budget driven by a larger increase in fast track packages of care and some one-off costs associated with some higher cost patients being delayed and then discharged from the Acute Trust.

To support the overall financial plan and deliver the breakeven requirement the CCG utilised planned reserves held to support the overall financial plan.

Financial Allocation for 2019/20

Our income predominately comes through an approved NHS England allocation which is based on a national funding formula. The allocations for 2019/20 and future years have been published and CCG control totals set by NHS England. The CCG is required to maintain an in-year breakeven position for 2019/20. The allocations for 2019/20 included the additional funding awarded to the NHS as part of the NHS 70th Birthday in July 2018 with an announcement from the Prime Mister that the NHS would receive an extra £20bn above inflation which would be front loaded in to the NHS Budgets. As part of the allocation this came with requirements around Mental Health investments, pricing uplifts on national tariffs and uplifts to cover NHS nationally agreed payawards.

The allocation will include the return of the 2018/19 surplus that was delivered this year which will bring the overall cumulative deficit down slightly. Current allocations - based on the national funding formula allocated under a place-based process - show that against the CCG programme budget the distance from target is now 4.19% under-funded at the end of 2019/20. The CCG received the average inflationary uplift in 2019/20 of 5.29%. This still leaves the CCG significantly underfunded based on the current NHS funding formula. This is funding that could be utilised to support the significant financial pressures within the Worcestershire Health economy. Whilst the distance from target is within the NHS England policy of 5%, this leaves the CCG with added financial pressure.

As part of the place-based funding formula our Primary Care allocation remains above fair share funding. On top of this pressure initial modelling shows that implications of the new GP Contract for 2019/20 will leave the CCGs within Worcestershire with a significant financial pressure. This is being discussed currently with NHS England. Whilst the growth uplift was above 5%, this was still lower than other CCGs factoring in the current small level of over-funding of Primary Care within Redditch & Bromsgrove. This will continue to present a financial challenge to the Co-Commissioning Committee in terms of how it balances its overall Primary Care budgets for 2019/20.

Other challenges

In addition to the challenging financial allocations we will continue to have financial pressures to manage, mainly around the need to ensure value for money for every Worcestershire pound spent. We will also have on-going recurrent efficiency and productivity savings to make with an ageing population and demand increasing for NHS services.

The overall plan requires Redditch & Bromsgrove to make a further financial improvement in 2019/20. Whilst the CCG is required to deliver a breakeven position again this is without

CSF support that the CCG received in 2018/19. This means the CCG has to recurrently find another £2.3m in savings to manage the overall financial plan.

The CCG will need to ensure focus and attention remains on the underlying surplus position which is a key indicator in terms of the overall financial health of the CCG. The plan set for 2019/20 looks to improve this again based on the continued financial sustainability within the CCG.

The biggest financial focus for the CCG in 2019/20 will continue to be the need to recurrently deliver the target savings requirement for 2019/20 of £10.7 million (4.4% of overall allocation). This represents a significant financial challenge for 2019/20 as the opportunity to deliver savings reduces year on year. This target will require further difficult decisions to be made through the Financial Recovery Programme to ensure we live within the financial resources allocated to the CCG.

To further ensure the financial resilience of our organisation is protected we have again agreed a full financial risk with NHS Wyre Forest CCG and NHS South Worcestershire CCG.

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

Long term expenditure trends

As part of the CCG Financial Plan and development of a Medium Term Financial Strategy (MTFS) linked with the overall financial strategy underpinning the Hereford and Worcestershire Sustainability and Transformation Plan (STP) the CCG has modelled in investment in a number of key areas as per NHS Planning guidance and also looking as part of the wider Health economy about how Worcestershire lives within its financial means. This will be a key theme with the new NHSE/I regulators during 2019/20 and beyond.

Going concern

Our annual accounts have been prepared on the going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The following is clear evidence that the CCG meets the requirements as set out in section 4.13 of the Department of Health Manual of Accounts:

- The CCG was established on 1 April 2013 as a separate statutory body
- The CCG has an agreed Constitution which it is operating to for the governance of its activities
- The CCG has been allocated funds from NHS England for the following financial year 2019/20
- The CCG has been allocated indicative allocations to 2023/24
- The CCG is allocated a cash drawdown which is based on the cash requirements of the CCG.

The directors have a reasonable expectation that the CCG has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt a going concern basis in preparing the accounts.

Performance analysis

Development and performance during 2018/19

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 2018/19 based on the following areas of work:

1. Improving care and quality

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

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

2. Delivery of GP Forward View and Integrated Care Plan

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

3. Financial Recovery and Sustainability

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

Sustainable development

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

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

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

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

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

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

Policies

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

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

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

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

Partnerships

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

Travel

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

Improve quality

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

We consider the components of quality (patient safety, clinical outcomes and patient experience) to be central to our function as effective commissioning bodies. During 2018/19 the continued contribution of the Quality Team ensured that each commissioning decision was subject to a robust Quality Assurance process, and - where required- a full Quality Impact Assessment.

We work in close partnership with our commissioning partners in Public Health and Worcestershire County Council, and our providers, to ensure that all quality issues across the health economy in Worcestershire have appropriate oversight and scrutiny. Areas of commissioned service quality requiring or achieving improvement are shared with senior management and Executives at the Quality, Performance and Resource Committee in Common for Worcestershire, and with CCG Governing Bodies, in public.

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

Key quality improvement achievements in 2018/19 include:

- Recognition by NHS England of the continued positive performance of Worcestershire in Transforming Care for people with a learning disability in Worcestershire, supporting proactive case management to enable care close to home for those who have high levels of complex need and the minimal use of restrictive hospital placements
- Embedding the Learning Disability Mortality Review programme (known as LeDeR) across Worcestershire. Building on strong foundations Worcestershire partners have, through an established Steering Group, agreed five key Priority Action work groups to secure progress in areas of concern that will improve health outcomes and reduce premature death amenable to quality health care
- Working collaboratively with partners across commissioning and provider organisations to agree a Suicide Prevention Strategy and underpinning suicide reduction plan, including a zero tolerance to suicide in healthcare inpatient areas
- Leading the facilitation of a forum for quality assurance practitioners across neighbouring commissioning organisations within the region
- Overseeing the second year of a two year plan for the implementation of a number of incentivised quality improvement schemes within provider organisations (Commissioning for Quality and Innovation- CQUIN) in areas including physical healthcare for people with enduring mental health needs, the experience of transitions for young people moving from Child and Adolescent Mental Health services to Adult Mental Health services, the timely recognition of sepsis in acute hospital to improve life chances through access to timely treatment and integrated support to provide effective alternatives for those who have used Emergency Departments to access support for mental health needs
- Working with partners to agree the implementation of NHS Improvement guidance for pressure ulcers. This has enabled clear collaborative processes to be agreed for the timely detection of pressure ulcers, irrespective of the location in which they may

have been acquired, in order to promote the early identification of learning to influence improvements in practice
- Working closely with Worcestershire Acute Hospitals NHS Trust to identify and make progress in areas of patient safety improvement. This has included gaining assurance of action taken following reviews of adverse events to ensure that learning is effective in improving practice
- Continuing to strengthen a programme of Safeguarding training for Primary Care and Continuing Healthcare Teams including the application of the Mental Capacity Act and Deprivation of Liberty Safeguards
- Providing expert support to inform Worcestershire County Council's Children's Social Services Alternative Delivery Model which will result in "Worcestershire Children First" go live on the 1st October 2019
- Preparation for the introduction of new Liberty Protection Safeguards (within the Mental Capacity (Amendment) Bill [HL] 2017-19), set to replace the Deprivation of Liberty Safeguards (DoLS) during 2020, once agreed through parliament
- Working closely with Registered Care Home providers to embed an outbreak toolkit and minimise the spread of infection outbreaks. This included support to ensure the early identification of those who had been in contact with flu so that timely access to antiviral medication could be arranged
- Facilitation of the agreement and implementation of system wide processes for the identification and management of Carbapenemase Producing Enterobacteriaceae (CPE) to ensure consistent practice across the health economy to reduce the potential for harm to patients when exposed to this emerging organism
- Commissioned dedicated Care Home placements for end of life care in order to secure improvements in the quality of service provision and patient / carer experience
- Continued to facilitate a stakeholder forum to improve the delivery of End of life and palliative care education across organisation boundaries, increasing engagement and extending into Herefordshire during 2018
- Engaging in collaborative work with partners across the West Midlands, to develop the West Midlands Integrated Urgent Care Service supporting patients to access the right care at the right time to manage their urgent care need outside of hospital where possible.

Principles for Remedy

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

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

In 2018/19 we received 102 complaints about services that we commission. The complaints are categorised as follows:

Subject	Number of complaints
Commissioning - CHC	29
Commissioning - other	57

Provider - Acute	8
Provider - Community	3
Provider - NHS111	1
Provider - Independent Sector	2
Provider - Ambulance	1
Provider - Nursing Home	1
Total	**102**

Patient and public involvement

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

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

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

- A Patient and Public Involvement (PPI) Lay Representative who is a member of the Governing Body and presents the PPI Highlight Report, including notes from the Patient Advisory Group meetings
- Patient Advisory Group (PAG) – chaired by the Lay Representative for PPI and is attended by a panel of patient representatives from across the county, meeting bi monthly
- Worcestershire Involvement Network (WIN) membership scheme - the 387 active members receive monthly updates and opportunities to engage further with the CCG
- Patient Participation Groups (PPGs) and their virtual network – the CCG supports PPG's to meet together, share best practice and provide them with regular updates. An event to support PPG's took place on 1st March 2019
- Supporting Lay Members (SLMs) – new roles based within three Worcestershire localities (Redditch and Bromsgrove, South Worcestershire and Wyre Forest) to work across the health system and champion the patient and public voice
- Integrated Care Patient and Stakeholder Groups – chaired by the SLMs and aimed at providing meaningful engagement within the Primary Care Networks across the county
- Partners across the Sustainability and Transformation Partnership (STP) including local Councils, Health Providers, Healthwatch, Seldom Heard Groups, Voluntary and Community Sector (VCS) organisations, Health Overview and Scrutiny Committee
- Meeting with communication and engagement colleagues across the Herefordshire and Worcestershire Sustainability and Transformation Partnership every month.

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

Patient experience

Patient Experience is a vital part of The Engagement Cycle as well as being a fundamental part of delivering and ensuring Quality. Transforming Participation in Health and Care

(NHSE 2013) outlined statutory guidance for CCGS regarding the requirement to understand and learn from the patient experience of the CCG's local population.

The patient and public voice provides NHS organisations, irrespective of whether it has a provider or commissioning focus, with a reminder of the core purpose of the organisation. Patient stories continue to be a key focus of the Quality, Performance and Resource Committee that reports directly to the Governing Body. Examples of the experience of health services by members of our local population are gathered and are presented by the Lay Member for Patient and Public involvement. During 2018/19 patient stories have focused upon a range of agreed themes including access to Urgent Care, experiences of cancer services, the use of maternity services and stroke services.

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

Key highlights

Our major achievements this year have included:

- Aligning the the engagement framework across Worcestershire and establishing new engagement groups and systems. We met all the previously existing groups face to face and discussed the plans with feedback from those groups influencing the final set up
- The CCG has started to consider how to improve stroke services across Herefordshire and Worcestershire and we have spoken with stroke survivors to find out what their experience have been, including attending Stroke Association groups. This influenced the creation of support pages on our website for strokes survivors
- As part of the Financial Recovery Programme focus groups were organised to engage patients in the Elective Care Workstreams including Gynaecology and Urology
- The CCGs have been co-producing the new Musculoskeletal (MSK) pathway to streamline it for patients and professionals and ensure equal access across Worcestershire. Three patient representatives, all with MSK conditions, have worked closely with the project team and clinicians to establish new ways of working
- Internal staff engagement regarding organisational culture
- Supporting the closure of Woodrow Medical Practice through engaging with patients and stakeholders and robust communications
- Evaluating the success of our Winter Plan including patient experience surveys of the Urgent Treatment Centre
- Holding the first Worcestershire wide Patient Participation Group (PPG) Event focusing on celebrating and supporting PPGs.

Seeking representative views

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

- Engaging with a parents group in Redditch about the Handi App providing paediatric health advice and the Urgent Treatment Centre

- We have visited nursing homes and discussed quality of care with a focus on activities and improvements for the activities co-ordinators network
- Working closely with Worcestershire County Council and Malvern Hills District Council we circulated an alcohol awareness video on social media, which was aimed at mothers
- Furthered our relationship with the Carers Partnership, which discusses carer issues across Worcestershire
- We have attended the Worcestershire County Council run Older People's Consultative Group and have plans to work closely with them in the future
- Alzheimer's Support Group - we have engaged with a group who support those living with and caring for loved ones with Alzheimer's and dementia. We discussed access to healthcare services and keeping well over winter
- We have worked closely with young people through our regular Youth Takeover Day activities and have links with our local secondary schools
- Continued participation in the Diocesan Health and Wellbeing Group of Worcester, ensuring that their large network of churches and parishes are aware of issues in the health service.

Looking ahead to 2019/20

As part of the Sustainability Transformation Partnership (STP) the three Worcestershire CCGs will be working increasingly more closely with Herefordshire CCG.

The Communications and Engagement Team is already working across the two counties and supporting the four CCGs and will be focused on strengthening engagement and involvement across the STP and is planning extensive engagement on a potential merger of CCGs in the future.

We will also be seeking to engage with the public on the NHS Long Term Plan, especially on how the priorities can be reflected locally. In addition, we will be working and engaging with young people in order to include a Young People section in our Communications and Engagement Strategy.

You can find out more about our Patient and Public involvement activities, including a Summary Annual Report, on our involvement pages at http://www.redditchandbromsgroveccg.nhs.uk/get-involved/.

Reducing health inequality

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

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

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

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

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

We have built on previous years Social Prescribing Pilots as part of the High Impact Actions for Primary Care. Social prescribing is a way of enabling primary care services to refer patients with social, emotional or practical needs to a range of local non-clinical services. This year, the majority of Worcestershire patients have been able to access a Social Prescriber through their GP Practice. We have worked with Public Health to evaluate this project and will develop this through the national Directed Enhanced Service in 2019/20 for all of Worcestershire patients.

The CCG has match funded the Hospital Discharge worker specifically for homeless people. This post is now employed by Worcester City Council on behalf of the District Councils in Worcestershire and works across the hospitals. She ensures homeless people are supporting in hospital and that appropriate plans for discharge are in place. Once they have been discharged she supports the patient to sustain their tenancy.

The CCG is working to implement the Long Term Plan's priorities locally and we have recently launched an engagement exercise with partners and Healthwatch Worcestershire and Herefordshire regarding eight priorities, including Health Inequalities.

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

Equality, inclusion and human rights

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

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

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

Legal Compliance

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

Workforce

Redditch and Bromsgrove CCG, Wyre Forest CCG, and South Worcestershire CCG are dynamic organisations with 210 staff, as of 31st July 2018. We have robust policies and procedures in place which help to ensure that all staff are treated fairly and with dignity and respect, and are committed to promoting equality of opportunity for all current and potential employees. We are aware of the legal equality duties as a public sector employer and service commissioner and have equality and diversity training in place for all staff. Governing Body and staff training sessions have taken place in 2018/19 and further training will be scheduled throughout 2019/20 so that all staff will have had face to face training in addition to online training for Equality, Inclusion and Human Rights.

Equality Impact and Risk Assessment (EIRA) Process

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

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

Our commissioners have carried out a range of equality analysis and human rights screening when carrying out their duties to ensure that we are paying 'due regard' to the three aims of the equality duty and the Human rights Act. Our Clinical Executive Committee is the governance mechanism where service redesigns and key decisions are taken around commissioning and decommissioning of services. We have put in place mechanisms where all policies and services consider the impact on age, disability, gender, race, religion or belief, sexual orientation, gender re-assignment and human rights principles before approval is given. The organisational online programme known as VERTO requires all commissioners

and authors of projects and proposals to undertake a stage 1 EIRA process and where required a stage 2 for a more in-depth analysis. Once EIRA stage 1 is complete, the Equality and Inclusion Business Partner quality reviews the equality analysis and provides support, advice and guidance as necessary.

We have been working closely with STP stakeholders in the development of a unified and consistent method of undertaking equality impact analysis and this will be rolled out in 2019/20.

Equality Strategy 2017-2021 and Equality Objectives

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

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

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

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

Non-compliance with requirements are escalated to the quality and contracts team for further action.

For **Equality Objective 3,** training has been delivered to relevant staff on the importance of completing the EIRA forms on all projects in the summer of 2018. All the projects and proposals on the CCGs' online VERTO system now direct commissioning staff to complete the EIRA paperwork before the project can be approved. More work needs to be undertaken to ensure that all committees are checking for EIRA completion - not only on projects and proposals but also on key organisational policies and decisions. Progress around creating a

single Equality Impact Assessment framework for use on joint STP footprint is ongoing with further discussions to be held with partners in 2019. It is envisaged that this will pave the way to a single framework which is fit for all.

Governing board training in 2017 on roles and responsibilities, in respect of the Public-Sector Equality Duty was delivered with a refresh session planned for 2019 which will include members from Herefordshire CCG. **(Equality Objective 4)**

Equality Delivery System 2

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

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

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

This year we have focused on Goal 1. Plans will be put in place to address Goals 2 in 2019/20 as part of the overall action plan. Goal 1 has been completed and the outcome is detailed in the Equality and Inclusion Annual report which will be published on our website in 2019. In subsequent years the aim will be to increase the number of projects and themes whilst looking to improve on previous year's assessment.

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 2019/20 contract.

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

Meeting Human Rights requirements

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

Workforce Race Equality Standard (WRES)

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

Accessible Information Standard (AIS)

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

Priorities for 2019/20 and beyond

In 2019/20 NHS England will introduce the Workforce Disability Equality Standard (WDES). This will apply to the CCGs as well as Providers and mirrors the current standard around race equality. We will be in a position to implement the WDES as guidance starts to filter through from NHS England on timescales for 2019.

The following list describes the areas which the CCG will prioritise and will form part of the work plan for 2019/20:

1. Development of Action Plan based on the organisational priorities and the Equality Strategy 2017-2021
2. Extension of the equality service offer to Herefordshire
3. Development of an Action Plan and objectives for Herefordshire including Board development training for all 4 CCGs.
4. Annual Review of Equality Objectives 2017-2021
5. Continued work on Workforce Race Standard and Implementation of Disability Workforce Equality Standard
6. Work in partnership with colleagues across the STP footprint on equality and inclusion projects.
7. One to one training for appropriate commissioning staff on the Equality Impact and Risk Assessment process.
8. Implementation of the newly formed Disability Workforce Equality Standard (DWES)
9. Staff training on Equality, Inclusion, Diversity and Human Rights
10. Better and on-going engagement with seldom heard communities should be a focus in 2019 and beyond for the three CCGs. This will help the CCGs to better understand the health needs and priorities for these communities.
11. Incorporate the revised Equality Delivery System 3 into the organisational action plan and devise action plan for the evaluation of appropriate goals and outcomes
12. Quality review of Provider annual report on equality
13. Continued work within the procurement process on equality evaluation

Our performance

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

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

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

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

NHS Constitutional Targets achievement is a priority to the CCG. During 2018/19 performance has not been at the level across a number of areas that the CCG expects or commissions.

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

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

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

Indicator		Target	Achieved
A&E waits	Patients should be admitted, transferred or discharged within four hours of their arrival in an A&E Department	95%	77.67%
	Trolley waits in A&E < 12 hours	0	535
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%	84.90%
	Number of 52 week waiters on an incomplete pathway	0	0
Cancer - 2-Week Waits	Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	93.44%
	Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	100.00%
Cancer Waits - 31-Days	Maximum one month (31 day) wait from diagnosis to first definite treatment for all cancers	96%	96.43%

Indicator		Target	Achieved
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	92.86%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%	100.00%
	Maximum 31 day wait for subsequent treatment where that treatment is a course of Radiotherapy	94%	100.00%
Cancer Waits - 62-Days	Maximum two months (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	72.88%
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	83.33%
	Maximum 62 day wait for first definitive treatment following a consultant decision to upgrade the priority of the patient (all cancers)	TBC	100.00%
Diagnostic Test Waiting Times	Patients waiting for a diagnostic test should have been waiting less than six weeks	99%	96.39%
Category A ambulance calls	Red performance – response average within 7 minutes	7 minutes	06:41
	Ambulance handover times - % < 30 minutes (Worcestershire Acute position)	85%	81.47%
Mixed Sex Accommodation Breaches	Minimise breaches	0	145
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%	100.00%
	IAPT - % of patients with depression and/or anxiety disorders who receive psychological therapies	16.8%	14.36%
	IAPT recovery - % of patients who have completed treatment who are moving to recovery	50%	54.55%
	% of people that wait six weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	75%	90.91%

Indicator		Target	Achieved
	% of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	95%	100.00%
	% of people that wait six weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	75%	90.91%
	% 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%	100.00%
	Estimated diagnosis rate for people with dementia for those patients aged 65+	67%	63.71%
Health Care infections	Incidence of healthcare associated infections - MRSA	0	4
	Incidence of healthcare associated infections – C Difficile	63	40

** Figure represents combined performance across Worcestershire*

Improving Performance

The achievement of constitutional standards and key performance measures has been recognised as a key priority for the CCG and the local health economy. Consequently, these areas were captured within the CCG's three Corporate Objectives for 2018/19; thereby ensuring that they are embedded as core areas of strategic focus.

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

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

This mode of reporting provides a whole system approach to the reporting and management of performance against quality, patient safety and constitutional standards, as the BAF clearly shows the interdependent relationship of how objectives produce quarterly milestones which in turn require a series of enablers to be delivered; and how delivery could be threatened by the strategic risks. It also promotes focused and coordinated analysis by having key information included within a single framework.

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

Improvement and Assessment Framework

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

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

Under the Well-led domain the quality of the CCG's leadership was rated as 3 (out of a possible 4).

The latest published annual rating for all CCGs is 'Good'. This relates to the 2017/18 Improvement and Assessment Framework.

We expect the 2018/19 ratings to be published in July 2019 on the My NHS website at: www.nhs.uk/service-search/Performance/Search.

Accountability Report

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24 May 2019

Corporate Governance Report

Members Report

Our GP membership

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

Bromsgrove

- Barnt Green Surgery, 82 Hewell Road, Barnt Green
- Catshill Village Surgery, 36 Woodrow Lane, Catshill, Bromsgrove
- Churchfields Surgery, BHI Parkside, Stourbridge Road, Bromsgrove, B61 0AZ
- Cornhill Surgery, 65 New Road, Rubery, B54 9JT
- Davenal House, 28 Birmingham Road, Bromsgrove, B61 0DD
- The Glebeland Surgery, The Glebe, Belbroughton, DY9 9TH
- New Road Surgery, 46 New Road, Bromsgrove, B60 2JS
- New Road Surgery, 104-106 New Road, Rubery, B45 9HY
- St Johns Surgery, BHI Parkside, Stourbridge Road, Bromsgrove, B61 0AZ

Redditch

- The Bridge Surgery, 8 Evesham Road, Redditch
- Crabbs Cross Medical Centre, 39 Kenilworth Close, Crabbs Cross, Redditch B97 5JX
- Crabbs Cross Surgery, 38 Kenilworth Close, Crabbs Cross, Redditch B97 5JX
- The Dow Surgery, William Street, Redditch B97 4AJ
- Elgar House, Church Road, Redditch, B97 4AB
- Hillview Medical Centre, 60 Bromsgrove Road, Redditch, B97 4RN
- Hollyoaks Medical Centre, 229 Station Road, Wythall, B47 6ET
- Hollywood Medical Practice, Beaudersert Road, Hollywood, B47 5DP
- Maple View Medical Practice, Tanhouse Lane, Church Hill, Redditch
- The Ridgeway Surgery, 6/8 Feckenham Road, Astwood Bank, Redditch, B96 6DS

- St Stephens Surgery, Adelaide Street, Redditch, B97 4AL
- Winyates Health Centre, Winyates, Redditch, B98 0NR

Our Governing Body

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

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

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

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

Committees

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

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

Appraisals

The performance of our Accountable Officer is appraised by the members of our Remuneration Committee, which includes Lay Members and the three CCG Clinical Chairs.

The performance of our Chair is appraised by NHS England.

Register of Interests

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

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

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

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

Our Governing Body is not aware of any relevant audit information that has been withheld from our external auditors, and members of our Governing Body take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

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

Personal data related incidents

No personal data related incidents were reported to the Information Commissioner's Office during 2018/19.

Emergency Planning

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

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

The CCG's Governing Body received a report on the results of the Core Standards assurance process in September 2018, which indicated that the CCG was 'Substantially Compliant'. The CCG also works with its key providers to support and monitor their compliance with the Core Standards.

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

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

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

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Simon Trickett to be the Accountable Officer of NHS Redditch and Bromsgrove CCG.

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis.

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

I also confirm that:

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

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24 May 2019

Governance Statement

Introduction and context

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

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

As at 1 April 2018, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

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

a) Agreement to change the group's constitution*

b) Approve the vision, values and overall strategic direction of the group

c) In exceptional circumstances if a member of the group continually behaves inconsistently to the terms of reference and despite attempting to resolve the situation utilising dispute resolution process, the approval to dismiss members of the group*

d) Approval of applications to be a member of the group*

e) Ratify the appointment of elected members of the CCG Governing Body

f) Approve the removal of elected members of the CCG Governing Body

g) Approve the appointment of the Chair of the CCG Practice Forum

* Subject to NHSE Approval Process

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

Governing Body

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. The role of the Governing Body, the types of decisions taken by the Governing Body or delegated to committees or Executive Officers are detailed in the scheme of delegation and reservation.

Roles and Responsibilities

The Governing Body voting membership in 2018/19 and attendance rates were as follows:

Name	Role	In office during 2018/19	Attendance
Dr Richard Davies	Chair and Clinical Lead	1 April 2018 – 31 March 2019	5/6
Dr Carl Ellson	Strategic Clinical Lead	1 April 2018 – 31 March 2019	5/6
Simon Trickett	Accountable Officer	1 April 2018 - 31 March 2019	6/6
Dr Jonathan Leach	Governing Body GP Member	1 April 2018 – 31 March 2019	6/6
Dr Moheb Shalaby	Governing Body GP Member	1 October 2018 – 31 March 2019	3/3
Mari Gay	Chief Operating Officer	1 April 2018 - 31 March 2019	5/6
Mark Dutton	Chief Finance Officer	1 April 2018 – 31 March 2019	6/6
Nicola Malyon (Nominated Deputy of CFO)	Deputy Chief Finance Officer	Attendance in lieu of CFO	-
Lisa Levy	Chief Nurse and Director of Quality	1 April 2018 - 31 March 2019	5/6
Rob Parker	Lay Member for Finance and Governing Body Vice Chair	1 April 2018 – 31 March 2019	6/6
Sarah Harvey Speck	Lay Member for Patient, Public Involvement and Quality	1 April 2018 - 31 March 2019	6/6
Trish Haines	Lay Member for Primary Care	1 April 2018 - 31 March 2019	5/6
Dr Martin Lee	Secondary Care Doctor	1 April 2018 – 31 March 2019	6/6
Fred Mumford	Lay Member for Audit and Governance	1 April 2018 – 31 March 2019	5/6

Re-elections & Appointments to the Governing Body

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

Commitment

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

Development

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

Evaluation & Effectiveness

Individual performance reviews for Governing Body members were completed in 2018/19 and the effectiveness of the Governing Body and committees is reviewed annually. NHS England reviews the performance of the CCG quarterly. This also included a review of the CCG's Improvement Assessment and Framework which examined whether the Governing Body operates effectively as a team. Redditch and Bromsgrove was rated as green across all domains. The CCG has maintained the nationally required Governing Body composition and membership through 2018/19.

Meetings of the Governing Body

The Governing Body met six times during 2018/19 and held all meetings at alternative locations in the Worcestershire area. The dates of the meetings were published at least three months in advance and papers were made available to members and the public through the CCG's website seven days prior to the meeting. Members of the public are invited to put questions to the Governing Body at least 24 hours prior to the meeting and the Governing Body welcome the opportunity to provide a response.

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

- Review and approval of strategic commissioning plans, including Sustainability and Transformation Partnership (STP) and Integrated Care Plans
- Monitoring of quality, performance and finance
- Review of progress against the financial recovery programme
- Review and approval of shared governance proposals
- 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, sub-committees reporting to the Governing Body are formally established. Following the formation of a shared management team across the three CCGs in Worcestershire, during August and September 2016 the CCGs established the following committees as committees in common:

- Audit Committee
- Remuneration Committee
- Primary Care Commissioning Committee

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

The remit and terms of reference of these committees were reviewed during the year to ensure robust governance and assurance. Each of these committees report into 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 2018/19 the key areas of work of the committees were:

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

The membership of the committee in 2018/19 was as follows:

Name	Role	Membership of the committee during 2018/19
Fred Mumford (Chair)	Lay Member for Audit and Governance	1 April 2018 – 31 March 2019
Carol Thompson	Co-opted Lay Member	1 April 2018 - 31 March 2019
David Wigley	Co-opted Lay Member	1 April 2018 - 31 March 2019
Rob Parker	Lay Member for Finance	1 April 2018 - 31 March 2019
Dr Martin Lee	Secondary Care Clinician	1 April 2018 - 31 March 2019

Remuneration Committee

This committee makes recommendations to the Governing Body on determinations about pay and remuneration including salary awards and pension as well as other terms and conditions of employment contracts. During 2018/19 the key areas of work of the committee were:

- Make decisions about the remuneration of GP, Lay and Secondary Care Clinicians and other Governing Body members;
- Approve the remuneration and conditions of service of the Accountable Officer and VSM staff;
- Review the performance of the Accountable Officer and other staff on VSM contracts and approve annual salary awards, if appropriate;
- Approve the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms excluding ill health and normal retirement for all employees;
- Consider the severance payments of the Accountable Officer and other staff on VSM contracts, and approve these seeking HM Treasury approval as appropriate in accordance with the guidance “Managing Public Money” (HM Treasury.gov.uk);
- Agreeing any significant changes to the number of sessions of Governing Body Members

The membership of the committee in 2018/19 was as follows:

Name	Role	Membership of the committee during 2018/19
Rob Parker (Chair)	Lay Member for Finance	1 April 2018 – 31 March 2019
Fred Mumford	Lay Member for Audit and Governance	1 April 2018 – 31 March 2019
Dr Martin Lee	Secondary Care Clinician	1 April 2018 – 31 March 2019
Dr Richard Davies	Governing Body Clinical Chair	1 April 2018 – 31 March 2019

Primary Care Commissioning Committee

NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. The function of the committee is to evaluate service proposals and make decisions regarding the commissioning and primary care services, ensuring all decisions are underpinned by robust clinical advice and within agreed governance arrangements. The committee focused on the following key areas of work during 2018/19:

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

The membership of the committee in 2018/19 was as follows:

Name	Role	Membership of the committee during 2018/19
Trish Haines (Chair)	Lay Member for Primary Care	1 April 2018 - 31 March 2019
Sarah Harvey- Speck (Vice Chair)	Lay Member for Patient, Public Involvement and Quality	1 April 2018 - 31 March 2019
Tricia Lowe	Supporting Independent Lay Member	1 April 2018 - 31 March 2019
Simon Trickett	Accountable Officer	1 April 2018 - 31 March 2019
Mari Gay	Chief Operating Officer and Lead Executive for Quality and Performance	1 April 2018 - 31 March 2019
Lynda Dando	Director of Primary Care	1 April 2018 - 31 March 2019
Mark Dutton	Chief Finance Officer	1 April 2018 - 31 March 2019

Joint Committees

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

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

QPR Joint Committee

The committee focused on the following key areas of work during 2018/19

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

The membership of the committee across all three CCGs in 2018/19 was as follows:

Name	Role	Membership of the committee during 2018/19
Martin Lee (Chair)	Secondary Care Doctor	1 April 2018 - 31 March 2019
Sarah Harvey Speck (Vice Chair)	Lay Member for Patient, Public Involvement and Quality	1 April 2018 - 31 March 2019
Rob Parker	Lay Member for Finance	1 April 2018 - 31 March 2019
Trish Haines	Lay Member for Primary Care	1 April 2018 - 31 March 2019
Tricia Lowe	Supporting Independent Lay Member	1 July 2018 - 31 March 2019
Dr Richard Davies	Redditch and Bromsgrove Clinical Chair	1 April 2018 - 31 March 2019
Dr Anthony Kelly	South Worcestershire Clinical Chair	1 April 2018 - 31 March 2019
Dr Clare Marley	Wyre Forest Clinical Chair	1 April 2018 - 1 March 2019
Dr George Henry	GP Quality Lead	1 April 2018 - 1 March 2019
Lisa Levy	Chief Nurse and Director of Quality	1 April 2018 - 1 March 2019
Mari Gay	Chief Operating Officer and Lead Executive for Quality and Performance	1 April 2018 - 1 March 2019
Simon Trickett	Accountable Officer	1 April 2018 - 1 March 2019

Mark Dutton	Chief Finance Officer	1 April 2018 - 1 March 2019
Dr Carl Ellson	Strategic Clinical Lead	1 April 2018 - 1 March 2019

Clinical Executive Joint Committee

The committee focused on the following key areas of work during 2018/19

- Lead and oversee the development of the CCG's commissioning strategy and annual commissioning intentions, ensuring local health needs and service issues are addressed within available resources;

- Lead and oversee the annual commissioning cycle, ensuring it is clinically led, supports improvements in health and health outcomes and enables a whole system wide transformation;

- Through receipt of highlight reports, consider and approve recommendations relating to the following:

    - STP Work Programmes, for areas which are not within the scope of the Herefordshire and Worcestershire Joint Committee

    - Integrated Care Systems, as taken forward through the Alliance Boards

- Receive and consider updates relating to any projects managed on the Verto system, for which Clinical Executive is the responsible committee

- Sign off Clinical Policies and Strategies;

- Receive and approve outline business cases for proposed developments and service changes, ensuring appropriate clinical, financial and quality input and challenge has been part of the process

- Receive reports/ recommendations from the Clinical Innovation Group (CIG)

- Receive quarterly reports from the Area Prescribing Committee on the use of drugs in Worcestershire and where necessary make decisions in relation to drug use and the utilisation of resources

- Oversee procurement activity and provide assurance to the Governing Bodies that this is being carried out effectively and appropriately; through receipt of a quarterly highlight report

- Review the CCGs Communications and Engagement Strategy prior to submission to Governing Bodies;

- Act as the lead committee for Organisational Development (OD) and Human Resources (HR) including:

    - Review the OD strategy prior to submission to Governing Body;
    - Receive and approve HR policies, reports and highlight reports at agreed intervals and monitor any staff related trends;

- Ensure that a meaningful appraisal process is in place and embedded within the organisation;
- Maintain close links with the Staff Council and receive their reports as required;
- Review organisational training and development needs.

- Act as the lead committee for the following services including approval of strategies, policies and reports:
  - Equality and Inclusion
  - Business Continuity and Emergency Planning
  - Health and Safety

- Receive and consider highlight reports relating to IT matters, making decisions as required

The membership of the committee across all three CCGs in 2018/19 was as follows:

Name	Role	Membership of the committee during 2018/19
Simon Trickett (Chair)	Accountable Officer	1 April 2018 - 31 March 2019
Mari Gay (Vice Chair)	Chief Operating Officer and Lead Executive for Quality and Performance	1 April 2018 – 31 March 2019
Sarah Harvey- Speck	Lay Member for Patient, Public Involvement and Quality	1 April 2018 – 31 March 2019
Fred Mumford	Lay Member for Audit and Governance	1 April 2018 – 31 March 2019
Dr Martin Lee	Secondary Care Clinician	1 April 2018 – 31 March 2019
Dr Carl Ellson	Strategic Clinical Lead	1 April 2018 – 31 March 2019
Dr Richard Davies	Redditch and Bromsgrove Clinical Chair	1 April 2018 – 31 March 2019
Dr Anthony Kelly	South Worcestershire Clinical Chair	1 April 2018 – 31 March 2019
Dr Clare Marley	Wyre Forest Clinical Chair	1 April 2018 – 1 March 2019
Mark Dutton	Chief Finance Officer	1 April 2018 – 31 March 2019
Ruth Lemiech	Director of Strategy	1 April 2018 – 31 March 2019
Lisa Levy	Chief Nurse and Director of Quality	1 April 2018 – 31 March 2019
Andrea Guest	Associate Director of Transformation and Delivery	1 April 2018 – 31 March 2019
Lucy Noon	Director of Partnership and Change	1 April 2018 – 31 March 2019

Financial Recovery Board

The committee focused on the following key areas of work during 2018/19

- Development and approval of a robust Financial Recovery Plan (FRP)

- Ensure that the actions contained within the FRP are delivered and report to the Governing Bodies on progress.

- Provide assurance to the Governing Bodies on the sufficiency of actions to secure delivery of in year financial targets and progress towards medium term financial sustainability.

- Make specific recommendations to the Governing Bodies of any additional actions that may

be necessary.

- Take decisions on actions necessary to support delivery of the FRP, within approved delegated limits.

The membership of the committee across all three CCGs in 2018/19 was as follows:

Name	Role	Membership of the committee during 2018/19
Robert Parker (Chair)	Lay Member for Finance	1 April 2018 - 31 March 2019
Fred Mumford (Vice Chair)	Lay Member for Audit and Governance	1 April 2018 - 31 March 2019
Sarah Harvey- Speck	Lay Member for Patient, Public Involvement and Quality	1 April 2018 - 31 March 2019
Trish Haines	Lay Member for Primary Care	1 April 2018 - 31 March 2019
Tim Tebbs	Financial Sustainability Director	1 April 2018 - 31 March 2019
Simon Trickett	Accountable Officer	1 April 2018 - 31 March 2019
Mark Dutton	Chief Finance Officer	1 April 2018 - 31 March 2019
Mari Gay	Chief Operating Officer and Lead Executive for Quality and Performance	1 April 2018 - 31 March 2019
Lisa Levy	Chief Nursing Officer and Director of Quality	1 April 2018 - 31 March 2019
Dr Carl Ellson	Strategic Clinical Lead	1 April 2018 - 31 March 2019
Lucy Noon	Director of Partnership and Change	1 April 2018 - 31 March 2019
Lynda Dando	Director of Primary Care	1 April 2018 - 31 March 2019
Ruth Lemiech	Director of Strategy	1 April 2018 - 31 March 2019
Dr Anthony Kelly	GP Chair SWCCG	1 April 2018 - 31 March 2019
Dr Clare Marley	GP Chair WFCCG	1 April 2018 - 1 March 2019
Dr Richard Davies	GP Chair RBCCG	1 April 2018 - 31 March 2019
Emily Godfrey	Head of PMO	1 April 2018 - 31 March 2019

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

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

The purpose of the joint committee is to:

- Provide a joined up strategic approach to the commissioning of heath and care services, enabling the CCGs to work effectively with providers to ultimately deliver improved quality of outcomes for patients

- Provide strategic leadership and decision making relating to the transition to future commissioning arrangements

- Provide strategic leadership in relation to the development of new integrated care systems arrangements and make recommendations accordingly to the CCG Governing Bodies

- Provide strategic decision making relating to the implementation of STP programmes and lead the development of commissioning strategies for joint clinical transformation programmes.

- Lead the joint commissioning of those services, identified in the joint clinical transformation programmes and provide a mechanism for joint decision making which will ensure quality and service outcomes are an integral part of the commissioned pathway

- Enable the Herefordshire and Worcestershire CCGs to manage financial risks more effectively

- Reduce unwarranted variation across the STP footprint in the range and quality of services available to people living across the footprint by improving outcomes in areas that are below average and driving up outcomes overall

The core membership of the committee across all three CCGs in 2018/19 was as follows:

Name	Role	Membership of the committee during 2018/19
Dr Anthony Kelly	Clinical Chair, South Worcestershire CCG	1 April 2018 - 31 March 2019
Dr Richard Davies	Clinical Chair, Redditch and Bromsgrove CCG	1 April 2018 - 31 March 2019
Dr Clare Marley	Clinical Chair, Wyre Forest CCG	1 April 2018 - 1 March 2019
Dr Ian Tait	Clinical Chair, Herefordshire CCG	1 April 2018 - 31 March 2019
Simon Trickett	Accountable Officer	1 April 2018 - 31 March 2019
Mark Dutton	Chief Finance Officer, Worcestershire CCGs	1 April 2018 - 31 March 2019
Jill Sinclair	Chief Finance Officer, Herefordshire CCG	1 April 2018 - 31 March 2019
Trish Haines	Lay Member for Primary Care, Worcestershire CCGs	1 April 2018 - 31 March 2019
Tamar Thompson	Lay Member for Primary Care, Herefordshire CCG	1 April 2018 - 31 March 2019
Sarah Harvey Speck	Lay Member for Patient, Public Involvement and Quality, Worcestershire CCGs	1 April 2018 - 31 March 2019
Dianne Jones	Lay Member for PPI, Herefordshire CCG	1 April 2018 - 31 March 2019

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

The purpose of the joint committee is to:

Progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents through

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

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

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

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

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

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

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

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

undertaken to ensure delivery of the strategy and the capacity to handle risk across the organisation and its member practices.

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

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

The risk management process observes the following principles:

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

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

- Horizon scanning

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

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

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

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

Risk Assessment

The key strategic risks to delivery of the strategic objectives for the CCG during 2018/19 were:

- Consistent failure to achieve the 4 hour Emergency Access Standard (EAS) due to sustained Emergency Department (ED) pressures and the AEDB workplan actions potentially not having the required impact, resulting in a lack of assurance of the impact of ED pressures upon patient safety and experience and continued poor performance

- Lack of assurance for commissioned services surrounding the impact of delays in Referral to Treatment Time (RTT) performance, as evidenced through attainment against the RTT incomplete standard, on patient safety and experience
- Potential that agreed cancer recovery actions are not successfully implemented and will fail to support improvements in the performance of pathways, which could impact upon rates for cancer survival
- Potential inability to achieve dementia diagnosis rates due to the CCG recovery delivery plan not producing the desired outcomes, resulting in a continued gap between dementia prevalence and diagnosis
- Lack of assurance regarding the adequacy of WAHT's governance structures and processes, which consequently impedes their ability to independently identify and take appropriate action to address quality concerns, which could impact on patient safety and experience
- Potential lack of system wide ownership & commitment to accountable care system development, adversely impacting upon buy-in of key partners and inhibiting progress
- Due to challenging commissioning environment and organisational pressures, there is potentially inadequate capacity and capability across the system to effect the level of transformational change required
- Schemes will not deliver as planned to meet trajectories and close the GP workforce gap due to potential non achievement of a number of key factors as detailed below:
    - GPs in training not converting to local posts and uptake of GP retention schemes being lower than planned
    - Inability to recruit sufficient GPs through local marketing and schemes such as Targeted Enhanced Recruitment Scheme (TERS) and international recruitment
    - Joint initiatives with acute and community trusts not being successfully mobilised
- Potential inability to achieve the national improving access trajectory in 18/19 for 100% coverage of the practice population and meeting national criteria; due to a number of factors including funding streams and non-delivery of the enablers highlighted above.
- Potential for deterioration of the financial position and underlying surplus due to the financial recovery workstreams not delivering the required profile of savings, with extremely limited scope for mitigations and financial headroom

- Potential for the implementation of the financial recovery programmes to adversely impact upon quality (safety, effectiveness and experience), due to service rationalisation, to a level that is unacceptable to the CCGs or the public

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

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

Other sources of assurance

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

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

Data Quality

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

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

Information Governance

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

The CCG has achieved a score of 100% on the IG toolkit and is therefore fully compliant with the toolkit requirements

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

There are processes in place for incident reporting and investigation of serious incidents.

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

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

There have been no level 2 incidents involving personal data reported to the Information Commissioner's Office (ICO) in 2018/19.

Business Critical Models

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

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

Third party assurances

During 2018/19, the CCG commissioned the following services from the Midlands and Lancashire Commissioning Support Unit (CSU):

- Business intelligence
- Procurement
- Information Technology
- Human Resources and Payroll
- Corporate Services (Equality and Inclusion, Information Governance and Freedom of Information).

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

Control Issues

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

- **Delivery of Control Totals and QIPP Target**

  - Cap and collar contractual arrangement agreed with WAHT, which limits risk and incentivises activity reduction
  - Identification of QIPP opportunities aligned to provider Cost Improvement Plans (CIPS) to reflect over-arching strategy of taking costs out as a Health Economy rather than as individual organisations
  - Full financial risk share agreed with NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG.
  - Dedicated, senior Financial Sustainability Director engaged across Worcestershire CCGs
  - Delivery of a Financial Recovery Plan (FRP) which sets out the actions to be taken to reduce the deficit during 18/19, and the further actions necessary to address the underlying deficit at the 18/19 exit point.
  - Financial Recovery Board (FRB) established and meeting monthly, which provides executive oversight of the process. Extra-ordinary FRB meetings scheduled in between FRB meetings – to seek further assurance on high risk areas, review exceptions and agree recovery actions

- **Delivery of 4 Hour EAS Standard**

- Continued implementation of the A&E Delivery Board Plan (AEDB) overseen through the A&E Delivery Board which meets monthly

- Winter plan developed and agreed, which escalates aspects of the AEDB plan and adds capacity in both acute and community beds and focusses on admission avoidance

- A weekly system Chief Operating Officer meeting is in place, with implementation of a “Winter Room” to provide significant oversight of improvements required at any point in the system. Emergency Care Intensive Support Team (ECIST) as the national leads for urgent care continues to support the trust.

- **Delivery of RTT Standard**

- The RTT recovery plan is reviewed monthly by Elective Care Executive, to ensure delivery

- Rigorous validation of all patients above 18 weeks at the weekly Patient Tracking List meeting

- CCGs close monitoring of all patients at 40 weeks plus

- Waiting List Initiatives being undertaken and reviewed

- Engagement with clinicians to prevent breaches and speciality meetings now focus on performance

- Recruitment processes in place for challenged specialties such as neurology, thoracics and gynaecology

- **Delivery of Dementia Diagnosis Rate**

- CCGs Fast Track Recovery Plan established with COO (Chief Operating Officer) as Executive Lead, subject to fortnightly monitoring by NHSE

- The recovery plan is focussing on using the PCE (Promoting Clinical Excellence) Contract to increase practice registers

- Increased sessions provided to Clinical Pathway Lead, in order to provide targeted support to practices
- Capacity and demand review undertaken by WHCT Memory Service, additional capacity will be required to increase efficiency and a business case will be considered through the CCGs Planning discussions
- A revised specification for the Post-diagnostic service is being procured, with the new service commencing 1st April 2019.

- **Delivery of Cancer 62 Day Standard**

- Monthly review meetings with CCG, WAHT, NHSE, NHSI and Cancer Alliance
- Cancer Recovery plan reviewed monthly at Elective and Cancer Care Executive, with weekly patient tracking list meetings attended by cancer Multidisciplinary Team (MDT) leads
- Recovery plans in place for Breast, Colorectal, Dermatology and Urology specialties
- Weekly cancer Patient Tracking List meetings with clinician involvement, timely referral to tertiary centres to avoid breaches
- Ongoing working with Primary Care on informed patient choice

- **Worcestershire Acute Hospitals NHS Trust (WAHT) Contract and Section 29a Warning Notice**

- Reassessment is due to take place in June 2019 across all areas rated as inadequate. Quality Risk Summits have taken place in order to discuss how collaborative working across the health economy could assist the trust in achieving the prerequisite improvements

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

Review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have

responsibility for the development and maintenance of the internal control framework. It is also informed by comments made by the external auditors in their annual audit letter and other reports.

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

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control includes committees reviewing their work plans and responsibilities against the annual work plan and allocated areas of responsibility. The Audit Committee receive assurance on committee effectiveness and the Board Assurance Framework.

Counter Fraud arrangements

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

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

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

This year in accordance with standard 1.4 of the NHS Counter Fraud Standards for Commissioners 2019/20, a comprehensive risk assessment has been completed in 2018/19 to identify fraud, bribery and corruption risks. The CFS considers risks identified from historical work, national cases and NHS CFA data, with assistance from the CCGs, risks have been recorded in line with the CCGs risk management policy and included on the appropriate risk register. The risk assessment was then used to create a risk based annual work plan and to direct proactive fraud resources towards relevant 'at risk' organisational areas and activities. Progress will be monitored and results fed back to audit committee.

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

Head of Internal Audit Opinion

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

Roles and responsibilities

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

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

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with

assurances that actions are or will be taken where appropriate to address issues arising

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

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

Limitations inherent to the internal auditor's work

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

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

The Opinion

The purpose of my annual HOIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its Annual Governance Statement.

My **overall opinion** is that:

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

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

1. An initial assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

2. An assessment of the current range of individual opinions arising from risk based audit assignments, contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses

3. Any reliance that is being placed upon third party assurances

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

The design and operation of the Assurance Framework and associated processes

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

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2018/19 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The system of internal control based on internal audit work undertaken

My Opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. An internal audit plan for 2018/19 was developed to provide you with independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this our internal audit plan was divided into two broad categories; work on the financial systems that underpin your financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that you had identified in your Assurance Framework. I am satisfied that we have completed sufficient work during the course of the year to provide my Head of Internal Audit Opinion. The assurance levels provided for all assurance reviews undertaken is summarised below:

** This report For external reporting purposes to NHSE, the corresponding NHSE assurance level to our "significant" assurance rating in this context is "full" assurance overall (the NHSE assurance grading's provided here are not comparable with the International Standard on Assurance Engagements (ISAE 3000) issued by the International Audit and Assurance Standards Board and as such the grading of 'Full Assurance' does not imply that there are no risks to the stated control objectives).

Area of Audit	**Level of Assurance Given**
Conflicts of Interest	Full
BAF	Full
QIPP Performance	Full
Commissioning and Contracting	Full
Financial Systems	Significant
Budget Setting and QIPP Planning	Significant
Financial Delivery including QIPP	Significant
Performance Management	Significant
PCC**	Significant
Continuing Healthcare	Moderate

Assurance statements were not provided against the following reviews, due to the scope and nature of work undertaken:

- DSP Toolkit* - Advisory review where it was noted the CCG still has some actions to complete

I have set out summary details of the review where we provided moderate assurance levels below:

- CHC: Our review has identified that issues raised in the 2017/18 review still need to be addressed. Further the review noted that PHB procedures and processes need to be strengthened.

Some work related to our 2018/19 internal audit plan has not yet been finalised and this has been drawn to the attention of the Audit Committee. I am satisfied that this has not affected my ability to provide a comprehensive Head of Internal Audit Opinion. Given that fieldwork is substantially complete or reports issued in draft, I am also satisfied that the results of remaining work would not affect my overall assessment of significant assurance, in relation to the organisation's overall system of internal control.

Following up of actions arising from our work

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

All recommendations and agreed actions are uploaded to a central web-based database as and when reports are finalised. Management are then required to update the status against agreed actions. This is a self-assessment and is supplemented by our independent follow-up reviews where this is deemed necessary (for example, following the issue of a limited or moderate assurance report). The status of agreed actions as at 22nd March 2019 is shown below:

Summary	1 Critical	2 High	3 Medium	4 Low	Total
Due by (22/03/19)	0	4	4	2	10
In progress but not completed	0	0	1	2	3
Outstanding (not yet started)	0	4	3	0	7

Reliance on third party assurances

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

It is my understanding that the NHS SBS service auditor report and full year assurance reports regarding Midlands & Lancashire CSU have not yet been made available to the CCG. As such, at this stage I have not been able to take any assurance from this work in forming my opinion. If this report highlights any significant control failures, then I will necessarily have to re-assess my own opinion.

Kristina Woodward

Assistant Director

CW Audit Services

Wayside House

Wilsons Lane

Coventry

CV6 6NY

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

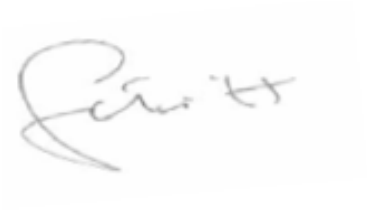
Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

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

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

Conclusion

No significant internal control issues have been identified.



Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24 May 2019

Remuneration Report

Remuneration Policy

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

The following Governing Body members are members of the committee:

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

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

The main responsibilities of the Remuneration Committee are to:

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

Senior manager remuneration

The tables on the following pages set out the remuneration and pension benefits for our senior managers in 2017/18 and 2018/19..

Salaries and allowances (2018/19) – subject to audit

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

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

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

Salaries and allowances (2017/18) – subject to audit

Name	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Total salary of shared staff (bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000
Judith Adams	5-10	-	-	-	-	5-10	-
Lynda Dando	25-30	-	-	-	5-7.5	30-35	85-90
Richard Davies	55-60	-	-	-	-	45-50	-
Mark Dutton	30-35	-	-	-	12.5-15	40-45	105-110
Carl Ellson	40-45	-	-	-		40-45	140-145
Jo Galloway	20-25	-	-	-	2-2.5	25-30	35-40
Mari Gay	30-35	-	-	-	2.5-5	35-40	110-115
Nigel Higgenbottam	5-10	-	-	-	-	5-10	-
Rupen Kulkarni	15-20	-	-	-	570-572.5	585-590	-
Jonathan Leach	85-90	-	-	-	20-22.5	110-115	-
Martin Lee	15-20	-	-	-	-	15-20	30-35
Ruth Lemiech	15-20	-	-	-	2.5-5	20-25	55-60
Lisa Levy	25-30	-	-	-	7.5-10	35-40	90-95
David Mehaffey	5-10	-	-	-	0-2.5	5-10	20-25
Bridget Nisbet	15-20	-	-	-	-	15-20	-
Lucy Noon	25-30	-	-	-	5-7.5	30-35	85-90
Simon Trickett	35-40	-	-	-	15-17.5	55-60	130-135

Pension benefits (2018/19) – subject to audit

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

* No lump sum applicable as Section 2008 Member

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

Pension benefits (2017/18) – subject to audit

Name	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Lynda Dando	0-2.5	2.5-5	20-25	70-75	565	501	59
Richard Davies	0-2.5	0-2.5	15-20	40-45	239	231	5
Mark Dutton	2.5-5	0-2.5	25-30	65-70	360	305	52
Jo Galloway	0-2.5	0-2.5	35-40	90-95	640	587	47
Mari Gay	0-2.5	2.5-5	45-50	140-145	898	812	77
Rupen Kulkarni	22.5-25	72.5-75	20-25	70-75	490	0	490
Jonathan Leach	0-2.5	*	10-15	*	216	183	31
Ruth Lemiech	0-2.5	0-2.5	15-20	35-40	231	211	11
Lisa Levy	0-2.5	5-7.5	30-35	95-100	603	530	68
David Mehaffey	0-2.5	*	0-15	*	160	132	28
Lucy Noon	0-2.5	2.5-5	30-35	90-95	585	523	57
Simon Trickett	2.5-5	*	45-50	*	477	406	67

* No lump sum applicable as Section 2008 Member

Cash equivalent transfer values – subject to audit

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

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

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

Real increase in CETV – subject to audit

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

Losses and special payments – subject to audit

There were no losses or special payment cases in 2018/19.

Pay multiples – subject to audit

	2018-19	**2017-18**
Banded remuneration range of the highest paid member	£140,000 - £145,000	£140,000 - £145,000
Mid-point of the banded annualised remuneration of the highest paid member	142,500	142,500
Median of the annualised remuneration of workforce	36,644	41,787
Pay multiple (ratio of highest paid member to median workforce)	3.89	3.41
Range of annualised staff remuneration excluding the highest paid member	£2,200- £144,304	£4,185 - £142,957

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

The banded remuneration of the highest paid director/member in Redditch and Bromsgrove CCG in the financial year 2018/19 was £140,000 - £145,000 (2017/18 £140,000 - £145,000).

This was 3.89 times (2017/18 3.41) the median remuneration of the workforce, which was £36,644 (2017/18 £41,787)

In 2018/19 (2017/18 no employee) one employee received remuneration in excess of the highest paid director/member. Remuneration ranged from £140,000 to £145,000 (2017/18 nil). NHS Redditch and Bromsgrove CCG has restructured some functions during the year, including the establishment of a shared management team and other staff functions with NHS South Worcestershire CCG and NHS Wyre Forest CCG, and an increase to the level of clinical input to the organisation. This has driven up the range of annualised staff remuneration.

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

Non-disclosure of information

No disclosures have been omitted under GDPR Article 21.

Staff Report

Staff numbers and costs – subject to audit

Staff composition

The total breakdown of people employed by NHS Redditch and Bromsgrove CCG (based on 31 March 2019) is as follows:

Staff Grouping	Female		Male		Total
	Headcount	%	Headcount	%	
Governing Body	4	30.8%	9	69.2%	**13**
Other Senior Management (Band 8C+)	8	61.5%	5	38.5%	**13**
All Other Employees	38	76.0%	12	24.0%	**50**
Total	**50**	**64.86%**	**26**	**35.14%**	**76**

The workforce analysis by Band (based on 31 March 2019) is as follows:

Pay Band	Headcount	Pay Band	Headcount
Apprentice	0	Band 8A	13
Band 3	2	Band 8B	7
Band 4	5	Band 8C	5
Band 5	5	Band 8D	1
Band 6	8	VSM	19
Band 7	10	Medical Payscale	1

The workforce analysis by Function (based on 31 March 2019) is as follows:

Staff category	Permanent Staff	Other Staff	Total Staff
Administration and Estates	63	2	63
Medical and Dental	7	-	8
Nursing, Midwifery and Health Visiting	4	-	4
Other	-	-	1
Scientific, Therapeutic and Technical	-	-	0
Total	**74**	**2**	**76**

Staff costs (2018/19)

Employee Benefits	Permanent employees			Other		
	Admin	Programme	Total	Admin	Programme	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	1,593	529	2,122	54	42	96
Social security costs	172	58	231	0	0	0
Employer contributions to the NHS Pension Scheme	206	77	282	0	0	0

Apprenticeship Levy	4	0	4		0	0
Gross employee benefits expenditure	1,975	664	2,639	54	42	96
Total - Net admin employee benefits expenditure including capitalised costs	1,975	664	2,639	54	42	96
Net employee benefits excluding capitalised costs	1,975	664	2,639	54	42	96

Staff costs (2017/18)

Employee Benefits	ADMIN			PROGRAMME			TOTAL		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	1240	206	1446	508	87	595	1748	293	2041
Social security costs	134	0	134	22	0	22	156	0	156
Employer contributions to the NHS Pension Scheme	152	0	152	28	0	28	180	0	180
Apprenticeship Levy	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	1526	206	1732	558	87	645	2084	293	2377
Total - Net admin employee benefits expenditure including capitalised costs	1526	206	1732	558	87	645	2084	293	2377
Net employee benefits excluding capitalised costs	1526	206	1732	558	87	645	2084	293	2377

Organisational Development

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

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

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

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

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

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

Staff Survey 2018

In September 2018 the CCG undertook a local staff survey in response to some concerns that had been raised both formally and informally in relation to areas where the environment and culture could be improved. This was carried out on the basis that receiving this sort of feedback is valuable and that it demonstrates the organisation to be one that listens to its workforce.

The CCG received 58 responses to the survey. The full set of responses were shared with the Executive Leadership Team where it was agreed that an action plan would be developed to address those issues that were felt to be within the CCGs' control.

At the CCG Away Day in October 2018 some of the key themes were presented to the CCG workforce, along with actions that were being considered to address those areas of concern. Following the Away Day a more detailed action plan was developed with the support of the CCG Staff Council Chair to specify more clearly what actions the CCGs intend to take. This work has continued throughout 2018/19 and continues to be monitored by the CCG Staff Council.

Sickness absence data

Sum of FTE days sick	Sum of FTE days available	Average annual sick days per FTE
617	18641.4	7.44

Our approach to the effective management of sickness absence includes:

- Developing the role of line and senior managers in their engagement with managing absence and the health and welfare of their staff
- Monitoring, measuring and understanding absence
- Managing sickness absence when it happens
- Tackling the underlying causes of absence
- Assessing any underlying causes of absence, especially where they might be improved through better organisation and job design
- Helping people to remain in work when they have health problems and facilitating their return to work following illness or injury (this can include making reasonable adjustments in line with our duty as an employer e.g. changes to duties, shifts or hours, changes to the place of work, allowing staged/phased return to work)
- Creating a working environment where people can be provided with the support and encouragement to take responsibility for improving their own health

- Supporting early intervention where applicable, such as occupational health services, counselling and confidential employee assistance support
- Applying HR / Health and Safety-related policies such as Health and Safety, Lone-working, Respect in the Workplace, Working Time and Stress Awareness policies

Staff policies

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

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

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

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

Trade Union Facility Time

Table 1: Relevant union officials

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

Table 2: Percentage of time spent on facility time

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

Table 3: Percentage of pay bill spent on facility time

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

Table 4: Paid trade union activities

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

Expenditure on consultancy

During 2018/19 we spent £3,000 on consultancy fees.

Off-payroll engagements (non-payroll expenditure)

Table 1: All off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	2
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

Table 2 - All new off-payroll engagements, or those that reached six months in duration. between 1 April 2018 and 31 March 2019, 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 2018 and 31 March 2019	1
Of which:	
Number assessed as caught by IR35	1
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	1
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3 - Off-payroll engagements of Governing Body members and/or senior officers with significant financial responsibility, between 1 April 2018 and 31 March 2019

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.	23

Exit packages – subject to audit

There were no exit packages agreed in 2018/19.

Parliamentary Accountability and Audit Report

NHS Redditch and Bromsgrove CCG is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes within the Financial Statements of this report.

An audit certificate and report is also included in this Annual Report at page 71.

Annual Accounts

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove CCG
24 May 2019

Contents

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(858)	(1,683)
Other operating income	2	(256)	(749)
Total operating income		**(1,114)**	**(2,432)**
Staff costs	4	2,735	2,377
Purchase of goods and services	5	235,105	231,744
Depreciation and impairment charges	5	39	28
Other Operating Expenditure	5	433	299
Total operating expenditure		**238,312**	**234,448**
Total Net Expenditure for the Financial Year		**237,198**	**232,016**
Comprehensive Expenditure for the year		**237,198**	**232,016**

The CCG made a surplus of £6k in year.

Statement of Financial Position as at 31 March 2019

	Note	31-Mar-19 £'000	31-Mar-18 £'000
Non-current assets:			
Property, plant and equipment	8	103	142
Total non-current assets		103	142
Current assets:			
Inventories	9	230	228
Trade and other receivables	10	8,359	7,984
Cash and cash equivalents	11	109	35
Total current assets		**8,698**	8,247
Total assets		**8,801**	8,389
Current liabilities			
Trade and other payables	12	(14,099)	(13,956)
Total current liabilities		**(14,099)**	(13,956)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(5,298)**	(5,567)
Assets less Liabilities		**(5,298)**	(5,567)
Financed by Taxpayers' Equity			
General fund		(5,298)	(5,567)
Total taxpayers' equity:		**(5,298)**	(5,567)

The notes on pages 97 to 112 form part of this statement.

The financial statements on pages 93 to 96 were approved by the Governing Body on 24 May 2019 and signed on its behalf by

Simon Trickett
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19		
Balance at 01 April 2018	(5,567)	**(5,567)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(5,567)**	**(5,567)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19		
Net operating expenditure for the financial year	(237,198)	**(237,198)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(242,765)**	**(242,765)**
Net funding	237,467	**237,467**
Balance at 31 March 2019	**(5,298)**	**(5,298)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18		
Balance at 01 April 2017	(5,359)	**(5,359)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(5,359)**	**(5,359)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18		
Net operating costs for the financial year	(232,016)	(232,016)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(237,375)**	**(237,375)**
Net funding	231,808	231,808
Balance at 31 March 2018	**(5,567)**	**(5,567)**

The notes on pages 97 to 112 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2019

	Note	**2018-19 £'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(237,198)	(232,016)
Depreciation and amortisation	5	39	28
(Increase)/decrease in inventories		(2)	(169)
(Increase)/decrease in trade & other receivables	10	(375)	1,275
Increase/(decrease) in trade & other payables	12	143	(865)
Net Cash Inflow (Outflow) from Operating Activities		**(237,393)**	(231,747)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	(54)
Net Cash Inflow (Outflow) from Investing Activities		**0**	(54)
Net Cash Inflow (Outflow) before Financing		**(237,393)**	(231,801)
Cash Flows from Financing Activities			
Parliamentary Funding Received		237,467	231,808
Net Cash Inflow (Outflow) from Financing Activities		**237,467**	231,808
Net Increase (Decrease) in Cash & Cash Equivalents	11	**74**	7
Cash & Cash Equivalents at the Beginning of the Financial Year		**35**	28
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**109**	35

The notes on pages 97 to 112 form part of this statement.

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 2018-19 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 the going concern basis.

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

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

The CCG is currently undertaking a consultation event with other Worcestershire & Herefordshire CCGs regarding a formal merger from 1st April 2020

1.2 Accounting Convention

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

1.3 Section 75 Agreements

The clinical commissioning group is party to a section 75 agreement under the National Health Service Act 2006 and as party to a 'jointly controlled operation', recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical Judgements in Applying Accounting Policies

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

As disclosed in note 15 to the financial statements, the clinical commissioning group's management have made a number of critical judgements in relation to section75 accounting policies. The substance of each programme has been assessed as to whether it meets the principles within IFRS11: 'Joint Arrangements'. Specific programmes have been assessed as either (1) Joint Commissioning arrangements under which each pool partner accounts for their share of expenditure and balances with the end provider; (2) 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; or (3) Sole Control arrangements under which the provisions of IFRS11 do not apply.

1.4.2 Key Sources of Estimation Uncertainty

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

- Partially completed spells (based on workings by NHS provider trusts). The estimates by providers have been updated based on work in progress in the hospitals as at 31 March 2019. These will be settled as part of the April and May actual activity paid once discharged from hospitals. (£900k 2018-19, £723k 2017-18).

-Maternity prepayments (based on workings by NHS provider trusts). The estimates have been updated based on the outstanding treatment at the year end (£1,221k 2018-19, £1,291k 2017-18).

- Prescribing position for March 2019 (based on April-January Itemised Prescribing Payment (IPP) forecast for February & March). This will be resolved during May when the final year-end position is reported (£3.75m 2018-19, £3.9m 2017-18)

- Continuing Healthcare (CHC) accruals - NHS South Worcestershire CCG derives the accruals for continuing healthcare services based on the CHC database and then passes on the relevant charges via a debtor/creditor relationship with NHS Redditch & Bromsgrove CCG. (£377k 2018-19, £483k 2017-18).

1.5 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption 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.

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

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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

1.5.1 **Revenue from NHSE Resource Allocations**

The CCG receives annual revenue resource allocations from NHS England to fund net operating expenditure. Revenue resource allocations are accounted for by crediting the General Fund when the funding is drawn down to meet payments as they fall due. Resource allocations are not accrued as receivable. In 2018/19 the CCG received £2.3m Commissioner Sustainabilty Funding (CSF) and this was accounted for in the same way as the annual revenue resource allocation.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

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

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

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Following a transfer from Worcestershire County Council on 1 December 2015, NHS Redditch and Bromsgrove CCG has one employee that is a member of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. Although the scheme assets and liabilities attributable to this employee could be identified and recognised in the clinical commissioning group's accounts, the CCG does not consider them to be material, nor the cost of identifying the attributable assets and liabilities to represent good use of NHS resources. The employer contributions made to the scheme by the CCG are included within operating expenditure.

1.7 **Other Expenses**

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

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.8 **Property, Plant & Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.8.2 **Valuation**

All property, plant and equipment are 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. All assets are measured subsequently at valuation.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

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. Fair values are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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.

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

1.8.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 **Leases**

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

1.9.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.10 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**

The clinical commissioning group has no provisions as at 31 March 2019

NHS England has a provision in its accounts relating to historical claims that were outstanding in respect of CCG patients as at the demise of the former Worcestershire Primary Care Trust

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

1.15 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group 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 reviewed based on 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.

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

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

1.16.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.17 **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 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

1.20 **Accounting Standards Adopted in 2018-19**

IFRS 9 (Financial Instruments) and IFRS 15 (Revenue for contract with customers) were adopted in 2018-19, however the impact of this is not material and so no transitional IFRS changes are shown in these accounts.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

● 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.

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

2 Other Operating Revenue

	2018-19 Total £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**16**	**-**
Non-patient care services to other bodies	**842**	**1,683**
Total Income from sale of goods and services	**858**	**1,683**
Other operating income		
Other non contract revenue	**256**	**749**
Total Other operating income	**256**	**749**
Total Operating Income	**1,114**	**2,432**

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

3 Disaggregation of Income

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

	Education, training and research £'000	Non-patient care services to other bodies £'000
Source of Revenue		
Non NHS	15	843
Total	**15**	**843**

	Education, training and research £'000	Non-patient care services to other bodies £'000
Timing of Revenue		
Point in time	15	843
Total	**15**	**843**

3.2 Transaction price to remaining contract performance obligations

The CCG has no contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits **Total** **2018-19**

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

4.1.1 Employee benefits Total **2017-18**

	Permanent Employees £'000	Other £'000	**Total £'000**
Employee Benefits			
Salaries and wages	1,748	293	**2,041**
Social security costs	156	-	**156**
Employer Contributions to NHS Pension scheme	180	-	**180**
Gross employee benefits expenditure	2,084	293	2,377
Total - Net admin employee benefits including capitalised costs	2,084	293	2,377
Net employee benefits excluding capitalised costs	2,084	293	2,377

In 2018-19 due to joint working relations between NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG the vast majority of staff costs were split across the three CCGs : 50% South Worcestershir 30% Redditch and Bromsgrove and 20% Wyre Forest. This has resulted in increased costs for Redditch & Bromsgrove.

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**50**	**2**	**52**	**42**	**5**	**47**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 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 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:

4.3.1 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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.

4.3.2 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

For 2018-19, employers' contributions of £282k was payable to the NHS Pensions Scheme (2017-18: £180k) was payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,216	1,392
Services from foundation trusts	33,171	30,726
Services from other NHS trusts	119,816	118,734
Purchase of healthcare from non-NHS bodies	30,172	28,329
Prescribing costs	25,616	27,069
GPMS/APMS and PCTMS	24,216	24,172
Supplies and services – clinical	(115)	70
Supplies and services – general	211	269
Consultancy services	3	9
Establishment	484	546
Premises	178	235
Audit fees	49	49
Other professional fees	40	33
Legal fees	45	53
Education, training and conferences	3	58
Total Purchase of goods and services	**235,105**	**231,744**
Depreciation and impairment charges		
Depreciation	39	28
Total Depreciation and impairment charges	**39**	**28**
Other Operating Expenditure		
Chair and Non Executive Members	205	239
Inventories consumed	228	59
Other expenditure	-	1
Total Other Operating Expenditure	**433**	**299**
Total operating expenditure	**235,577**	**232,071**

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

Regulation 2008, the CCG must disclose the principal terms of the limitation of the auditors liability. This is detailed as follows:

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

6 Better Payment Practice Code

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 **Number**	2017-18 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,554	58,584	3,676	55,968
Total Non-NHS Trade Invoices paid within target	3,463	56,969	3,530	54,810
Percentage of Non-NHS Trade invoices paid within target	**97.44%**	**97.24%**	**96.03%**	**97.93%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,114	162,611	2,198	160,513
Total NHS Trade Invoices Paid within target	2,033	158,682	2,142	157,497
Percentage of NHS Trade Invoices paid within target	**96.17%**	**97.58%**	**97.45%**	**98.12%**

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

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

7. Operating Leases

7.1 Payments recognised as an Expense	**Buildings £'000**	**Other £'000**	**2018-19 Total £'000**	2017-18 Buildings £'000	2017-18 Total £'000
Payments recognised as an expense					
Minimum lease payments	83	1	**84**	81	**81**
Total	**83**	**1**	**84**	**81**	**81**

The lease payments disclosed above relate to The Triangle, Barnsley Court and Barnsley Hall

7.2 Future minimum lease payments	**Buildings £'000**	**Other £'000**	**31-Mar-19 Total £'000**	**31-Mar-18 Buildings £'000**	**31-Mar-18 Total £'000**
Payable:					
No later than one year	86	1	**87**	74	**74**
Between one and five years	46	2	**48**	96	**96**
Total	**132**	**3**	**135**	**170**	**170**

The future minimum lease payments disclosed above relate mainly to Barnsley Hall, Barnsley Court and Acton House (new CHC base)

8 Property, plant and equipment

2018-19	Information technology £'000	Total £'000
Cost or valuation at 01 April 2018	195	195
Cost/Valuation at 31 March 2019	**195**	**195**
Depreciation 01 April 2018	53	53
Charged during the year	39	39
Depreciation at 31 March 2019	**92**	**92**
Net Book Value at 31 March 2019	**103**	**103**
Purchased	103	103
Total at 31 March 2019	**103**	**103**
Asset financing:		
Owned	103	103
Total at 31 March 2019	**103**	**103**

8.1 Economic lives	Minimum Life (years)	Maximum Life (Years)
Information technology	0	5

9 Inventories

	Consumables £'000	Total £'000
Balance at 01 April 2018	228	**228**
Additions	230	**230**
Inventories recognised as an expense in the period	(228)	**(228)**
Balance at 31 March 2019	**230**	**230**

10 Trade and other receivables	Current 31-Mar-19 £'000	Current 31-Mar-18 £'000
NHS receivables: Revenue	5,756	6,230
NHS prepayments	1,221	1,291
Non-NHS and Other Whole of Government Accounts (WGA) receivables: Revenue	657	313
Non-NHS and Other Whole of Government Accounts (WGA) prepayments	723	149
VAT	2	1
Total Trade & other receivables	**8,359**	**7,984**
Total current and non current	**8,359**	**7,984**

10.1 Receivables past their due date but not impaired

	31-Mar-19 Department of Health & Social Care (DHSC) Group Bodies	31-Mar-19 Non DHSC Group Bodies	31-Mar-18 DHSC Group Bodies	31-Mar-18 Non DHSC Group Bodies
	£'000	£'000	£'000	£'000
By up to three months	228	319	441	44
By three to six months	-	-	17	2
By more than six months	365	39	684	3
Total	**593**	**358**	**1,142**	**49**

£260k of the amount above has subsequently been recovered post the statement of financial position date

10.2 Impact of Application of IFRS 9 on financial assets at 1 April 2018

The CCG's opening financial assets comprise of short-term receivables and cash which are held at amortised cost. The introduction of IFRS 9 has not had any impact on the classification of these financial assets and they remain classified as held at amortised cost, rather than at fair value.

10.3 Movement in loss allowances due to application of IFRS 9

The CCG's opening loss allowance is held against short-term receivables and is held at amortised cost. The introduction of IFRS 9 has not had any impact on the classification of the loss allowance and it remains classified as

11 Cash and cash equivalents

	31-Mar-19 £'000	31-Mar-18 £'000
Balance at 01 April 2018	35	28
Net change in year	74	7
Balance at 31 March 2019	**109**	**35**
Made up of:		
Cash with the Government Banking Service	109	35
Cash and cash equivalents as in statement of financial position	**109**	**35**
Balance at 31 March 2019	**109**	**35**

12 Trade and other payables	**Current 31-Mar-19 £'000**	Current 31-Mar-18 £'000
NHS payables: Revenue	4,072	4,613
NHS accruals	900	723
Non-NHS and Other WGA payables: Revenue	1,425	2,018
Non-NHS and Other WGA accruals	7,334	6,165
Social security costs	41	41
Tax	37	35
Other payables and accruals	290	361
Total Trade & Other Payables	**14,099**	**13,956**
Total current and non-current	**14,099**	**13,956**

Other payables include £248k outstanding pension contributions at 31 March 2019 (£307k at 31 March 2018)

12.1 Impact of application of IFRS 9 on financial liabilities at 1 April 2018

The CCG's opening financial liabilities comprise of short-term payables which are held at amortised cost. The introduction of IFRS 9 has not had any impact on the classification of these financial liabilities and they remain classified as held at amortised cost, rather than at fair value.

13 Financial instruments

13.1 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.

13.1.1 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.

13.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England (NHSE). The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

13.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

13.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

13 Financial instruments cont'd

13.2 Financial assets

	Financial Assets measured at amortised cost	
	Total 31-Mar-19 £'000	Total 31-Mar-18 £'000
Trade and other receivables with NHSE bodies	**2,031**	3,586
Trade and other receivables with other DHSC group bodies	**3,433**	2,745
Trade and other receivables with external bodies	**949**	212
Cash and cash equivalents	**109**	35
Total at 31 March 2019	**6,522**	6,578

13.3 Financial liabilities

	Financial Assets measured at amortised cost	
	Total 31-Mar-19 £'000	Total 31-Mar-18 £'000
Trade and other payables with NHSE bodies	**2,526**	2,457
Trade and other payables with other DHSC group bodies	**2,446**	2,879
Trade and other payables with external bodies	**8,758**	8,182
Other financial liabilities	**290**	361
Total at 31 March 2019	**14,020**	13,879

14 Operating segments

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

15 Section 75 Agreements

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

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

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

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

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

Schemes	CCG retained sole control	Council acted as lead commissioner	Council retained sole control	Jointly controlled	Grand Total
	£'000	£'000	£'000	£'000	£'000
BCF	7,068	1,419		2,175	10,662
Children's Services (including Child & adolescent mental health services)		4,796			4,796
Funded Nursing Care	3,452				3,452
Integrated Community Equipment Service				295	295
Learning Disabilities	59	1,273			1,332
Mental Health	16,024	159	1,538		17,721
Other Community Services	31	68	42		141
Wheelchairs Service		535			535
Total Agreement	**26,634**	**8,250**	**1,580**	**2,470**	**38,934**

16 Events after the reporting period

There were no relevant events after the end of the reporting period

17 Related Party Transactions

The Department of Health is regarded as a related party. During the year Redditch and Bromsgrove CCG has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

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

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

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

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

GPs that are members of the governing body are no longer considered to have significant control within the GP Practice unless they are sole members of that Practice

None

Prior Year Comparator

NHS Redditch and Bromsgrove Clinical Commissioning Group - Annual Accounts 2017-18

The Department of Health is regarded as a related party. During the year Redditch and Bromsgrove CCG has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

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

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

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

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

GPs that are members of the governing body are no longer considered to have significant control within the GP Practice unless they are sole members of that Practice

Related Party		**Purpose of Transaction**
University of Worcester	Sarah Harvey-Speck	Conference

18 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:

	2018-19 Target £'000	**2018-19 Performance £'000**	**Duty Achieved? Yes/No**	**Explanation**	2017-18 Target £'000	2017-18 Performance £'000
Expenditure not to exceed income	238,318	238,312	Yes	The CCG underspent its in-year 2018-19 revenue resource limit by £0.006m	229,669	234,501
Capital resource use does not exceed the amount specified in Directions	not applicable	not applicable	not applicable	not applicable	54	54
Revenue resource use does not exceed the amount specified in Directions	237,204	237,198	Yes	The CCG underspent its in-year 2018-19 revenue resource limit by £0.006m	227,183	232,015
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable
Revenue administration resource use does not exceed the amount specified in Directions	3,756	3,342	Yes	The CCG underspent its 2018-19 administration revenue resource allocation by £0.414m	3,739	3,190