NHS
North East Lincolnshire
Clinical Commissioning Group

Annual Report & Accounts

2016/17

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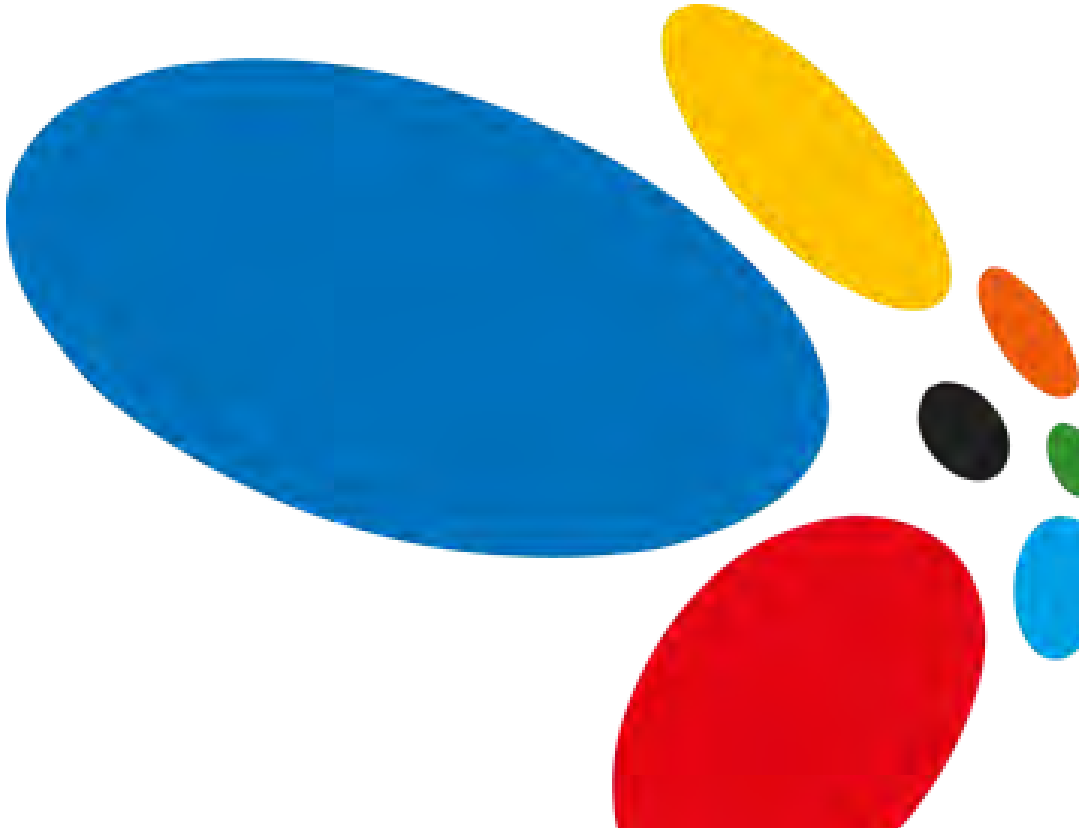

Performance Report 1.0

"This section describes how we carry out our role as a Clinical Commissioning Group (CCG) and what our responsibilities are. It also tells the story of the previous 12 months between 1 April 2016 and 31 March 2017, including our achievements and challenges, and sets out some of the risks that could hinder us achieving our plans for the coming year."

1.1 The Overview

Welcome

NHS organisations like the CCG have to publish an annual report and financial accounts at the end of each financial year.

The first section describes how we carry out our role as a CCG and what our responsibilities are. It also tells the story of the previous 12 months between 1 April 2016 and 31 March 2017, including our achievements and challenges, and sets out some of the risks that could hinder us achieving our plans for the coming year.

More detailed information about our performance, the way we make decisions and our structure and staffing is available in the body of the Annual Report. The Financial Statements for the year 2016-17 are presented at the end.

In the interests of sustainability we do not routinely produce large printed documents. However, a printed copy of the Annual Report and Accounts can be provided on request. The information contained in this report can also be made available in other languages and different formats such as audio, large print and Braille.

For further information or to request a copy of this report in your preferred format, please contact us at the address opposite.

If you would like to contact us

The CCG is always very keen to hear from people who use health or care services in North East Lincolnshire, as well as from their carers or families. Your experiences can effectively help us to improve and shape future services.

You can contact us in the following ways:

By post:

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Grimsby, DN31 2UJ

By phone:

Switchboard
0300 3000 400
Media line
03300 249301

By email: **nelccg.askus@nhs.net**

Visit our **website** for more information about the CCG

You can also follow @nelincsccg on **Twitter**

Welcome from the Chair and Clinical Chief Officer

Dr Peter Melton
Clinical Chief Officer

Mr Mark Webb
Chair

The NHS is rarely out of the headlines these days. Even if you only follow the news casually, you will be aware that nationally our health and care services have been facing unprecedented difficulties, especially during the past winter.

Here in North East Lincolnshire local services are under similar strain. However, the CCG and North East Lincolnshire Council continue to work hard in partnership to improve advice, support and care services to support local people to have a good quality of life, recover from periods of ill health as close to home as possible, make healthier choices and remain active, engaged and independent for as long as they can. We also want to encourage our local communities to do more for themselves and for each other.

You will be aware our local hospital trust is facing severe financial pressures and recently went into special financial measures. We will continue to support Northern Lincolnshire and Goole NHS Foundation Trust (Nlag) and NHS Improvement as they work to reduce the financial deficit while improving quality and experience for patients.

However, achieving financial balance will require a fundamental and significant change to the way we deliver services.

The Trust and other local health and care providers are already working with us to look at new ways of providing care to help people avoid unnecessary stays on a ward, be supported to recover at home or in community beds as soon as they are ready to leave hospital and avoid attending A&E when it's more appropriate for them to be treated elsewhere.

Our local hospital continues to face quality issues which were recognised in its recent Care Quality Commission (CQC) report. CCG GPs are playing an important role and working closely with their counterparts in the acute trust to ensure areas of concern are tackled as a priority from a clinical perspective.

To tackle some of the big issues facing health and adult social care, we are also working with different health, care and voluntary organisations from across a wider area than North East Lincolnshire to develop a set of proposals. We call this region Humber, Coast and Vale because of the geographical area it covers and working this way will let us share resources in areas where we are currently stretched, providing a better service to people who use health and care services.

Most of the things we do, however, will aim to deliver the best care we can locally, shaped around what the people living in our area really need. The proposals are set out in the Humber Coast and Vale Sustainability and Transformation Plan (STP) and these are reflected in our local plans outlined later in this report.

We are also working closely with the five other CCGs within our STP area to ensure that we can work together when solutions are needed on a bigger footprint.

Working together across this larger area will also help us to see where we can be more efficient and spend our limited financial resources to the best advantage because if we do nothing, our health and care system will be £420m in the red by 2020.

We can look back at our activities and achievements in 2016/17 with some pride. The CCG has made significant improvements in many areas and continues to lead the way in others.

For example, figures published last year on the My NHS data website showed North East Lincolnshire as the top performing area in our region for a package of key clinical priorities. All CCGs are assessed on how they match up to six priorities and how they compare against others nationally. North East Lincolnshire is among the top seven CCGs in the country overall, with services for people with Dementia and Diabetes being rated particularly highly.

North East Lincolnshire is also performing well in Mental Health with good recovery rates through access to psychological therapies and a pathway offering early intervention for people experiencing psychosis.

There was room for improvement in the 62 day from referral by a GP to treatment for cancer locally and cancer survival rates, however. Work is underway to improve cancer pathways as well as awareness and early diagnosis which can vastly improve outcomes for patients.

North East Lincolnshire also has more mothers smoking at the time of giving birth than many other areas of the country.

Other CCGs and councils across the country are now working towards adopting the way we already support people with Learning Disabilities in our local community.

Our work as part of the National Diabetes Prevention Programme is also leading the way in this area providing lifestyle courses for patients who have been found to be at risk of developing this serious disease.

Sometimes a stay in hospital is needed. However, many patients have better outcomes with the right treatment where they live.

In North East Lincolnshire we are beginning to see fewer people needing to go into hospital as emergencies by putting the right community support in place.

We also want to end the practice of patients being sent to hospital for unnecessary appointments and tests when their condition could be investigated and resolved at their own GP surgery. The CCG has encouraged local practices to share what works best, and patients across North East Lincolnshire are now experiencing fewer differences in the treatment and care they can expect from practice to practice.

Our Community Cardiology service is starting to help people get the support they need closer to home and will continue to see even more patients outside of a hospital setting in the next 12 months.

This is part of detailed plans to improve the situation we have unfortunately seen during the last year where people have been waiting too long for hospital appointments in some specialist areas.

The A&E department at Diana, Princess of Wales Hospital has also been extremely busy, especially during the winter months, and we have put plans in place with the hospital trust to improve waiting times during 2017/18.

Although service demand and costs continue to rise faster than the money the government provides us with to pay for them, we must continue to make sure our local population benefits from new services and treatments.

Health and adult social care must respond to the changing needs of the local population and our budget is based on a complex funding formula which looks at the overall health and wellbeing of people living in our area.

One of our major responsibilities is to balance our books. Each year, CCGs have to decide how to share the money they are allocated across the wide range of services that local people need. These include health services like life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions such as dementia, heart and breathing problems, diabetes and associated complications, which we see a lot of in this area.

Across North and North East Lincolnshire the total healthcare community is currently spending £2 million per month more than it has coming in.

Our CCG is unique in that it is also allocated money from the local authority to organise and pay for adult social care – this includes services such as homecare, residential homes and adult social work.

Adult Social Care in North East Lincolnshire is facing similar financial and capacity pressures to health. The CCG is well aware these are challenging times for home care providers, for example, as there are known issues with recruitment and retention of care staff but we are working closely with them to ensure they can continue to deliver quality and compassionate services within the funding available.

We have been working with partners, stakeholders and providers to develop an innovative new approach to delivering home care in North East Lincolnshire and the first phase went live at the end of March in the Humberston area.

We are working hard to ensure that services for the most vulnerable will continue to be available in the future and unlike some areas of the country, we do not have waiting lists for people needing home care and vulnerable people are not spending unnecessary extra nights in hospital waiting for home care arrangements to be put in place.

We decided in October 2016 to explore the benefits of enhanced Partnership working between the CCG and North East Lincolnshire Council (NELC). There has been significant activity to clarify the ambition and to progress work which would underpin implementation if a decision is taken to move to new arrangements. This has included scoping strategic direction, exploring new models, considering connectivity within the wider context of local, regional and national drivers (for example, North East Lincolnshire as a ‘place’, development of STPs and Accountable Care Partnerships), identifying opportunities to deliver benefits by working more closely together and examining what re-shaped leadership would best support any new arrangements.

As a CCG in 2016/17 we have delivered savings of £6.3 million for health and £1.9 million for adult social care. Continuing to deliver further efficiencies going forward will require all our skill and innovation as well as strong partnerships. However, we are pleased to be able to say we are forecasting the CCG will achieve financial balance over the next two years.

At the outset of the year, the CCG set out an ambitious range of actions for delivery during 2016/17 and we are pleased to say we have achieved 100% of these objectives. To read about how we have performed as an organisation in more detail, please click here to jump to the relevant section of the annual report.

We have been proud to witness the on-going commitment and enthusiasm and energy shown from CCG members, employees, partners and the public to achieving our vision and for delivering and maintaining a high quality service to the public during challenging times.

Our CCG continues to be led by local GPs and is very much driven by the community we serve. The decisions we make about services for this area are shaped and influenced by our Community Forum and taken in collaboration with our community, for example through our network of local people, known as Accord. We have found that our decisions and our plans are the richer for their contribution.

People should be at the very front of planning their own care. What you tell us is seen as an opportunity to review the services we plan and buy to make sure they are fit for purpose and meet the needs of the people who live and work in North East Lincolnshire.

On behalf of the entire CCG Board, we present our Annual Report and place on record our sincere thanks to our entire team – including managers, staff, community members and partners - for their continued enthusiastic support throughout 2016/17.

Our Year in Brief

April

Thames Ambulance Service Limited is announced as the new provider of non-emergency patient transport services across North East and North Lincolnshire. This followed a public engagement exercise and competitive procurement.

Local people were urged to only go to the emergency centre at Grimsby Hospital if absolutely necessary as junior doctors carried out industrial action across the country, including in our area.

Patients with COPD were asked to give their views on the support available to them in North East Lincolnshire.

"Social Care and Me" - a new booklet about adult social care - was made available to download.

May

Mental Health Awareness Week 2016 focused on how good relationships can support us to live healthier and happier lives with fewer emotional or mental health problems. These are the connections that we share with other people such as friends, family, work colleagues and our community. Investing in these relationships can be as important to our health and wellbeing as other lifestyle factors such as eating well, exercising more and stopping smoking. The CCG shared resources and ideas on its popular Twitter feed throughout the week.

June

Carers Week saw a range of activities across our area. This annual campaign highlights the challenges the 16,000 carers in North East Lincolnshire face and recognises the huge contribution they make to families and local communities. The local Carers' Support Service and staff from a range of organisations (including Alzheimer's Society, Age UK and Healthwatch NEL) were out and about in North East Lincolnshire, letting carers know what support they can access.

The CCG presented a report to North East Lincolnshire Council's Health Scrutiny Committee about its decision in 2015 to move to funding one cycle of IVF. The report discussed a number of lessons that had been learned in the way the 2015 decision had been made, including more timely communication with our stakeholders and improving the way we speak to people who will be directly affected by a decision.

July

North East Lincolnshire became part of the first wave of the eagerly-anticipated Healthier You: NHS diabetes prevention programme. Clinical commissioning groups and local authorities across Greater Lincolnshire have teamed up with ICS Health & Wellbeing to offer people at risk of Type 2 diabetes a place on a new health scheme. Healthier You' helps at risk patients - who will be referred to the initiative by their GPs if they have raised blood sugar - make healthier lifestyle choices and reduce their risk of developing the disease.

People need access to good, useful information and advice about health and social care. In July the CCG started a campaign to improve what is available here by asking local people what they thought of the advice and information that is available in North East Lincolnshire. What people told us will be used to develop a plan to make sure we give out the right information and advice as and when people need it, to help support their wellbeing.

Young people with experience of mental health services were asked to help shape a new inpatient service for North East Lincolnshire, North Lincolnshire, Hull and the East Riding of Yorkshire. The service will offer hospital care for young people

Our Year in Brief

aged 13-18 needing specialist mental health support, much closer to home, which we know is important to families in our community.

Two events were organised to give young people and their families the chance to work with NHS England and mental health charity Young Minds to make sure the new service looked and felt right for local needs.

Local people were given advice about what to do if their August Bank Holiday did not go to plan. There are often better options (that mean patients will be seen quicker) than going to A&E for minor injuries or illnesses and people were urged to call our Single Point of Access (01472 256256) for advice about urgent health or care needs.

August

People who care for a friend or relative or who get support from a friend or relative were invited to help shape the future of support for carers in North East Lincolnshire at a workshop in Grimsby.

An apartment building that has been specially adapted to help vulnerable adults develop their independence and have their own front door was officially opened. The refurbished scheme provides 12 self-contained apartments in Grimsby and is the result of partnership working between NHS North East Lincolnshire Clinical Commissioning Group, Homelife Supported Accommodation, a specialist developer of health and social care schemes, and Inclusion Housing, a social enterprise and registered housing provider.

We held our AGM and our membership Accord held its Annual Members Meeting to give local people the chance to find out about the past 12 months in health and social care in North East Lincolnshire.

September

Nominations were opened for the North East Lincolnshire annual Health and Social Care Awards.

Our Year in Brief

Thames Ambulance Service Limited launched its new non-emergency patient transport service in North East and North Lincolnshire. NHS funded Patient Transport Services (PTS) are there to help people get to their hospital appointments when they are too poorly or are physically unable to get there otherwise.

October

People with epilepsy in North East Lincolnshire were offered the opportunity to take part in a focus group where they could highlight their needs and the information and support that would help them.

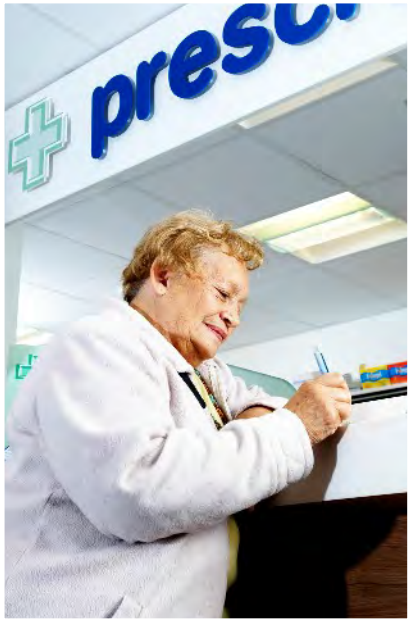
The CCG and North East Lincolnshire Council held a workshop to give people the chance to find out more about the support services on offer for children with autism and their families and carers.

The CCGs in North and North East Lincolnshire are working with different health, care and voluntary organisations from across a wider area to develop a set of proposals to tackle the big issues that cause problems for people living here. This will also let us share resources in areas where we are currently stretched, providing a better service to patients. This is known as the Humber Coast and Vale Sustainable Transformation Plan (STP). The plan was published in November.

November

A new Minor Ailments Scheme was launched in North East Lincolnshire to provide local people with easy access to advice and medicine, and encourage self- care for long term and minor conditions. The Minor Ailment Scheme can save time and enable people to avoid waiting to see a GP, and if a person's prescriptions are free of charge then the pharmacist can offer the same free advice and free treatment. The scheme is open to all patients registered with a GP in North East Lincolnshire and will signpost patients to their local pharmacy for treatment for a defined list of minor ailments or conditions.

December



Pregnant women were encouraged to have their flu vaccine to protect themselves and their baby from serious complications. This was part of the CCG's winter health campaign encouraging the public to take steps to *"**Stay Well this Winter**"*.

Our Year in Brief

January

Non-Emergency Patient Transport was in the news again with the CCG reminding people about the criteria. There are national criteria about who is eligible for NHS Patient Transport. These are medical criteria and not, for example, about how much people can afford to pay or whether they have access to their own transport. It was reported that in November, for example, 33 people out of a total of 1431 calls (2.3%) requesting transport did not meet the criteria.

The CCG talked about some of the results from a recent survey about how people would like to access routine primary care services. We had asked local people for their views about how best we can make Primary Care services more accessible as we move to a 7 day NHS. The report had not yet been published. However, it does support various Patient Survey findings that Sunday opening is the least preferred option. 70% of people who responded said they can see a health professional for routine appointments within existing opening times. 87% of people said they would be willing to see a suitably qualified professional rather than their GP such as physiotherapist or pharmacist. 70% said they were satisfied with the ways in which they can get advice from their practice at the moment, and there was significant interest in using technology such as phone consultations,

The commitment and hard work of organisations, teams and volunteers were recognised at the annual North East Lincolnshire Health and Social Care Awards held in February. The awards ceremony took place at the Humber Royal Hotel following a great response for the awards with well-deserved nominations for local teams and individuals who provide an exceptional level of care and who are proactively working to improve quality in the industry. From this the community representatives on the judging panel had the difficult job of shortlisting the finalists and selecting the winners of the 12 categories. It was a memorable event celebrating the very best of health and social care in North East Lincolnshire and an opportunity to highlight the achievements and dedication shown by these remarkable people in their roles working within health and social care locally. ***You can see pictures on the following page.***

February

A survey was launched giving people the chance to share their opinions about improvements being made to local urgent care services. North East Lincolnshire Clinical Commissioning Group (CCG) is looking at ways to improve how people access urgent care so that the right care is made available in the right place, at the right time. We sought the views of patients about improvements that have already been made and to inform future decisions about what services should be put in place to provide high quality urgent care in North East Lincolnshire.

March

The Trust that runs Grimsby Hospital appealed for patients who were referred to see a consultant at Scunthorpe, Grimsby or Goole hospitals before October 2016 but are yet to receive their first appointment to get in touch with them.

Following the launch of a new central referral team, Northern Lincolnshire and Goole NHS Foundation Trust was carrying out reviews and checks of its waiting lists and believed there may be some patients who had been referred before the new system was in place who had not been added to the waiting lists. The CCG was aware of the issue and local GPs had already been working with the hospital trust to ensure all patients they have referred to hospital appear on the appropriate list. However, we understood the need to ask the public directly in order to make sure all lists are fully up to date and include everyone who should be there.

The hospital trust announced it had been placed into financial special measures by NHS Improvement. Financial special measures were introduced by NHS England and NHS Improvement (NHSI) to help Trusts facing the biggest financial challenges (those facing significant and unsustainable deficits) to improve their financial performance rapidly.

2016 Health and Social Care Awards

For more images and details of these exciting awards please click here.

Who we are and what we do

Clinical Commissioning Groups were established in April 2013 and are made up of GPs alongside other people who work in health or care and members of the public who together decide what healthcare services there should be available in their local area. Our CCG is made up of 27 practices providing health services to families

We have been unique in England because we are not only responsible for most health care but also all adult social care services for our local population of more than 165,000 people. Like all other CCGs, we are not responsible for commissioning preventative or some very specialist health services.

CCGs are told by the Government how much money they will have to spend on health services each year. They then have to decide how to share this across the wide range of services that local people need. These are services like life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions. Long term health conditions include dementia, heart and breathing problems, diabetes and their complications, which we see a lot of in this area.

North East Lincolnshire CCG also receives funds from North East Lincolnshire Council to pay for care and support services for adults who are in need of practical support due to illness, disability or old age.

We work with our partners in the local council and public health, as well as with a panel of volunteers from our local community (known as the Community Forum) and the organisations that provide health care to appraise the health and social care needs of people in North East Lincolnshire and decide how to spend the money allocated. Planning and buying both health and adult social care services means we are able to use the total funds we receive to get the very best value for money for our local population. It also means we can make the way that services are delivered across health and social care much more joined up. This helps us to make sure people don't experience wasteful and frustrating duplication of services and minimises the risk of people falling through gaps in services.

The range of NHS services commissioned for our population is set out in the Health and Social Care Act 2012.

The responsibility for commissioning Adult Social Care to the local population is delegated to the CCG through a legal Partnership Agreement with North East Lincolnshire Council. The CCG Constitution sets out the membership of the CCG and describes the rules and the internal controls (governance) that put quality – for example, patient safety, effectiveness of care and the experience of people who use commissioned services - at the heart of everything.

In 2016/17, the CCG was allocated £232.724 million by NHS England. This money comes in two parts. The first is a 'running cost' allocation, for funding the management and operation of the organisation. The second 'programme' allocation funds commissioned services. The income to fund Adult Social Care is set by North East Lincolnshire Council as part of its annual resource and priorities process, and in 2016/17 the CCG received £39.844 million.

What we want to achieve & the risks that could affect us

Our latest Operational Plan sets out what we intend to do in the coming year to improve health outcomes and the quality of health and care services for people living in North East Lincolnshire. This is available on the CCG website

Our plan is based on what local people need and continues the work set out in the CCG's Five Year Strategic Plan. However, what we do in North East Lincolnshire also has to take into account national ideas to improve the way the NHS works that were published in a document called the Five Year Forward View.

Every local health system is expected to stick to **nine** 'must dos' for 2017-18 which have been set out nationally for the NHS. Working as part of our STP is our first ***To Do*** and the CCG is fully involved in turning STP priorities from plans into real projects that will help us both address some of the big issues facing our communities here in North East Lincolnshire, and close the financial gap.

We are working with different health, care and voluntary organisations from across a wider area than North East Lincolnshire to develop a set of proposals to tackle the big issues that cause problems for people living here. We call this region Humber, Coast and Vale because of the geographical area it covers. Working together across this larger area will also help us see where we can be more efficient and spend limited financial resources to the best advantage because if we do nothing, our health and care system will be £420m in the red by 2020.

The proposals are set out in the Humber Coast and Vale Sustainability and Transformation Plan (STP) and these are reflected in our local plans outlined in our operational plan.

The Humber Coast and Vale area covers six NHS CCGs and six local authority boundaries representing our communities here in North East and North Lincolnshire alongside Hull, East Riding, York and Scarborough and Ryedale. This will let us share resources in areas where we are currently stretched, providing a better service to patients. Support services such as finance can be shared to make things more efficient and save money. You can download the STP by visiting the Humber Coast and Vale website.

Most of the things we do, however, will aim to deliver the best care we can locally, shaped around what the people in our area really need.

Managing Risks

The CCG adopts an integrated approach to risk management which enables consideration of the potential impact of all types of risks on processes, activities, stakeholders and commissioned services. The CCG Risk Management Framework provides strategic direction and guidance on embedding the integrated risk management approach in all CCG business. Further analysis of the main risks, can be found in the 'risk assessment' section of the Annual Governance Statement.

Going Concern Basis

This Annual Report and Accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended) on the going concern basis

In addition:

Clinical Chief Officer: As Accountable Officer, the Clinical Chief Officer is accountable for achieving organisational objectives within an appropriate business framework.

***Chief Financial Officer*:** As the Senior Responsible Officer for NHS finances, the Chief Financial Officer is accountable for compliance with Standing Financial Instructions to achieve financial balance.

Performance Summary

NHS England introduced a new CCG Improvement and Assessment Framework in 2016/17. The framework is intended as a focal point for joint work and draws together the NHS Constitution, performance and finance metrics and transformational challenges and will play an important part in the delivery of the Five Year Forward View.

The Forward View and the planning guidance set out national ambitions for transformation in a number of vital clinical priorities such as mental health, dementia, learning disabilities, cancer, maternity and diabetes. NHS England publishes a rating for each of these six clinical areas for each CCG. The 2016/17 year end assessments will be available from July 2017 on My NHS.

How we compare nationally

North East Lincolnshire CCG's assurance rating against these six clinical priority areas when compared to how others are performing is as follows:

- In terms of Dementia and Diabetes, NELCCG are amongst the 'top performing' CCGs in the country.
- For Mental Health NELCCG is rated at 'performing well' which is similar to approximately a third of other CCGs in the country. (It should be noted more than half the CCGs are in the '*needs improvement'* rating). However, despite performing well the CCG is focusing on improving performance on rates of recovery for people accessing psychological therapies.
- NELCCG is rated as *'needs improvement'* for Learning Disabilities (in particular, on LD health checks performance), Cancer and Maternity. However when compared nationally the majority of other CCGs are rated the same in these areas too.
- The CCG's overall assessment against these six clinical domains has been evaluated to be within the best in the country with only three of 209 CCGs with a better assessment.

Measuring our performance helps us to ensure our services are being delivered to a high quality standard and providing value for money.

The CCG has internal processes in place to manage performance against a range of national and local indicators including a mechanism to work with internal and external colleagues to identify areas of risk and implement action plans to mitigate these.

This ensures improvements in performance are delivered. Throughout the year, reports are provided to our Partnership Board setting out our performance against the agreed local and national measures.

This 'Integrated Assurance and Quality Report' describes how, in partnership with our providers, we are meeting the CCG's commitment to ensure that the commissioning decisions and actions we take improve healthcare for the people of North East Lincolnshire and ensure patients receive the highest quality health and social care.

The bi-monthly reports can be found on our **website**

Spending Wisely

We have to make tough decisions sometimes… This is because across North & North East Lincs, our healthcare community currently has to spend £2 million each month more than it has coming in.

Every year we are told by the Government how much money we can spend on local health & care. This money has to be shared across the wide range of services people in North East Lincolnshire need.

One of the CCG's main duties is to "balance the books", while still making sure local people have services that are high quality, safe, affordable & delivered by skilled people who really care about what they do

To do this, we need to work smarter & save £££££££

No one wants to see waste & inefficiency. Health & care organisations have been working closely together to develop new & innovative ways of maintaining high quality care in what are challenging financial times.

"As a CCG we deliver both health services & Adult Social Care"

In 2016/17 we were able to save:

£6.3 million in Health

£1.9 million in Social Care

"We are pleased to be able to say we are forecasting the CCG will achieve financial balance over the next two years"

We plan health & social care for a lot of people - **about 165,000 people!**

Health services include life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions including dementia, heart and breathing problems, diabetes.

Adult Social Care is about support services for adults who need practical support because of illness, disability or old age.

Do you know how much healthcare costs?

Here's a few basic examples:

A&E attendance - **£107**
Outpatient first attendance - **£158**
Planned inpatient stay in hospital - **£668**
Unplanned stay in hospital - **£2,112**

1.2 Performance Analysis

1.2.1 Performance Measures

The performance of our providers (hospitals, ambulance and community services) in terms of achieving national and local targets have not been as good as we would have wished in 2016/17, a reflection, in part of the general pressures on the NHS.

In areas where we have faced challenges to meet performance targets we are aware of the underlying reasons and are taking action to address these.

For instance, the failure to meet targets for A&E four-hour waiting times was disappointing but not unexpected.

We know that current demand for emergency care outstrips capacity both regionally and nationally, and this is why we now have the Northern Lincolnshire A&E Delivery Board in place to ensure progress against the mandated elements of the A&E recovery plan.

We will continue to work with all our providers to help them to achieve not just national targets, but sustainable improvements in quality of care and performance.

Areas of particular scrutiny in 2016-17 for North East Lincolnshire CCG

A&E waiting times – The CCG's main emergency care provider Northern Lincolnshire and Goole Foundation Trust (NLaG) has struggled to achieve the national standard of 95% of patients waiting for no longer than four hours. The year to date performance for the overall trust was 88.76% at January 2017 and locally at Diana, Princess of Wales Hospital the performance was 84.07%. As highlighted above the current demand for emergency care outstrips capacity both regionally and nationally. A recovery trajectory is being set to bring performance back in line with the national standard.

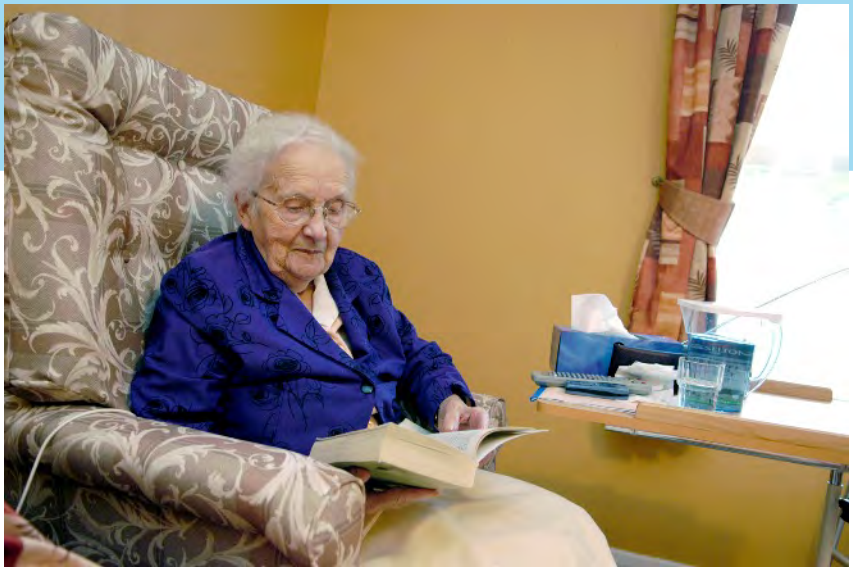
Cancer waiting times (62 days) – The year to date performance for this measure is 79.47% at January 2017 against the national standard of 85% of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer. Performance on this measure has been affected due to a significant increase in 2 week wait referrals. Northern Lincolnshire and Goole Foundation Trust (NLaG) now have in place a Cancer Delivery Plan which is being monitored by the Northern Lincolnshire Cancer Locality Board and we have also sourced additional capacity with another provider for MRI/ endoscopy/dermatology to improve performance. A recovery trajectory is being set to bring performance back in line with the national standard.

Elective waiting times (incomplete pathway) – The CCG is working with the Trust to ensure that delivery of this key national target is achieved. The NHS operating standard for elective waiting times (incomplete pathway) is that 92% of patients start their first definitive treatment within 18 weeks of referral. North East Lincolnshire CCG's year to date average performance across 2016/17 was 83.38% at January 2017. The current hospital pressures are impacting on the delivery of this target and the specialties where there is particular concern are Cardiology, Dermatology, ENT, Ophthalmology and General Surgery. The Trust has also had major issues with patient record validation and this coupled with the capacity issues means we have seen three patients waiting longer than 52 weeks for treatment. A recovery trajectory is being set to bring performance back in line with the national standard.

Diagnostic waiting time – The year to date performance for this measure is 2.65% at January 2017 against the national standard of 1% of patients waiting for no longer than six weeks. Performance on this measure has been affected due to a significant increase in 2 week wait referrals, this is a national issue and Cancer Alliances are working to address/increase capacity and Northern Lincolnshire & Goole Hospital (NLaG) are insourcing additional capacity for diagnostics and coronary angiography. A recovery trajectory is being set to bring performance back in line with the national standard.

Areas of particular success in 2016-17

- Estimated diagnosis rate for people with dementia – North East Lincolnshire CCG 71.59% at January 2017 against the national target of 66.7%.
- Our rate of non-elective spells (general and acute specialties) per 1000 patient's performance is in the **best** quartile when compared nationally and we currently have the 50th **lowest** rate of admission out of the 211 CCG's. In particular North East Lincolnshire has realised a 6% reduction in activity whilst there has been a 3% increase nationally.
- Our total number of delayed transfers of care (DToCs) per 100,000 population performance is in the **best** to median quartile when compared nationally and we are currently ranked 39th lowest out of the 151 Local Authorities. Nationally there has been a 26% rise in DToCs whilst North East Lincolnshire has only seen a 0.8% increase.



Our Cancer waiting times

- Two week wait for first outpatient appointment with suspected cancer - year to date performance 96.11% at January 2017 against the national target of 93%.
- Two week wait for first outpatient appointment with breast symptoms - year to date performance 96.99% at January 2017 against the national target of 93%.
- 31 day wait for patients receiving first definitive treatment - year to date performance 98.8% at January 2017 against the national target of 96%.
- 31 day wait for patients receiving subsequent treatment of surgery - year to date performance 97.3% at January 2017 against the national target of 94%.
- 31 day wait for patients receiving a subsequent/adjuvant anti-cancer drug regimen - year to date performance 99.67% at January 2017 against the national target of 98%.
- 31 day wait for patients receiving subsequent/adjuvant radiotherapy treatment - year to date performance 96.61% at January 2017 against the national target of 94%.
- 62 day wait for patients receiving first definitive treatment following referral from screening service - year to date performance 100% at January 2017 against the national target of 90%.

For the latest Performance information please visit our website

1.2.2 Our 2016/17 Objectives

The Corporate Business Plan is split into four objective themes;

1) Planned Care: Episodic
2) Planned Care: Long term Condition Management
3) Urgent & Emergency Care
4) Women & Children's Care

The Corporate Business Plan comprises of more than 40 projects and initiatives, each of which has milestones and key performance indicators used to measure progress and achievement. The areas of work described below are headline achievements for the organisation which reflect a cumulative achievement of these 40+ projects and initiatives.

To support the transformation of Out of Hospital care the following priorities for action in 2016/17 were identified:

Objective	Work Areas	
Planned Care: Episodic	Cancer management in primary care	Dermatology
	Support to care homes	Social prescribing
	7 day services	End of life care
	Diabetes prevention	
Planned Care: Long term Condition Management	Integrated community services – COPD	Enhanced dementia beds
	Supported living	Extra care housing
	Cardiology community service	
Urgent & Emergency Care	Out of hospital urgent care model	
	GP front ending	
Women & Children's Care	Autism diagnosis pathway	Perinatal mental health
	Children & Adolescent Mental Health Services (CAMHS)	
	Paediatric Surgery & Anaesthetics	Children's community nursing
Other essential areas of work continued	Quality framework for care homes	
	Work on prescribing practice	

1.2.3 Financial Information

North East Lincolnshire CCG is in its fourth year of operation and this report covers the year ending 31 March 2017. The financial performance in this year has built on the excellent performance of previous years, despite continued pressures on health and social care funding.

The CCG has a range of statutory and operational duties and all these have been met as shown in the table below:

Statutory Duties

- Revenue resource use does not exceed the amount specified in Directions (Reported Surplus = £6.74m)

  Achieved

- Revenue administration resource use does not exceed the amount specified in Directions

  Achieved

- Capital resource use does not exceed the amount specified in Directions

  Achieved

Operational duties

- Manage cash within the 1.25% of monthly drawdown

  Achieved

- Partnership Agreement (Planned to break even)

  Achieved

- Meet the “Better Payment Practice Code” (95%)

  Achieved, by value

Statutory Financial Duty

There are statutory (legal) financial duties for Clinical Commissioning Groups, as follows:

A) Revenue resource use does not exceed the amount specified in Directions (Reported Surplus = £6.740m)

This duty requires the CCG to achieve an in year surplus equivalent to no less than 1% of its health allocation. The CCG’s total health allocation for 2016/2017 was £232.724m, and had a planned surplus of £4.531m (2%). The £6.740m reported surplus includes the impact of the release of the £2.209m system risk reserve, which the CCG was mandated by NHS England to release as detailed below:

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs’ 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS North East Lincolnshire CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £2.2m. This additional surplus will be carried forward for drawdown in future years.

There were a number of significant pressures in year, despite this, as shown in the Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2017, this duty was met precisely.

B) Revenue administration resource use does not exceed the amount specified in Directions

This duty requires the CCG not to spend in excess of its Running Cost Allocation. This allocation for 2016/17 was **£3.638m** with the CCG spending **£3.137m** on running costs.

C) Capital resource use does not exceed the amount specified in Directions

The CCG received no capital resource in 2016/17.

Administrative Financial Duties

There are a number of administrative financial duties applied to all CCGs in the same way as all other NHS organisations. Although these are not statutory duties, they are critically important in determining the performance and financial health of the organisation. Therefore performance is rigorously monitored internally and externally.

A) Manage cash within 1.25% of monthly drawdown

The CCG is required to have a cash balance at the end of each month that is no greater than 1.25% of the cash drawn down in that month. This requirement was met every month.

B) Partnership Agreement (Planned to break even)

Under the Partnership Arrangements the CCG has with NELC with regard to Adult Social Care, the CCG achieved its planned break even position. There were a number of significant pressures in year, despite this, as shown in *note 34* Operating Segments & *note 35* Pooled Budgets this duty was met.

C) Better Payment Practice Code

The Better Payment Practice Code states that 95% of invoices should be paid within 30 days of receipt of goods or a valid invoice (whichever is later). Performance is measured in terms of both numbers of invoices and value of invoices. For 2016/2017 the CCG, on average, paid 94.99% of invoices by number and 98.70% of invoices by value in compliance with the code

Conclusion

North East Lincolnshire Clinical Commissioning Group has fulfilled all its statutory and administrative financial duties in its fourth year of existence. The consistent excellent performance is a credit to all the staff and members of the organisation.

This has given the organisation a strong basis from which to tackle the significant financial risks and pressures that continue to face us.

The CCG has a number of financial duties under the National Health Service Act 2006 (as amended).

Please refer to finance performance duties note 40 within the annual accounts.

1.2.4 Commissioning Activity & Service Redesign

The CCG, in its strategic role as the commissioner at the centre of the local health and social care economy, has two functions:

- To commission and procure a range of health and social care services on behalf of local people.
- To empower individuals to procure services directly which meet their particular need.

North East Lincolnshire is unique as it has responsibility for commissioning both health and adult social care services on behalf of its registered population. In other areas adult social care is commissioned by the council.

North East Lincolnshire Council has delegated its responsibility to the CCG through a formal partnership agreement so that these two areas of care can be brought together with the aim of improving the services that individuals receive on a day to day basis.

Through this arrangement the CCG has been able to align fee rates and quality requirements for people in long term care, irrespective of whether payment is from health or social care funds, bought services that people might need to access in a crisis together and has been able to come up with innovative solutions to help people better manage their health care needs.

Examples of the services and organisation that the CCG commissions include:

- The majority of hospital services that an individual will access. Its main provider of hospital services is Northern Lincolnshire and Goole Foundation Trust (NLaG), but it also commissions services from Hull & East Yorkshire Hospitals, Sheffield Teaching Hospitals Foundation Trust and others.
- Community health and social care services, such as community nursing, meals on wheels, and learning disability services, from Care Plus Group.
- Adult Mental health services from NAVIGO. Children's mental health services are commissioned on the CCGs behalf by North East Lincolnshire Council from Lincolnshire Partnership Trust.
- Residential and Nursing home care for those with eligible needs.
- Home based / domiciliary care, to help people with eligible needs with the tasks associated with daily living.

In addition to commissioning health and social care services the CCG also commissions a range of support services from external organisations. *Further information can be found in the Annual Governance Statement.*

The CCG does not currently have responsibility for the provision of General Practice, Pharmacy, Dentistry and Optician services or specialist services. These are commissioned for our registered population by NHS England.

During 2016/17, the CCG has been working to deliver a number of service developments (both new services and service improvements), some of the service developments started in 2016/17 will not be fully implemented until 2017/18.

A number of the service developments undertaken during 2016/17 have been to address issues that have arisen in the system, most notably, the length of time that people had to wait for treatment in some specialities following referral by a GP, and the length of time that people had to wait for treatment in A&E.

To help improve waiting times the CCG has:

- Commissioned additional activity from St Hughs for surgical procedures, in particular orthopaedics, and ophthalmology. We have also obtained additional capacity for ENT and endoscopy.
- Commissioned additional Ophthalmology capacity from a company called Newmedica which will be delivering its services from the Cromwell Road Primary Care Centre from April 2017.
- Re-commissioned its Dermatology service to secure additional capacity and ensure the service delivered improves waiting times and outcomes for our local population. Virgin Medical will be providing this service from Cromwell Road from April 2017.
- Developed a community Cardiology service to provide care closer to home within a community setting and reduce demand on secondary care service. Patients are usually seen within 2 weeks and are offered specialist assessment and provided with a care plan and discharged back to the GP.
- Developed a model for managing individuals with chronic obstructive pulmonary disease (COPD), within a primary care setting supported by a specialist consultant. This will increase the knowledge and skills within primary to avoid unnecessary use of secondary care services where appropriate.

Please refer to service redesign section for full details on service areas.

Service Redesign - Planned Care

Ophthalmology

We have commissioned extra capacity through Newmedica, to support the Trust with long wait times for both new and follow up appointments for ophthalmology.

The service has been available since April 10th and includes a wide range of ophthalmology services providing additional choice for patients who will be able to choose the service via their GP referral. This is a short term solution to increase capacity over the next year to ensure patients are seen within appropriate time frames. The future model of ophthalmology services is being developed in parallel, working with STP partners and stakeholders to ensure a safe sustainable service is provided in future.

Chronic obstructive pulmonary disease (COPD)

Changes have been made to how COPD reviews are delivered. Groups of practices are working together and a group of clinicians (nurses, community pharmacists and GPs) have trained up with the hospital consultant to meet a higher level of skills around COPD.

The enhanced staff is providing yearly reviews for all patients in the practice group using a specially designed template. The reviews always take place at the patient's GP practice and where the nurse is from a different GP practice, the patient is notified by a letter. The aim is that all patients receive a high quality review and are supported to self-manage their condition. The training is expected to be completed by the middle of the year. This model will be rolled out to include other long term conditions.

The CCG has been working with Northern Lincolnshire and Goole NHS foundation Trust to understand the demand and capacity constraints that they have in order to come up with solutions to the gaps identified going forward.

Community Cardiology Service

We have developed and implemented a Community Cardiology Service including heart failure nurse specialist and access to echo tests and Cardiology Consultant in the community. This service is a two year pilot and means a greater number of patients are seen within the community and in a timely manner.

Additionally, the specialist consultant is working with local GP practices to provide practice staff with the skills so they are better able to manage patients within that setting, avoiding referral to secondary care where appropriate. Advice and guidance is also offered to GPs by the consultant and technicians involved in the service.

The service has received very positive feedback from patients and GPs and we are currently working with stakeholders to develop the future cardiology model, post pilot.

Healthier You - National Diabetes Prevention Programme

Following a successful expression of interest in collaboration with 5 other CCGs in Lincolnshire and the respective Local Authorities, we were selected to be part of the first wave of CCGs for the Healthier You - National Diabetes Prevention Programme with NEL CCG leading the programme locally. At the end of the first year, Healthier You has been very successful, meeting the numbers of referrals into the programme which offers support and education to those at high risk of diabetes, helping individuals to make lifestyle changes to reduce their risk.

Two local case studies have identified very positive feedback and significant benefits to individuals attending the programme in reducing their likelihood of developing diabetes

Service Redesign - Unplanned Care

A&E Performance

- Through a whole system coordination approach, supported Diana, Princess of Wales (DPoW) A&E pressures by commissioning additional short term capacity in a variety of out of hospital services, e.g. GP Out of Hours, patient transport services for discharge and spot purchasing of step-down beds.
- Established the Northern Lincolnshire A&E Delivery Board in line with the NHS England mandated model of oversight and assurance for A&E performance.
- Through this Board and the emerging NEL ACP delivery models, developing plans to enhance and improve:
    - **Out of hospital services:**

      Single Point of Access
      Crisis Response
    - **Hospital "front door " and streaming:**

      GP in A&E services
      Ambulatory Care
    - **Patient flow and discharge:**

      Best practice in admitted patient review
      Integrated Discharge Team
      Discharge to Assess & Trusted Care Home assessor model
      Intermediate Care capacity

The overall CCG Urgent Care Programme is aligned to the national "must do's" set in the context of the NEL population, demographics and services and is structured to look at:

- Managing demand for A&E
- Freeing up hospital bed capacity

Managing demand for A&E considers every aspect of out of hospital services to ensure appropriate alternatives are available for urgent care needs. In North East Lincolnshire these services are;

- Extended access to GP Practices
- The Single Point of Access (SPA)
- Rapid Response services
- GP Out of Hours services
- Primary Care Streaming in A&E

There is an extensive programme of work to improve the responsiveness, effectiveness and efficiency of all of these aspects of Urgent Care. In clear recognition of financial constraints and rising demand there is an emphasis of how service providers can cooperate and work together more effectively – in the longer term within a single Accountable Care Partnership.

Service Redesign - Unplanned Care

A&E Performance Continued

For the Extended access to GP Practices and for Primary Care Streaming in A&E, NHS national guidance is a significant factor in the definition of what must be done, by when and the scope and conditions for some of the funding.

The CCG is actively involved in the national requirement to support A&E departments by providing a Primary Care stream (GPs and nurses) able to quickly see A&E attendees who do not need specialist hospital accident and emergency services. This is required to be in place by October 2017.

Freeing up bed capacity concerns the hospital processes for timely patient review and decision making, how other services work together with the hospital to assess patients for services required on hospital discharge and the timely availability of those services.

The CCG is working with all providers to implement best practice approaches to discharge planning and onward care to further reduce the level of delayed discharges. There are key elements of this that are required to be in place by October 2017.

Residential and Care Homes

In addition to the above the CCG has also been working with residential and nursing homes to:

- Develop the long term care service specification to ensure it reflects the requirements of the Care Act
- Revised the quality scheme for long term care to simplify its requirements and ensure that it builds on the requirements within the new long term care specification
- Ensure more coordinated support is received into the homes from health care professionals who routinely attend to provide services to individuals.
- The aim of the Support to Care Homes and those with Multiple Long Term Conditions project is to offer support for those with complex long term conditions living in the community, nursing or residential care, in which primary care, social care, mental health, allied health professionals, pharmacy and the third sector work together to provide a coordinated, proactive response to an individual's needs.

Commencing during 2016, an initial cohort of six homes was identified as the first wave. The work with these six homes provided much needed information about the further rollout. This involved meeting relevant staff supporting residents and developing a support planning matrix. A pharmacy technician was also deployed to these homes to begin the implementation of the pharmacy reviews.

For 2017/18 the rollout will continue, initially with a second wave of 15 care homes before taking up the remainder. Other elements of the programme will begin to come into effect. This includes improving IT implementation, pharmacy reviews and Lead GPs. The alignment of the wrap round support has included professionals from focus, Navigo, Yarborough Clee, Care Plus Group and NLAG Therapy team.

Mental Health

During 2016/17 the CCG has also been working closely with our mental health provider NAVIGO to improve services for people with mental health issues, we have:

- Remodelled our acute service to provide a service for people requiring rehabilitation in a secure environment which until now people have had to go out of area to access.
- Developed a supported living service as a step down from the rehabilitation unit which has enabled us to provide services for four people locally that had previously had to go out of area.
- Developed a plan to deliver the key requirements of the 5 Year Forward View for Mental Health.

1.2.5 Sustainable Development

NHS North East Lincolnshire Clinical Commissioning Group is committed to commissioning Health and Social Care services that meet the needs of the local population and are financially and environmentally sustainable.

Travel

To continue our plans to reduce our carbon footprint we have continued the utilisation of communications tools as an alternative to face to face meetings. These include, teleconferencing with videoconferencing facilities expected on the back of the NHS Mail 2 roll out during 2017-18.

The CCG has developed Agile working over a number of years and continues to support and further encourage its staff to consider different ways of working including remote access and working from home.

Most staff take advantage of this for at least one day per week saving 20% on their home to work travel and associated environmental costs.

Due to staff transferring into the CCG from the eMBED Health Consortium, the CCG travel miles presented below are not directly comparable with previous year's figures, though we can adjust for three staff that have roles across a shared CCG area, which will indicate an overall fall in business mileage.

Additionally, the development of the Sustainability Transformation Plan (STP) with meetings held across the Yorkshire and Humber patch has meant a small number of staff have seen an increase in business miles, but still use telephone conferencing wherever possible. The further development across the large geographical area means that the CCG with its partners locally will need to ensure the development of alternative meeting facilities in order to minimise the effect of the new commissioning area.

Total Business mileage for 2016/17 is 69,181 compared to 64,440 in 2015/16, adjusting for three new staff from the eMBED transfer reduces the value by 10,380 to 58,801 (an 8.75% reduction).

Facilities Management

NHS Property Services (NHSPS) manage the Athena building from which the CCG operates.

The CCG has an agreement with NHSPS and all utility bills go directly to them as our building management company. We have been working with NHSPS to obtain our baseline position for electricity, gas, waste and water. NHSPA will be reporting total national usage through its Estates Returns Information Collection (ERIC), however due to a change to the local building configuration with associated premises on the same site we do not have current information but we will be working with NHSPA to establish a baseline for developing targets to reduce our carbon footprint during 2017/18.

Procurement

As part of the procurement process, the CCG takes social and environmental factors into consideration alongside financial factors in making decisions on the purchase of goods and the commissioning of services. Purchasing decisions where practicable consider whole life cost and the associated risks. The sustainability/environmental procurement principle is to deliver sustainable social and environmental activities both within our organisation but also in the services we commission. The CCG also consider the implications of the Social Value Act 2012 and within the setting of Public Contract regulations works with providers to recruit and source services locally, sustaining investment into the local economy.

All procurements have a schedule where we require bidders to answers questions on environmental controls. We ask:

- Does your firm have an Environmental, “Green”, or Environmental Management Policy?
- Please indicate what systems your company operates (together with supporting details) to ensure proper control of processes and procedures that may have an impact on the environment.
- Has your firm been prosecuted, or been issued with an Improvement Notice or Enforcement Notice or Order, by any enforcement body responsible for protecting the environment (including a Planning Trust in respect of breach of Planning Control)?
- How does your firm monitor its Environmental performance?
- Please provide evidence of the progress you have achieved in following your Environmental Strategy.
- Is your organisation certified to ISO14001 or are you working towards this?
- Please supply details of any Environmental Management System and Registration Body you may be working towards.

The responses to these questions form part of the overall evaluation of bidders within the procurement process.

Sustainability

North East Lincolnshire CCG continually reviews its sustainability to generate ideas for reducing our carbon footprint and reducing waste.

This includes extension of the paperless office, in light of Paperless 2020 supported by NHS Digital, The CCG has been paper light for many years as an agile organisation, relying on electronic filing of documents and the printing strategy, but is always looking for the extra area where it can remove the need to print papers.

This year we have moved a number of internal meetings into using Microsoft OneNote for agenda setting and note recording, eliminating the need for paper agendas and speeding up the recording and information dissemination process via email.

The printing strategy is supported by the fact the only two printers in the building print exclusively double sided and in black and white.

Paper and card are recycled separately and general waste is placed in a separate bin. There are appropriate bins inside and outside the building. We recycle ink cartridges rather than disposing of them and we have continued to have confidential waste shredded and recycled.

Our Workforce

As well as promoting reduction in travel and paper use, the CCG is also actively promoting sustainability of the workforce through a Health and Wellbeing Strategy. The CCG began the healthy workplaces award process in 2015 with support from North East Lincolnshire Council’s Lifestyle Services Team and the CCG’s own senior management who backed the CCG in obtaining the award. The CCG obtained silver status at the end of 2016 by putting in place a variety of measures aimed at protecting and promoting the health and wellbeing of its staff, ranging from signposting to appropriate services, to applying for funding from central government to make provisions for staff to commute to work in healthier ways.

The health topics that the scheme promoted were:

- Physical Activity
- Stop Smoking
- Healthy Eating
- Mental & Emotional Wellbeing
- Physical Wellbeing

The staff intranet has been updated with pages on exercise, eating and smoking with guidance on healthy living for all staff at their convenience. The site also includes staff member’s blogs on their activities relating to healthy living.

- We have a lunchtime walking group for all staff.
- We have a cycle shelter and lockers at Athena to support staff who wish to cycle to work.

- We have five trained Mental Health first aiders who act as a first point of contact for staff members and there is also a quiet room if a private space is required.
- There has also been a stress workshop session run within the CCG timeout session.

Community Engagement

Shaping and commissioning services now and for the future is key to delivering sustainable services for our local population. To support our vision we refreshed and renewed our Public and Stakeholder Engagement Strategy in 2016 which sets out our approach to commission services that are fit for purpose and sustainable.

The CCG is a member of the Humber Coast and Vale Sustainable Transformation Plan (STP), which seeks to work collectively to deliver the sustainable services with the available resources to meet the health & care needs of the population in the best way. The STP aim is to design a healthcare system that by 2021 helps people to start well, live well and age well, that improves the quality of care and services, whilst ensuring that the system is financially sustainable for the long-term. This is reflected in the programmes contained in the North East Lincolnshire local delivery plan:

- Prevention, self-care and staying well
- Better use of digital solutions
- Development of Primary Care
- Accountable Care Partnership (Integrated Working at Place)
- Better use of public estates

Adapting to climate change

Climate change brings new challenges to the CCG with the impact on communities and to patient health. The area has experienced extremes of weather including significant flooding in recent years where low lying coastal communities can be severely affected. As an integrated Health and Social care organisation we can mobilise partners in health and adult social care to respond at times of emergency, ensuring vulnerable patients and service users are identified and supported. Close working with an integrated leadership model with the Local Authority means we have a combined response to emergencies to ensure services are maintained, this includes support such as access to 4 wheel drive vehicles to ensure patients and service users can be seen in all weathers.

Development of the JSNA (Joint Strategic Needs Assessment) with public health in the local authority means we can look at the impact of changes in the local community and assess the impact and vulnerability of sections of that community so that we can factor these into any risk assessments on the local impact of any natural disasters as a result of climate change.

1.2.6 Statutory Duties

14Z2 – Patient & Public Involvement

This year the CCG continued to deliver its strategic aims to strengthen public and stakeholder involvement in our work as set out in our Engagement Strategy to:

- Effectively engage and communicate with member practices
- Have a community that is well engaged, well informed and interested in local health, well-being and social care
- Effectively involve the public and stakeholders in commissioning decisions
- Ensure our partners and other key interested parties are kept engaged and informed
- Have supported and valued staff who are well informed and engaged
- Actively engage with local providers and secondary care clinicians

An accessible Easy Read version of the strategy was also developed and published on the CCG website in May 2016.

The Accord membership scheme is an integral part of North East Lincolnshire CCG's Engagement Strategy.

The purpose of Accord is to provide local people with opportunities to influence decisions about local health and social care services that are safe, high quality and affordable.

People with an interest in health and social care who are registered with a GP in North East Lincolnshire can join Accord. Our 'Suits You' menu enables members to tell us what topics they are interested in and how they want to be involved which can range from receiving and reviewing information at home, participating in on-line surveys, attending meetings and focus groups; up to formal appointment as a member of the Community Forum, part of the CCG's governance structure.

Ambassadors are members of Accord who wish to become more involved and their role is to promote the membership scheme and opportunities for members to have their say. This year we recruited our second cohort of Accord Ambassadors who took part in over 50 hours of in-house training to equip them for their role. Some of the participants training went on to become Ambassadors and have joined their peers as members of the Accord Steering Group.

The steering group provides a link between the wider membership base of Accord and the CCG to ensure that all members of the scheme have the opportunity to influence CCG decision making. The group aims to develop the strategic direction and priorities for Accord to deliver a vivid and attractive membership scheme for people in North East Lincolnshire; and increase the number of members actively participating in engagement opportunities.

Ambassador's achievements over the year included:

- Participation in community events to promote Accord such as the Older People's Day.
- Giving talks and presentations locally to community and support groups.
- Supporting CCG engagement activity as hosts at the Accord annual members meeting and Way Forward event;
- Advising the CCG on engagement plans such as reviewing surveys and information for Accord members

For more information about Accord visit our website.

We continued to develop our extensive stakeholder list of local community groups, voluntary groups and organisations, including those that represent groups with protected characteristics. This is maintained and utilised to identify those people who may be interested in being involved in particular projects.

Through the Accord and stakeholder databases our engagement can be targeted to relevant communities thus increasing the potential for more active engagement.

Over the course of the year Accord members and stakeholders have been given the opportunity to have their say on a number of plans these include:

- Development of an Information, Advice and Guidance Strategy and model for North East Lincolnshire
- 'Urgent Care and You'- new approaches to Urgent and Emergency Care
- Review and refresh of the Carers Strategy (will be available on the CCG's website summer 2017)
- 'Doing the Right Thing' engagement to inform Ethical and Pragmatic decision-making (Care Act)
- 'Good Practice – quality services from the moment you step through the door' patient experience of general practices survey
- 'Keeping the Door Open' engagement to inform development of 7-day access to primary care services

Accord members are kept up to date with the outcomes of any engagement work they have participated in though the Accord newsletter and publication of engagement feedback reports on the CCG website.

The CCG held two public and stakeholder engagement events over the course of the year.

1. The Accord Annual meeting in September and,
2. The "Way Forward" event in March.

The purpose of these events is to share information about the CCG's priorities, plans and progress and provide opportunities for service leads to engage with participants in smaller discussion groups to inform their commissioning plans. Again the outcomes from these events are sent to all participants and published on the CCG's website.

Statement from Patient & Public Involvement Board Lay Member

"NEL CCG is unique in having the Accord membership and the Community Forum playing an integral role in planning, development and delivery of its services.

Accord has developed in the last two years to become a part of the CCG operation that is managed by representatives from its number and supported by CCG staff. The Accord Steering Group has been instrumental in the recruitment of, and training of, other Ambassadors to communicate with and engage with the local community and in particular, other community groups.

The Community Forum has been operating for a number of years and is constituted of lay members who are either members of 'Triangles' or key committees of the CCG process, including the Council of Members.

The Triangles are made up of a clinician, service lead/manager and lay member. Triangles are key to the planning and development of services and the link for the lay member to the Forum and then Accord is crucial. It provides an opportunity for the public view to be captured in a relatively short period of time as surveys can be set up at short notice and engagement with relevant groups identified expeditiously, if necessary.

It is accepted that not all Triangles are equally effective, some due to changes in clinical lead and some due to other issues, however this is an issue the CCG is aware of and support is being provided to ensure all Triangles are able to function at the same effective and efficient level.

The Community Forum, as a selective grouping, has recently accepted the need to provide more of a challenge to the CCG in service planning and management. The forum will increasingly become a key CCG governance committee where the CCG will be accountable to members representing the public in general. It is recognised that the forum will play a more active part as pressures increase to ensure both quality and value for money in service provision.

Aside from the Accord membership and Community Forum, the CCG supports a Committee of PPG (Patient Participation Group) Chairs. Whilst not a decision making group, it provides a conduit for information to be fed back to PPGs at surgery level. In time, that group may provide yet another route for the CCG to engage with its local community.

As PPI Lay Member, I believe the CCG discharges its duty for public involvement effectively. Engaging with the public is a difficult task at the best of times. Unfortunately, public involvement is strongest when a service is being taken away or changed in what is perceived to be a negative fashion.

North East Lincolnshire CCG has involvement of over 3000 of the local population who have committed to be involved and engaged in determining the way health services should be delivered. The Accord membership continues to develop and is fronted by its own members who enthusiastically embrace the challenge of involving others. The Community Forum will increasingly provide an opportunity for service changes to be challenged at early stages by lay members.

As a CCG, North East Lincolnshire is better placed than many in public involvement and engagement."

- **14T - Duty to reduce inequalities**

Equality, fair treatment and social inclusion lie at the heart of the Government's plans to modernise the health service, as required under the Equality Act 2010.

North East Lincolnshire CCG is committed to the following principles:

- To recruit, develop and retain a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals;
- To be a fair employer achieving equality of opportunity of outcomes in the workplace;
- To use its influence and resources as an employer to make a difference to the life opportunities and health of its local community

As a commissioner of health and social care services, North East Lincolnshire CCG works with other health and social care providers and contractors to ensure that valuing diversity and promoting fair access to services are core elements of care and that full consideration is given to all equality issues when planning or redesigning services and when assessing the health needs of our local population. This has been our approach since our inception and continues to be embedded in our practice.

As an employer, the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to working arrangements or practices. Our agile working approach facilitates flexibility for all workers and is particularly appropriate for those workers where adjustments are required.

The Public Sector Equality Duty has three key requirements that public bodies must comply with, these are as follows:

1) Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act

Building on the comprehensive training undertaken by all members of staff in equality and diversity and the specialist training undertaken by our contracting team the CCG has taken some key actions this year to make progress towards eliminating inappropriate behaviour towards our staff and the service users for whom we commission services. These actions have included:

- Updating our workforce equality data to understand the latest position with regards to protected characteristics amongst staff
- Offering training on our updated bullying and harassment policy

2) Advance equality of opportunity between people who share a protected characteristic and people who do not share it

As part of tackling health inequalities, North East Lincolnshire CCG has built in mechanisms to its service design process which ensure that disadvantages linked to protected characteristics are highlighted and mitigation measures are put in place. An equality impact assessment is undertaken for each service and our Equality Impact Assessment Panel (including community members) reviews and revises those assessments as necessary, ensuring relevant mitigating actions are taken.

We have completed the review of our interpreting and translation arrangements and brought the administration of this service in house so that we can better understand the use of interpreting and translation in primary care. This is part of the work we have undertaken to roll out good practice in relation to our providers to implement the Accessible Information standards.

3) Foster good relations between people who share a protected characteristic and people who do not share it

North East Lincolnshire CCG works proactively with local protected groups to ensure that their interests and their viewpoints are included within thinking and strategy development for the CCG and that staff are kept updated with current issues and emerging trends to tackle health inequalities.

The CCG provides leadership to local commissioners and providers to work together to foster good relations between protected groups and the public at large. This collaborative working aims to maximise local impact for the equality agenda and ensure those groups who are most disenfranchised are cared for appropriately. This approach has been particularly fruitful this year in relation to implementing the Workforce Race Equality Standards and the Accessible Information standards.

North East Lincolnshire CCG's Partnership Board receives regular updates on progress related to the organisations, Equality and Diversity practice and provides active leadership on this agenda.

We continue to actively undertake partnership working with the local voluntary and community sector to ensure that we engage appropriately with all local groups with protected characteristics and we share our practice as widely as possible
In relation to health inequalities, the need to reduce the gaps experienced by vulnerable groups continues to be embedded in our service design and equality impact assessment process and we have paid particular attention to those people affected by deprivation in our borough as we know this is where the greatest inequality occurs.

The effectiveness of our systems in relation to reducing health inequalities is monitored and evidenced through a number of mechanisms:

- Our on-going review of actions identified for services in their equality impact assessments – we check back with services that risks have been mitigated and outcomes are being achieved.
- Our comprehensive Quality Framework process for Care Homes which requires evidence of how needs are being met for groups with protected characteristics and remedial action if required standards are not being met.
- Our service design process includes targeting geographical communities of interest where health inequalities are experienced and putting in place measures and outcomes to tackle those inequalities.

During the financial year 2017/18 we have plans in place to understand and publish the Gender Equality Pay gap for the CCG and to prepare for the implementation of the Workforce Disability Equality Standards.

- **14Z15(2)(a) - Duty to improve quality of services**

Quality, along with innovation and consistency continues to be one of the core principles of North East Lincolnshire CCG.

The CCG has continued to develop its systems and processes for managing the quality agenda during 2016/17. The day to day management of this rests with the Director of Quality and Nursing.

Key achievements in 2016/17 include the following:

- Appointment of the Lead Nurse for Quality in March 2016 and the Clinical Nurse for Quality - responsible for the clinical quality oversight and provision of leadership and effective clinical quality systems and processes, in the CCG and around commissioned services for health and social care. They provide professional expertise to nursing and quality business processes and they work closely with commissioners to deliver challenge in terms of the quality elements of the contract arrangements. They have specifically been working on the CCG Strategy for Infection Prevention and Control, which should be completed by the summer of 2017 and the improvement of risk management across primary care and with providers of concern.

- Work was commenced to produce a CCG Quality Strategy and Quality Framework. This work was not completed due to conflicting demands on the team however the preliminary work helped us to develop our approaches during 2016/17.

- One new approach was the development of our "Noise in the System" approach to triangulation of all available data, intelligence and experience of commissioners providing a more structured approach to raising concerns as early as possible.

- Another new approach was the development of quality profiles, which provides an overview of risks to quality and performance. These still have further work to do to develop them fully to include patient experience and to ensure we create the right system for, creating the profiles once and using the information many times.

- The preliminary work on the strategy document has not been lost and will re-commence during 2017 to provide further clarity to our approach to quality and direction going forward.

- The Quality Committee has revised its Terms of Reference and introduced new workshops to enable drill-down into specific areas of concern and focus. During 2016 one workshop focused on workforce issues and another on patient experience.

- A GP Quality Lead has worked as part of the Quality Team and has provided expertise into the management and oversight of Serious Incidents. This has particularly given us an operational and medical viewpoint to the scrutiny of SI's. The same GP has also been working within a multi-agency and disciplinary group reviewing case notes of patients who have died within 30 days of discharge from acute services which has given us a depth of insight to inform our joint action planning and key messages for primary and community care.

- We have escalated areas of concern with regards to a number of providers across primary, community and secondary care and care homes, and have worked positively with other commissioners, the CQC and professional bodies to address shortfalls in the quality of care, whilst maintaining our approach to strong leadership to providers through our challenge and support to them.

- We have strengthened our Clinical Leads Group and the GP Clinical Leads roles, to report on quality assurances and the role of clinical leads in helping to address gaps in clinical quality.

- We introduced a new way of reporting incidents into the CCG through an App developed for staff desktops, which has seen a 135% increase in incident reporting. Staff using the new App report that it is easier to use and navigate than the previous system and that they now receive feedback as part of closing the loop.

- In addition through the Primary Care Quality Incentive Scheme the Quality Team worked on improving practice in primary care in relation to patient experience, practice audit or survey, and incident reporting. This work is still on-going and due to be complete in April 2017, however we consider that this work has influenced the increase in incident reporting across primary care and the work was well received by primary care.

- Another piece of work was undertaken by the quality team to develop a Directed Education package for self-delivery within primary care to increase their awareness of incidents, reporting, incident management and oversight and learning and sharing lessons. This was delivered to all North East Lincolnshire GPs, Practice Nurses and Pharmacists and was highly commended by GPs with practices agreeing an action plan to continue to improve their approaches. 94% of the practices reported that they found the package very useful.

- The CCG has attained significant assurance regarding the management of Incidents and Serious Incidents and the systems and processes that the CCG have in place from an audit conducted by East Coast Audit Consortium.

- In addition to the monthly Serious Incident meetings the CCG have an established monthly incident meeting to scrutinise the data for themes and trends. This year we have included within our membership at the Incident and Serious Incident Meetings a GP representative and a Pharmacist, in addition to Nursing, Safeguarding and Patient Safety Representatives, we have found the extension of membership to be invaluable.

- To share lessons learnt from Incidents the CCG have developed a 'Risky Matters' quarterly bulletin to enable cross-organisational learning from incidents.

- The CCG is working closely with the council to share good practice and ways of working in respect to Serious Incidents and Incident Management.

- With the Acute Hospital Provider other stakeholders the CCG Quality Team attended and contributed to a workshop focused on Serious Incidents and the application of the Framework.

- The Quality Team have developed a Local 'Patient Safety Alert' process and document which enables a more proactive local response to sharing lessons and recommending action in response to an identified incident.

- The CCG Serious Incident Meeting has been encouraging and facilitating cross-organisational learning. Providers are encouraged to share their learning with relevant organisations by disseminating their one Page Lessons Learnt documents.

- The CCG quality team facilitated a workshop with Practice Nurses regarding Nurse Validation which was well attended and ensured that they had access to the national toolkit and local support.

- We have worked closer during 2016/17 with our acute provider and community and primary care services to address concerns and issues in respect of deaths within 30 days of hospital discharge. This has led to a number of learning streams which have created pieces of work which will continue to develop. Further work is required to develop a strategic approach during 2017/18.

- The CCG has been working on the development of a new Long Term Condition specification for the commissioning of Domiciliary Care and has ensured this includes quality influences from both health and social care perspectives.

- Work has continued in respect of the Quality Framework applied to Care Homes commissioned by the CCG on behalf of the Council. A Care Home project has shed light on a number of significant areas where we can improve quality of care, efficiency of services, joint working and efficiencies. This work will continue into 2017/18

- Developing the role of Designated Nurse for Adults & Children and strengthening the teams approach to working with all partners including Primary Care, across the locality to develop strong leadership and joined up approaches to the delivery of the Safeguarding Adult Board and Local Safeguarding Children Boards.

Objectives, in relation to quality for 2017/18 are as follows:

The key objectives for 2017/18, in relation to assuring quality within our internal processes and externally with our commissioned providers, are to:

- The Quality Team will re-commence the work around the Quality Strategy and Delivery Plan with the intention of completing that by December 2017. The Quality Strategy will outline areas where a strengthened CCG wide approach to service quality, in relation to clinical effectiveness, patient safety and patient experience will be embedded. This will have to take into account the emerging Accountable Care Partnership (ACP), the work across the Sustainable Transformation Partnership (STP) footprint and strengthened partnership working with North East Lincolnshire Council.

- The CCG aims to develop a joint Outcomes Framework with North East Lincolnshire Council and will need to ensure that its CCG Commissioning Intentions has clear links to this and the Quality Strategy is aligned.

- The CCG is currently working with some providers where quality of care is not strong and requires continued focus on risk and harm, clinical outcomes and patient experience. We aim to work with other commissioners to learn from any national experience of such circumstances and provide leadership and influence to drive up improvements in the quality of care. We will be undertaking work to specifically identify the quality affected by poor performance e.g. breaches to RTT targets.

- We aim to work across the Sustainable Transformation Partnership (STP) through the Quality Group or through other work streams to learn from and influence areas of care, services or provision where quality could be improved. We will do this by our involvement in Sustainable Transformation Partnership (STP) activity and ensuring a connection with quality arenas in North East Lincolnshire.

- We will be working with the commissioners of care homes and domiciliary care during 2017/18 to improve incident reporting and Serious Incident reporting systems and processes to ensure that all stakeholders are assured of the processes, reporting, incident management and learning and sharing lessons.

- We will be working with colleagues and mortality leads from across primary, community and secondary care to agree a joint strategy for unexpected mortality including in-hospital deaths and out of hospital deaths. This will build upon a piece of work undertaken during 2016/17 to develop a joint End of Life Strategy and joint work to review deaths with 30 days of hospital discharge.

- We will further develop the quality profiles as described above to become a central resource for CCG Commissioners and Quality and Performance team members and information that can be shared with stakeholders as and when required.

- We will be looking at three clinical outcome areas as part of the ***Right Care Wave 2 programme*** which should give us efficiencies in both cost and clinical pathways with improved outcomes for patients.

- The patient experience domain of our strategy has developed but in terms of quality monitoring, still requires more work with our providers to ensure we are fully aware of patient experience, and we will build our approach into the developing Quality Strategy.

- We need to further strengthen the approach by the CCG to quality monitoring of smaller providers to ensure that all commissioned services are able to demonstrate the delivery of quality services. Whilst we have made progress in some areas there is still more to do by working with commissioning leads, the Community Forum and providers.

- We are due to appoint to a new Quality Assurance Manager post during 2017 that will strengthen our capacity to focus on the impact of poor performance on quality of care.

- To continue to improve cross-organisational learning from Serious Incidents and Incidents across North East Lincolnshire.

- In response to the CQC (2016) report on Candour and Accountability to work with colleagues within our organisation and with our commissioned providers to meet the recommendations.

14Z15(2(b - CCG's must contribute to the delivery of the joint H&W Strategy

The Health and Wellbeing Board has been established to drive health and wellbeing improvement for the population of North East Lincolnshire. It is chaired by the council's nominated cabinet member, who is also a member of the CCG Partnership Board. Its membership includes representatives from North East Lincolnshire Council, North East Lincolnshire Clinical Commissioning Group, NHS England, provider representatives, Health watch, voluntary sector and community representatives.

The CCG works closely with the Director of Public Health within the council to ensure that the CCG is appropriately supporting delivery of the Health and Wellbeing Strategy, the Director of Public Health, Chair of the Health and Wellbeing Board, and the CCG meet monthly outside of the formal meeting oversee and assure progress and discuss any issues.

As part of completing this annual report the chair of the Health and Wellbeing Board was asked to comment on whether the CCG was activity engaged in supporting delivery of the health and wellbeing strategy and provided the following statement:

"The CCG is very committed to supporting the work required to deliver the priorities within the health and welling strategy, they have been active participants in the refresh of the Joint Strategic Needs Assessment (JSNA) and the development of the Council's Outcome Framework both of which inform the Strategy. The CCG has regular attendance at the Board and is an active participant at the meetings".

The Health & Wellbeing Strategy (the current strategy will be reviewed and refreshed during 2017/18) agreed by the Health and Wellbeing Board and endorsed by the CCG Partnership Board, sets out the local approach to health and wellbeing which is focusing more on prevention and early intervention, and creates a clear expectation that there will be an increasing role for individuals to play in making healthy lifestyle choices (for example to avoid smoking and obesity), managing their own health and wellbeing without dependency on statutory NHS or Adult Social Care services whenever possible and appropriate.

There is also an expectation that communities will play a much greater role in supporting the health and wellbeing of their community.

The Health and Wellbeing strategy details the key drivers/outcomes to be achieved and via the JSNA the key actions that will have the greatest impact in delivering against the outcomes.

Detailed below are a few examples of how the work of the CCG is contributing towards achievement of those outcomes:

*Key driver/outcome – "**Increasing healthy life expectancy and quality of life"***

*Key action – **improve screening and early detection of illness***

- The CCG funds a number of "collaboratives", which work with local communities to both encourage individuals to participate in the various screening programmes to support earlier detection of cancer, heart disease etc and educate individuals about what the symptoms are and what to do if they have them.
- The CCG has also supported the mental health provider to undertake health checks for people who would not routinely access this service through traditional routes.
- The CCG has been leading a piece of work with partners in relation to the bowel screening to ensure that it is able to deliver to the national requirements, this has been sighted by good practice by the regional quality assurance lead for bowel screening.
- The CCG clinical lead is working with our practices and the hospital clinicians to improve pathways to support early diagnosis & treatment of cancer.

*Key driver/outcome – **"helping people who need care services live well longer and maintain independence"***

*Key action – **increase the number of people able to live safely in their own home***

- The CCG supported the development and establishment of the Assisted Living Centre, a facility where individuals can go and see the range of aids and adaptations available to help them to continue to live at home, this service enables people to "try before you buy" opportunity for people prior to purchasing something that may not be appropriate.

- The CCG is leading the development of Extra Care Housing facilities within North East Lincolnshire to support individuals to maintain their independence and minimise use of statutory services, but where their existing home is not able to work for them and their needs. The first facility opened in summer 2015, and a further 250 extra care homes will be developed in the coming years.

- CCG joint work with the council to increase "community capacity", by supporting development of community groups to create more opportunities for individuals and groups to tackle key issues including social isolation, promotion of self-care and self-management and healthy lifestyle choices, thus reducing dependency on statutory services.

Further details about its work, membership, and the Health and Wellbeing Strategy that has been agreed by partner agencies for North East Lincolnshire, can be found on the council website

1.2.7 Access to Information (FOI)

During the period 1 April 2016 to 31 March 2017, the CCG processed the following requests for information under the Freedom of Information Act (FOI) 2000

Number of FOI requests processed	321
Percentage of requests responded to within 20 working days	100%
Average time taken to respond to an FOI request	15

The CCG did not provide the information requested in 46 cases because an exemption was applied either to part of, or to the whole request e.g. information was accessible by other means, the cost of providing the information exceeded the limits set by the FOIA, information was intended for future publication, disclosure would be likely prejudice to law enforcement or information related to the personal data of third parties.

The CCG did not provide information in 47 cases where the CCG did not hold the information and, where possible, the applicant was redirected to the correct organisation for the information.

Our publication scheme contains documents that are routinely published; this is available on our website

1.3 - Accountable Officer Declaration

I, as Accountable Officer, certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

Dr Peter Melton
Accountable Officer

Date

Accountability Report 2.0

"This section has been prepared by the Partnership Board and provides an overview of GP practices who are members of the CCG, the composition of the Governing Body and Partnership Board and other key points of interest."

2.1 Corporate Governance Report

2.1.1 Directors & Members Report

2.1.1.1 Disclosure Statement

The Directors and Members' Report has been prepared by the Partnership Board and provides an overview of GP practices who are members of the CCG, the composition of the Governing Body, Partnership Board and Council of Members, and a biography of members of the Governing Body and Partnership Board and other key points of interest.

Each individual who is a member of the Partnership Board at the time the Members' Report is approved, confirms so far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is 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 entity's auditors are aware of that information.

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.

The table below provides details of the Chair and Accountable Officer during 2016/17 up to the signing of the Annual Report & Accounts.

Name	Designation
Mr Mark Webb	Chair
Dr Peter Melton	Clinical Chief Officer

2.1.1.2 Our member practices

We are a clinically-led organisation, which brings together 27 local GP practices and other health professionals to plan and design services to meet the needs of local patients.

Our member practices are listed below and on the following page. (** denotes – both have signed mandate to vote on behalf of their practice – only one vote is counted)

Practice	Representative/s	From/To
Dr E Amin, (MediAccess) Weelsby View Health Centre, Ladysmith Rd, Grimsby	Dr Amin	April 2013 – present
Roxton at Weelsby, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr Arun Nayyar Dr Laura Bernal-Gilliver	December 2015- July 2016 July 2016 – present
Dr P Suresh – Babu, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr P Suresh–Babu	April 2013 – present
Beacon Medical, Primary Care Centre, St Hugh's Ave, Cleethorpes, DN35 8EB	Dr Laura Bernal-Gilliver Dr T Bruning	February 2014 – July 2016 July 2016 – present
Birkwood Medical Centre, Westward Ho, Grimsby, DN34 5DX	Dr Karin Severin	April 2013 – present
Dr B Biswas & Partner, 142-144 Grimsby Road, Cleethorpes, DN357DL	Dr P Ray	April 2013 – present
Dr Chalmers & Dr Meier, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr I Chalmers** Dr V Meier**	April 2013 – present April 2013 – present
Chantry Health Group, Cartergate, Grimsby, DN31 1QZ	Dr A M Bamgbala	April 2013 – present
Clee Medical Centre, 323 Grimsby Rd, Grimsby, DN357XE	Dr Kazim Sibtain	October 2014 – present
Core Care Family Practice (previously Dr R Kumar), Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH	Dr RKumar Dr Arun Nayyar	April 2013 – July 2016 July 2016 – present
Field House Medical Group, Freshney Green Primary Care Centre, Sorrel Rd, Grimsby, DN34 4GB	Dr D Hopper Dr A Fazil	April 2013 – July 2016 July 2016 - present
Healing Health Centre, Wisteria Drive, Healing, DN41 7PU	Dr Thomas Maliyil	February 2016 - present

Dr S Kumar and Partners, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr AP Kumar	April 2013 – present
Littlefield Surgery, Freshney Green Primary Care Centre, Sorrel Road, Grimsby, DN34 4GB	Dr Nathalie Dukes	April 2013 – present
Open Door, 13 Hainton Ave, Grimsby, DN32 9AS	Jane Miller	January 2016 - present
Raj Medical Centre, 307 Laceby Road, Grimsby, DN34 5LP	Dr Rakesh Pathak	April 2013 – present
Pelham Medical Group, Church View Health Centre, Cartergate, DN31 1QZ	Dr David Elder	April 2013 – present
Humberview Surgery, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr David Elder	April 2013 – present
The Roxton Practice, Pilgrim Primary Care Centre, Pelham Road, Immingham, DN40 1JW	Dr Arun Nayyar Dr Laura Bernal-Gilliver	April 2013 – July 2016 July 2016 - present
Dr A Sinha, Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH	Dr Anupam Sinha	August 2013 - present
Scartho Medical Centre, Springfield Road, Scartho, Grimsby, DN33 3JF	Dr Sudhakar Allamsetty** Dr Catherine Twomey **	February 2016 – present February 2016 – present
Dr Dijoux and Partners, Taylors Avenue Medical Centre, Taylors Avenue, Cleethorpes, DN35 0LJ	Dr Sylvere Dijoux	April 2013 - present
Dr Mathews, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr Renju Mathews	April 2013 - present
Woodford Medical Centre, Freshney Green Medical Centre, Sorrel Road, Grimsby, DN34 4GB	Dr Peter S John	February 2015 - present
Dr O Z Qureshi Surgery, Taylors Avenue Medical Centre, Taylors Avenue, Cleethorpes, DN35 0LJ	Dr Omar Qureshi	April 2013 - present
Quayside Open Access, 76B Cleethorpes Road, Grimsby, DN31 3EF	Nicola Glenn Jane Miller	May 2015 – July 2016 July 2016 – present
Greenland Surgery & New Waltham Surgery, New Waltham, Grimsby, N E Lincolnshire, DN36 4QG	Dr Jeeten Raghwani	November 2015 - present

The following practice mergers have taken place during 2016/17

Practice	Representative/s	From/To
Dr Hussain, Weelsby View Health Centre Ladysmith Road, Grimsby, DN32 9SW (merged with Birkwood Practice)	Dr Hussain	April 2013-November 2016
Dr Opie & Dr Spalding, Weelsby View Health Centre Ladysmith Rd, Grimsby, DN32 9EF (merged with Roxton at Weelsby)	Dr Hasmuck Jethwa Dr Arun Nayyar	April 2013-Dec 2013 Dec 2015 – July 2016

2.1.1.3 Governing Body and Partnership Board members profiles.

Our Governing Body is responsible for ensuring the CCG has appropriate arrangements in place to exercise its functions ***effectively***, ***efficiently*** *and* ***economically*** and in accordance with the CCG's ***principles of good governance***. It is made up of a membership that includes doctors and healthcare professionals, executive members and local authority and lay members.

Our Partnership Board is responsible for those matters delegated to it within the constitution; its principal functions are to, effectively *manage the discharge of the CCG's statutory duties for the commissioning of health and adult social care services, and effective discharge of the Section 75 Partnership Agreement with North East Lincolnshire Council. It is made up of a membership of Governing Body membership with two additional members nominated by North East Lincolnshire Council.*

Details on all committees and sub-committees can be found in the Annual Governance Statement Profiles of the members of the board during 2016/17 can be found on the following pages. ***Governing Body and Partnership Board meetings are held regularly and members of the public are encouraged to attend any of our meetings that are held in public. Papers are available on our website***

Mark Webb **

CCG Chair

(1 April 2013 – present)

Mark Webb spent a number of years in publishing and now owns a small local newspaper publishing company. He also runs a commercial property and business support company that is a social enterprise dedicated to assisting local business and entrepreneurs.

Having spent many years in the commercial sector, Mark also has considerable experience in public/ private sector partnership and working with local communities.

A former chair of the local strategic partnership and current chair of the Growth and Development Board, Mark brings this experience to the fore to provide challenge and support in equal measures to all sectors making up the CCG.

Above all Mark is passionate about the real involvement of the community in the design and delivery of meaningful health and care to the population of North East Lincolnshire. He joined the Governing Body of the CCG at its commencement.

Peter Melton **

Clinical Chief Officer
(1 April 2013 – present)

Dr Peter Melton was born and brought up in North East Lincolnshire. After studying medicine in London he returned to the area to complete his General Practice training.

He became a partner in the Roxton Practice in Immingham in 1993 and remains there now.

He joined the Governing Body of the CCG at its commencement.

Helen Kenyon **

Deputy Chief Executive

(April 2013 – present)

Helen Kenyon is a qualified accountant and has worked in the NHS for more than 25 years. She has worked in North East Lincolnshire since 1999. On behalf of the Partnership Agreement between the CCG and North East Lincolnshire Council she oversees the commissioning, contracting and performance management of both Healthcare and Adult Social Care services. She chairs the CCG's Delivery Assurance Committee, and Care Contracting Committee.

She joined the Governing Body of the CCG at its commencement.

Dr Thomas Maliyil **

Vice CCG Chair/

Chair of Council of Members

(Sept 16 – present)

Dr Thomas Maliyil MBBS, MD, MRCP, MRCGP is a Partner at Healing Health Centre and Chair of the Council of Members for NELCCG. His other role is as a Director of Core Care Links Limited and Core Care Solutions Limited, providers of NHS services.

He has trained locally and lived in the area for more than sixteen years and is committed to developing and maintaining high quality services for the population of North East Lincolnshire.

He joined the CCG in February 2014.

Laura Whitton **

Interim Chief Financial Officer

(January 2017 – present)

After qualifying as a Chartered Accountant in Sheffield, Laura spent several years gaining experience working on audits in a number of different sectors and has worked in the NHS for over 20 years.

Since joining the NHS she has held a number of Senior Finance roles at both Deputy Director and Assistant Director level, across a range of NHS organisations, including South Humber Health Authority, NEL Primary Care Trust, NEL Care Trust Plus and NEL CCG.

In addition to her professional qualifications, Laura has a Bachelor's degree in Chemistry.

She joined NELCCG Governing Body in January 2017

Derek Hopper **

Vice Chair of Council of Members

(Sept 2016 – present)

Dr Derek Hopper retired from general practice on 30th September 2016.

He has agreed to continue in his role as vice chair of the NELCCG Council of Members (CoM) for a further year and will continue to support the CCG in the development of general practice and primary care in general through membership of the Joint Committee for Primary Care Co-Commissioning, the GP Development Group and supporting the Chair of Council of Members and the CCG's primary care lead.

Philip Bond **

Lay Member Community Engagement

(April 2013 – present)

Philip worked for thirty years as a lawyer in the Courts Service before ill health caused retirement. Prior to becoming a Lay Member on the CCG Philip had been an elected Public Governor at an NHS Hospital Trust for seven years, serving as Lead Governor.

He has many years of public sector voluntary service particularly in education. He is currently Chair of Directors of Tollbar Family of Academies, a chain of Academy schools. He chairs Governing Bodies at four academies within the Trust.

He joined the Shadow CCG Governing Body in June 2011 and was appointed to the substantive post in April 2013, being re-appointed in 2016. Philip is an active member of the Governing Body with a responsibility to ensure public and patient views are at the heart of CCG decision making. Philip attends monthly Community Forum meetings and he is also a member of the CCG Quality Committee, providing lay challenge to professionals within that group.

He provides the link between the CCG and Accord (the community membership of the CCG). He chairs meetings of the Chairs of Patient Participation Groups, a group developing sharing of information and good practice across North East Lincolnshire.

Arun Nayyar **

GP Representative
(April 2013 – present)

Dr Arun Nayyar joined Core Care Family Practice and Beacon Medical Centre as a partner in October 2016.

He is also the CCG Clinical Lead for planned care and the GP representative on the Governing Body.

He joined the CCG at its Commencement.

Rakesh Pathak **

GP Representative
(April 2013 – present)

Dr Rakesh Pathak is a full time GP. He was raised in the Grimsby area and is married to another GP.

He has an interest in tackling health inequalities.

He joined the CCG at its commencement.

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Juliette Cosgrove**

Clinical Lay Member
(April 2013 – present)

Juliette Cosgrove is the Assistant Director for Quality at Calderdale and Huddersfield Foundation Trust where she leads on Quality Governance and Improvement.

She joined the CCG Governing Body in April 2013 initially as the nurse on the Governing Body but now is a clinical lay member. She is the Chair of the CCG's Quality Committee and feels that this is an important part of the CCG's governance structure. It has increased the frequency of its meetings to monthly and is dealing with significant areas of work for the CCG.

Joe Warner **

Chief Executive focus Independent Adult Social Care Work
(Sept 2013 – present)

Joe Warner qualified as a social worker in 1987 and is registered with the Health and Care Professional Council. Joe is Chief Executive of
Focus Independent Adult Social Work CIC and has worked in senior management positions in several local authorities, including joint NHS and Council posts and also a London CCG.

He was also managing director of a not for profit company supporting people with a learning disability. He joined the CCG Governing Body in September 2013.

Tim Render **

Lay Member Governance & Audit
(Aug 2016 – present)

Tim is the retired Finance Director of a major local authority. He has worked in local authorities for most of his career: early posts included social work trainee, town planner, and transport planner before he qualified in finance. He now spends his time on a portfolio of voluntary and non-executive roles in the public, private and not-for-profit sectors.

He is a trustee of several charities in Leicestershire, where he lives. He is a governor of a Further Education college , chairs the Midland Academies Trust (which oversees 4 schools), and is a director of Greenwood Dale Academy Trust (which oversees 31 schools), a midlands housing association, and a joint venture school building company. He chairs the Audit Committee of North East Lincolnshire Council.

He enjoys the company of his family (as a father of four and grandfather to five), and a wide variety of classical music (which he also plays on the piano and pipe organ, but not well.)

He joined the CCG Governing Body as a lay member and Chair of the Integrated Governance & Audit Committee in August 2016.

Stephen Pintus **

Director of Public Health

(Jan 2105 – present)

Stephen has been Director of Health & Wellbeing for a little over two years. Prior to joining the local authority, Stephen had been working in Derbyshire, jointly with local government and the NHS, leading a reconfiguration of lifestyle services producing a profile of the health needs of the population and leading a process of renewing the Health and Wellbeing Strategy.

Having worked at a senior level in public health for over 20 years, Stephen has built up a body of experience of work in a variety of settings; these have included regeneration work with communities, work with the voluntary sector, project management in health inequalities, running partnerships, as well as work in both local government and the NHS commissioning health and wellbeing services.

Dr David James **

Secondary Care Doctor

(Nov 2015 – present)

Having trained and worked as a junior doctor in several London hospitals. Dr David James was appointed in 1984 as Consultant Rheumatologist to the (now) Northern Lincolnshire & Goole NHS Foundation Trust, a post held until retirement 30 years later.

As the first Rheumatologist to be appointed locally, he had the opportunity to develop and expand the work of the Rheumatology department, to undertake clinical research and to train junior doctors, several of whom have gone on to become Consultants in the specialty.

He joined the CCG Governing Body as a Secondary Care doctor November 2015.

Jan Haxby **

Director of Quality/Registered Strategic Nurse

(July 2015 – present)

Jan is a Registered General Nurse (RGN), Registered Sick Children's Nurse (RSCN), Specialist Community Public Health Nurse (BSc Hons) and is currently completing a Master's degree in Leadership in Health & Social Care.

Jan completed her nurse training in 1985 and worked for a number of years in adult services, including surgical and renal specialties. She spent a number of years working in the field of dialysis and renal transplants units across both Oxford and Hull and at this point started working with young people aged 14+ with renal disease.

She moved into a strategy lead and commissioning role for children's health services in 2003, which was a joint post between the Primary Care Trust and the Council, and then became Head of Children's Health Services in the Council in 2008, and finally Chief Nurse Commissioner in the Council in 2013, before taking up her current post of Director of Quality & Registered Strategic Nurse in July 2015 with the CCG.

Jan brings a range of values developed over 30 years of experience working in the NHS; around quality of services, patient experience and nursing as a caring profession.

Councillor Jane Hyldon-King ***

Deputy Leader & Portfolio Holder for Health & Wellbeing & Adult Social Care (NELC)
(July 2015 – present)

Councillor Jane Hyldon-King was born and brought up in Grimsby and has served in local politics for over 22 years initially as a member of the former Grimsby Borough Council starting in 1993 until the resurrection of NELC in 1996/7.

Jane gained experience in health from serving on Grimsby's Social Service Committee before continuing through to the Health Scrutiny Panel and was also the chair of environment served on several Scrutiny Panels from Health, Education and Environment. Jane was deputy Chair of the former CHC (Community Health Council) and then went on to spend several years as a Non-Executive member of the then newly formed Northern Lincolnshire & Goole Foundation Trust.

After a short break from the Council Jane returned in 2012 and again served on the Health Scrutiny Panel becoming Chair of the panel in 2013/14.
In June this year Jane took over the role as Portfolio Holder for health with the added role of Chair of the Health & Wellbeing Board along with her new position as Deputy Leader. She joined the CCG Partnership Board in May 2015.

Councillor Matthew Patrick ***

Portfolio Holder for Finance & Resources (NELC)
(May 2015 – present)

Councillor Patrick was first elected in 2011, representing the Heneage ward and was successfully re-elected recently, continuing from much success within his council duties where he has earned a reputation as a community champion. He has since sought to further his activities to endeavour to deliver first class healthcare needs within tight budgets.

He continues to oversee radical pioneering transformation within his current role as Portfolio Holder for Finance on North East Lincolnshire Council, ensuring that the Commissioning for Outcomes Framework is fit for purpose, allowing both delivery and value for money on council values and objectives.

He also leads on the agenda of growing key partnership working between the local authority and other public bodies including the CCG to facilitate the most efficient use of public finance to facilitate sustainability and delivery in an ever changing 21st century public sector. Working within an ageing and vulnerable community has given him key insights into the challenging demands that society has within Primary Care, and a background in customer focused industries nurtured a passion to see that service is truly built around empowering the needs of the individual in a complex system. He joined the CCG Partnership Board in May 2015.

*** denotes Governing Body member *** denotes Partnership Board member (those who are not members of the Governing Body)*

The following Governing Body and Partnership Board members resigned from their position during 2016/17	
Nicky Hull ** NEL Primary Care (non GP) Member	April 2015 – March 2017
Cathy Kennedy ** Deputy Chief Executive/Chief Financial Officer	April 2013 – December 2016
Susan Whitehouse ** Lay Member Governance & Audit	April 2013 – Sept 2016

2.1.2 Register of Board Members Declaration of Interest

The CCG maintains a register of interests, in line with our Managing Conflicts of Interests Policy.

All Board members are required to complete a declaration of interest form to identify any potential conflicts of interest. The register is reviewed regularly by the Integrated Governance & Audit Committee.

In addition, before each Board and Committee meeting, members are required to declare any conflicts of interest in the agenda items for consideration, and these are formally recorded in the minutes.

The registers can be viewed on the CCG website where you can read about how we avoid conflicts of interest.

"All Board members are required to complete a declaration of interest form to identify any potential conflicts of interest"

2.1.3. Additional Disclosures

Modern Slavery Act

North East Lincolnshire 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.

Principles of remedy

HM Treasury's Managing Public Money contains guidance at Annex 4.14 about the steps public bodies should take where they have caused injustice or hardship by maladministration or service failure. The Parliamentary and Health Service Ombudsman published revised Principles for Remedy in May 2010, setting out six principles that represent best practice and are applicable to clinical commissioning groups.

The CCG has adopted these six Principles for Remedy which forms part of its complaints handling procedure for healthcare and adult social care.

Those six principles are:

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

The CCG has demonstrated its compliance with these principles through the complaints reporting process to the Quality Committee. An annual report on complaints is received by the CCG's Partnership Board at a meeting held in public, and North East Lincolnshire Council Cabinet (consisting of elected members) for scrutiny.

The CCG website also has a 'You said, We did' section specifically relating to PALS and complaints.

All complaints are investigated and responded to in line with the Principles for Remedy, any employee errors or maladministration are dealt with accordingly.

The CCG's Deputy Chief Executive and Director of Quality & Nursing personally signs off all complaint responses and details all remedies or service improvements within the response. Remedies intend to put service users in the position they would have been had the issue leading to the complaint not occurred.

During 2017/18 the CCG will be seeking to develop a Duty of Candour policy in respect of both the CCG's ways of working and its expectation of providers through its commissioning arrangements.

Disclosure of Data Loss Breaches

Details can be found in the Control Issues section of the Annual Governance Statement.

Emergency Preparedness

NHS England is responsible for emergency preparedness in the Yorkshire and Humber region including North East Lincolnshire. This regional management is administered through a Local Health Resilience Partnership (LHRP) attended by CCGs and NHS funded organisations.

The basis of the LHRP is to seek assurance from NHS organisations that they meet the obligations of the national Emergency Preparedness, Resilience & Response & Framework (EPRR) which was revised and updated in 2015.

The purpose of the EPRR is to provide the framework for all NHS funded organisations in England to help with meeting the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012 (NHS Act 2006 (as amended)) and the NHS Standard Contract.

The CCG, though not a "Category 1" responder, has a key role in linking into NHS England in the event of a major incident and in a proportionate coordination role with local providers in the management of incidents depending on their nature.

The Humber Local Resilience Forum (LRF) also exists, consisting of Local Authorities, Emergency Services and the NHS funded organisations that are Category 1 NHS responders and this forum maintains an incident risk register which, for this region, is biased towards industrial accidents and flooding.
In contrast the EPPR is biased towards health related emergencies e.g. pandemic flu and on major service failure (any cause) of NHS providers.

The CCG is active in the LHRP forum and the EPRR assurance process and in November 2016 completed a mandatory self-assessment against the EPPR requirements and developed an action plan to improve compliance in year.

In 2016, the CCG created a forum of local providers to start to improve the coordination of response for any emergency arising which might impact on local health and care service provision. This Emergency Planning and Response Group (EPARG) meets regularly to consider plans and coordination and to run test scenarios of emergencies and incidents. The development of this group and its activity has contributed to improved compliance for the CCG for the EPPR assurance requirements.

Further, in 2016/17 a number of real scenarios arose which tested emergency planning arrangements and the ability of the CCG to support local response coordination and act as prime contact to NHS England. Industrial action by junior doctors and the threat of local coastal flooding are two examples where CCG led coordination and assurance responses took place.

In 2017/18 EPARG activities will continue and a programme of further test scenarios will be held along with the improved definition of the CCG's response to emergencies that pose a threat to the CCG workplace. This activity is planned to further improve preparedness and the CCG's compliance with the EPPR annual assurance process.

Health & Safety

North East Lincolnshire Clinical Commissioning Group recognises its responsibilities and duties under the Health & Safety at Work Act (1974) and is committed to ensuring so far as is reasonably practicable, the health, safety and welfare of its employees, visitors and other persons who may be affected by its activities.

North East Lincolnshire Clinical Commissioning Group will comply with legislation as a minimum and strive to improve performance on a continual basis by accepting best practice standards and the setting of performance targets in relation to the management of health & safety.

North East Lincolnshire Clinical Commissioning Group has commissioned its Health & Safety service from North East Lincolnshire Council ensuring that there are robust arrangements in place for the management of health and safety across the organisation. Some of these arrangements consist of in-house first aiders and DSE assessors. We also have a selection of staff trained in defibrillator usage.

Signature

Dr Peter Melton
Accountable Officer

Date

2.1.4 The 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 the Clinical Chief Officer to be the Accountable Officer of North East Lincolnshire Clinical Commissioning Group.

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; and,
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Signature

Dr Peter Melton
Accountable Officer

Date

2.1.5 Annual Governance Statement

Introduction & Context

North East Lincolnshire CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group'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 Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group 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 clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

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.

This has been achieved as follows:

The CCG's Constitution

The CCG's Constitution has been formally agreed by our member practices and sets out our arrangements for discharging the CCG's statutory responsibilities for commissioning care on behalf of our population. It sets out our governing principles, rules and procedures that ensure probity and accountability in the day to day running of our CCG, clarifying how decisions are made in an open and transparent way and in the interests of patients and the public.

More specifically, our Constitution includes:

- **Our membership;**
- **The geographical area we cover;**
- **The arrangements for the discharge of our functions and those of our Board (including roles and responsibilities of members of the Board);**
- **The procedures we follow in making decisions and to secure transparency in decision making;**
- **Arrangements for discharging our duties in relation to Registers of Interests and managing Conflicts of Interests;**
- **Arrangements for securing patient and public involvement.**

Our Constitution is a living document, which is updated to reflect changes in national guidance, our membership and composition. Any amendments are submitted in line with NHS England guidance, following consultation and approval by our Council of Members. The CCG Constitution can be viewed on our website

Changes made during 2016/17 are as follows:-

National guidance

Joint working / partnership arrangements, specifically in relation to the proposed Sustainability Transformation Plan (STP) Joint Commissioning Committee.

Establishment of two joint committees in support of development of the Sustainability Transformation Plan (STP).

Conflict of Interest requirements following changes to national requirements.

Members Information

Updated roles/responsibilities for Vice Chair of Council of Members.

Updated composition of Council of Members.

Changes to member practices.

Editorial changes

Scheme of Delegation updated to reflect the discharge of duties for joint arrangements.

In addition to the above, various minor formatting changes have been made. These changes have been approved by the Council of Members, Governing Body and subsequently NHS England.

Governing Body and the Committee Governance Structure

Our governance meeting structure is headed by the Governing Body. The Governing Body has responsibility to undertake the roles and responsibilities as delegated through the Constitution signed by the 27 Member Practices which constitute the CCG.

The constitution has delegated significant responsibility from the Governing Body to the Partnership Board. The Partnership Board enables the local authority to be engaged in the governance of the CCG throughout the year which is essential as part of the Partnership working between NELC and the CCG.

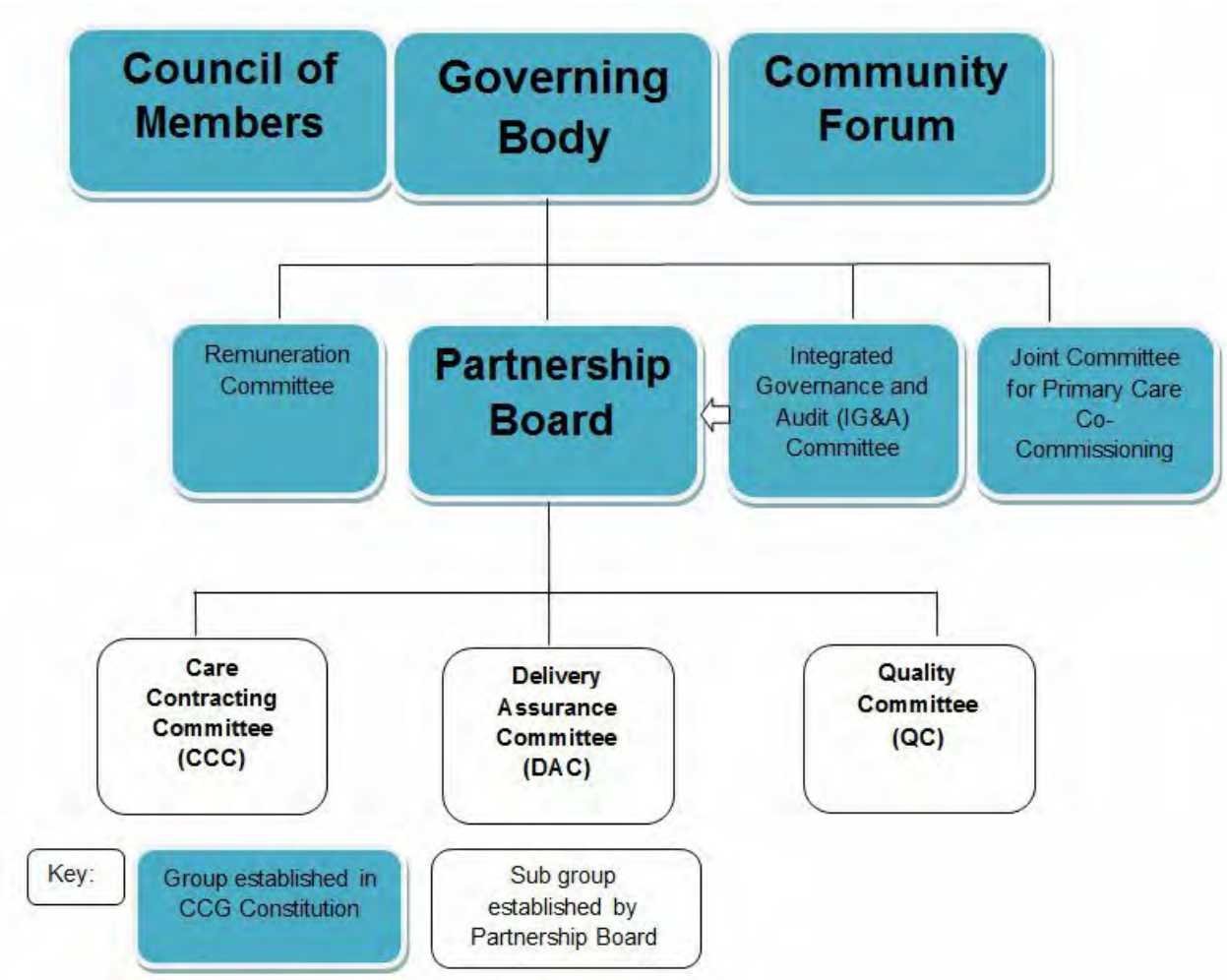
All committees have at least one Governing Body member as part of their membership, and minutes of all committees are shared with all Governing Body members.

The Governing Body has established several formal committees to which it has delegated responsibilities. The work of each committee is directed by the functions delegated to it by the Governing Body through their terms of reference. During 2016/17, the terms of reference of the committees were reviewed and amended; these amendments were approved by the respective committee and ratified by the Governing Body.

As part of the CCG's governance arrangements there is a requirement for "*public and patient involvement".* The CCG does this via the Community Forum (*please refer to Community Forum for full details).*

Community Contacts, who are drawn from the CCG's Accord Membership Scheme, have the opportunity to contribute to the CCG's governance arrangements through positions on Service Triangles, committees and working groups, where they sit as equal partners with health professionals to influence service improvements.

The following CCG Governance Committee structure has been established to support the Governing Body in fulfilling its functions



Corporate activity is captured via the corporate business plan and the performance report (which is received by the Partnership Board and the Delivery Assurance Committee on a bi-monthly basis).

The performance dashboard consists of six performance domains, five risk domains and three quality domains, which incorporate all areas that North East Lincolnshire Clinical Commissioning Group strive to improve on. A judgement has been made of the status for each domain based on the measures and intelligence underpinning them. These judgements try to balance the current position with the expected outcome at the end of the year and weightings with respect to priority.

They also represent the local perspective of performance and quality for North East Lincolnshire rather than the performance against the national definition which, on occasion, covers a broader footprint.

It should be noted that those issues that have an impact on the CCG's corporate performance assessment will continue to be scrutinised at the Delivery Assurance Committee.

The dashboards are managed via the Delivery Assurance Committee, the Quality Committee and the Integrated Governance and Audit Committee.

The committees are respectively asked to make a decision on the final status of the dashboards before reporting to the CCG Partnership Board.

The membership, attendance and activity Summary

The 2016-17 membership, attendance and activity summary of the Council of Members, Governing Body and the Governing Body committees are provided below.

The Council of Members

The CCG is a membership organisation comprising all of the GP member practices across North East Lincolnshire. The Council of Members consists of one representative and one deputy from each practice, to ensure that the CCG includes all GP practices in the area. In addition, there is representation of Adult Social Care (ASC), via the Executive director (CCG Deputy Chief Executive) with responsibility for ASC strategic commissioning and the ASC advisor to the Board are both members of the Council of Members.

A synopsis of the meeting notes, from Council of Members are added to the Practice Portal to ensure those unable to attend are kept fully informed

The Council of Members is the arena in which all member practices have the opportunity to come together to:

- consider and advise on the service commissioning agenda for Health and Social Care
- ensure that the continued development of the CCG is aligned to the principles and aspirations of the constituent practices
- shape the organisation's strategic direction and key objectives
- approve service strategies and significant service change proposals

The Council of Members met *every month* throughout 2016/17 (with January 2017 being a workshop) with all meetings were fully quorate. Engagement has improved during 2016/17. However, there are still a small number of practices with limited engagement either by the named representative or deputy.

Over the past year the Council of Members has approved a number of service changes, agreed changes to the CCG's constitution and received updates regarding service changes. These include:

- Agreement to the CCG's Commissioning Intentions (direction of travel for service strategy)
- Input into the evaluation of the following service (re)design proposals (please note: this list is not exhaustive):
    - Community dermatology services
    - Ophthalmology services
    - Community Pharmacy Minor Ailments Scheme
    - Revised Dementia Pathway
    - Social Prescribing service
    - Community Cardiology
    - Support to care homes

The Council of Members undertook a workshop in January 2017 to review the committee's effectiveness.

The workshop was well attended and consisted of:

- Constitution Q&A session
- A review of the committee's effectiveness against the key requirements
- Discussion on the current committee arrangement and future working
- Q&A Feedback session

Overall, the workshop showed positive engagement by the members and work plan for the committee will be reviewed in 2017/18 to address the outcomes/actions from the workshop.

Members	Attendance (Max 12 meetings)
Dr E Amin (Medi Access)	3 (12)
Dr P Suresh – Babu,	0 (12)
Beacon Medical Centre	6 (12)
Birkwood Medical Centre,	8 (12)
Dr B Biswas & Partner	9 (12)
Dr Chalmers & Dr Meier,	0 (12)
Chantry Health Group,	10 (12)
Clee Medical Centre	8 (12)
Core Care Family Practice (previously Dr R Kumar)	7 (12)
Dr Dijoux and Partners	3 (12)
FieldHouse Medical Group,	5 (12)
Greenland Surgery & New Waltham Surgery	5 (12)
Healing Health Centre	11 (12)
Humberview Surgery,	11 (12)

Members	Attendance (Max 12 meetings)
Dr S Kumar and Partners	2 (12)
Littlefield Surgery	7 (12)
Dr Mathews	1 (12)
Open Door	8 (12)
Pelham Medical Group,	11 (12)
Quayside Open Access	8 (12)
Dr O Z Qureshi	1 (12)
Raj Medical Centre	7 (12)
The Roxton Practice,	7 (12)
Roxton at Weelsby	7 (12)
Dr A Sinha	12 (12)
Scartho Medical Centre	4 (12)
Woodford Medical Centre	0 (12)
Vice Chair of CoM	10 (12)
Executive Director with responsibility for ASC strategic commissioning	8 (12)
ASC advisor	8 (12)

The Governing Body

The Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.

The CCG's Constitution delegates many of the functions and responsibilities normally discharged by the Governing Body to the Partnership Board, and therefore the activities and assurances provided by each of these bodies need to be considered in tandem when gaining assurance about the overall governance of the organisation.

In addition to its core business the Governing Body has effectively overseen the following key areas of work (please note: this list is not exhaustive).

- Annual Reports and Annual Accounts (AGM)
- Ratification of its sub-committees Terms of Reference
- Annual review of the Integrated Governance & Audit Committee Assurance report
- CCG annual assurance review – Well Lead Organisation (WLO)
- Annual constitution reviews
- Establishment of Joint Committees
- External Audit Service Procurement and Specification
- Approve CCG Scheme of Delegation

The AGM also includes a review of the previous year. The Governing Body was updated with the financial performance, as well as performance outcomes, noting the CCG's successes and challenges.

The quality team updated the Governing Body on quality issues across the health and care sector and reflected on how the team have responded to these issues.

The AGM also included a presentation on the CCG's strategy and the potential future influences.

The Governing Body met formally *three times* in public and *once* in private during 2016/17 and attendance records demonstrate that every meeting was quorate.

The Governing Body discharged its duties in full in 2016/17.

Members		Attendance (Max 4 meetings)
Mark Webb Chair NEL CCG		4 (4)
Dr Thomas Maliyil*** Vice CCG Chair/ Chair of Council of Members		3 (4)
Dr Peter Melton Clinical Chief Officer		2 (4)
Helen Kenyon Deputy Chief Executive		3 (4)
Cathy Kennedy Chief Financial Officer/ Deputy Chief Executive	Left December 2016	3 (3)
Laura Whitton Interim Chief Financial Officer	Joined January 2017	1 (1)
Derek Hopper** Vice Chair Council of Members		2 (2)
Jan Haxby Director of Quality and Nursing		4 (4)
Dr Arun Nayyar GP representative		2 (4)

Members		Attendance (Max 4 meetings)
Dr Rakesh Pathak GP representative		0 (4)
Philip Bond Lay Member Community Engagement		4 (4)
Sue Whitehouse Lay Member Governance and Audit	Left September 2016	1 (2)
Tim Render Lay Member Governance and Audit	Joined September 2016	2 (2)
Dr David James Secondary Care Doctor		3 (4)
Juliette Cosgrove Clinical Lay Member		2 (4)
Joe Warner Managing Director Focus independent adult social care work		2 (4)
Stephen Pintus Director of Public Health (Local Authority Officer)		2 (4)
Nicky Hull Non-GP Member	Left position March 2017	0 (4)

****change of role April 2016 from vice chair of CoM to Chair of CoM and vice chair of CCG*

*** left position of Chair of CoM/Vice Chair of CCG April 2016 and re-appointed September 2016 as vice chair of CoM*

The Partnership Board

The Partnership Board is responsible for those matters delegated to it within the constitution, its principle functions are:

- Effective discharge of the CCG's statutory duties for the commissioning of Health Care services.
- Effective discharge of the CCG's responsibilities for Adult Social Care as defined in the legal Partnership Agreement with North East Lincolnshire Council.

This includes the oversight and development of systems and processes for financial control, organisational control, clinical governance and risk management. In addition, the Partnership Board oversees strategic and corporate risks against the CCG's objectives via the performance dashboard (reported as part of the Integrated Assurance Report) and annually reviews the CCG Board Assurance Framework. The CCG's formal sub-committees have actively participated and been involved in the generation of principal risks to the organisation and Board Assurance Framework.

In addition to its core business (e.g. reviewing the CCG Integrated Assurance Report, monitoring the functions of its committees), the Partnership Board has effectively overseen the following key areas of work (please note: this list is not exhaustive):

- An updated report on Patient Experience - With the aim of continually driving improvements and the quality of services provided for the community, this update will provide information on the Patient Experience report and how it aims to collate intelligence about health and social care providers in North East Lincolnshire.
- 2016/17 Business Plan.
- An update on the Annual Budgets and Medium Term Financial Plans.
- An overview of the Board Assurance Framework.
- An outline of the objectives of the Service Triangles.
- The Public Health Annual Report.
- Regular updates regarding The Healthy Lives, Healthy Futures programme.
- Update on Resilience Planning.
- Annual Equality and Diversity Update.
- Update on 2016/17 Operational Plans and development of the Sustainability and Transformation Plan.
- Quality of services, including standardised Hospital Mortality Index (SHMI) performance and CQC reports.

The Partnership Boards also include the following standing agenda items:

- Integrated Assurance and Quality Report.
- Finance Report.
- The development of the Accountable Care Partnership.
- Commissioning and Contracting Report.
- An update given by a representative of the Community Forum and Council of Members meeting.

The Partnership Board will undertake a workshop in April 2017 to assess the performance and effectiveness to ensure it continues to discharge its duties efficiently and effectively.

The Partnership Board met ***six times*** throughout 2016/17 and attendance records demonstrate that every meeting was quorate.

Members		Attendance (Max 6 meetings)
Mark Webb Chair NEL CCG		6 (6)
Dr Thomas Maliyil Vice CCG Chair/ Chair of Council of Members		5 (6)
Dr Peter Melton Clinical Chief Officer		3 (6)
Helen Kenyon Deputy Chief Executive		5 (6)
Cathy Kennedy Chief Financial Officer/ Deputy Chief Executive	Left December 2016	4 (4)
Laura Whitton Interim Chief Financial Officer	Joined January 2017	2 (2)
Derek Hopper Vice Chair Council of Members		4 (4)
Jan Haxby Director of Quality and Nursing		6 (6)
Dr Arun Nayyar GP representative		5 (6)
Dr Rakesh Pathak GP representative		4 (6)
Philip Bond Lay Member Community Engagement		6 (6)

Members		Attendance (Max 6 meetings)
Sue Whitehouse Lay Member Governance and Audit	Left September 2016	2 (3)
Tim Render Lay Member Governance and Audit	Joined September 2016	4 (4)
Dr David James Secondary Care Doctor		5 (6)
Juliette Cosgrove Clinical Lay Member		5 (6)
Joe Warner Managing Director Focus independent adult social care work		4 (6)
Stephen Pintus Director of Public Health (Local Authority Officer)		5 (6)
Nicky Hull Non-GP Member	Left position March 2017	1 (6)
Cllr Jane Hyldon- King Deputy Leader & Portfolio Holder for Health & Wellbeing & Adult Social care (NELC)		6 (6)
Cllr Mathew Patrick Portfolio Holder for Finance & Resources (NELC)		5 (6)

****change of role April 2016 from vice chair of CoM to Chair of CoM and vice chair of CCG*

*** left position of Chair of CoM/Vice Chair of CCG April 2016 and re-appointed September 2016 as vice chair of CoM*

The Community Forum

The Community Forum provides assurance to the CCG Partnership Board that there are robust structures, processes and accountabilities in place for engagement with local people around the commissioning decisions of the organisation.

The Community Forum met *every month* throughout 2016/17. Meetings are always well-attended and minutes demonstrate that each meeting was quorate. The forum consists of 12 community members, the CCG Lay Member for Patient and Public Involvement, the CCG Engagement Lead and appointed representatives from the CCG Executive team including CCG administrative support.

The strategic aims of the forum continue to be:

- To work effectively as part of the CCG governance arrangements, supporting delivery of its business and priorities.
- To actively support the implementation of the CCG's strategic aims for public engagement (Engagement Strategy).
- To work pro-actively with the Voluntary, Community and Social Enterprise (VCSE) sector and wider community to cascade and receive information.
- To continue to develop the skills and knowledge of members to ensure quality and resilience.

In February 2017 the meeting was dedicated to a '*So what?*' session which sought to reflect upon and challenge progress against the forum's Action Plan.

Collectively, the forum highlights for 2016/17 include:

- Collaborated with the Partnership Board and Council of Members in strategic workshops to develop priorities and sustainability plans.
- Considered and commented on key commissioning plans and policies including Ethical and Pragmatic Decision Making, Information, Advice and Guidance, Commissioning Intentions/Corporate plans, Community Cardiology, Accountable Care Partnership and new models or care, Sustainability and Transformation Plan, Urgent Care Redesign and Quality initiatives.
- Considered, commented and advised on CCG engagement and communications plans.
- Attendance of representatives from the VCSE sector at a forum meeting to share information.
- Completion of Prevent Training.

Individually through participation in service triangles, committees and working groups, members' highlights include:

- Supporting the development of a 'people's panel' to steer the redesign of the supported living service specification and quality outcomes.
- Reviewing of health checks for vulnerable people.
- Development of plans to reduce use of antibiotic prescribing; reduce medicine waste and promote cost effective initiatives.
- Presenting to the Lincolnshire and Humber International Women's Group to raise awareness of public and patient involvement.
- Leading the public and stakeholder engagement of Urgent and Emergency Care service redesign.
- Interview and appointment of Pharmacists in General Practice and of Clinical Leads Prescribing Triangle).
- Interview panel for SPA manager role.
- Supporting engagement to inform the Dementia Vision and objectives.
- Mental Health Concordat review.
- Development of Learning Disability Forum for North East Lincolnshire.
- Helping with the redesigning of Community Nursing Service.
- Participation in multi-agency initiatives such as the SPA Board, the Good Governance group, Mortality Group, Good Neighbours Partnership, Cancer Collaborative, Health Check Review Group, Regional Urgent Care Network.
- Participation in cross-area planning such as the Area Prescribing Committee and Humber Coast and Vale Sustainability and Transformation Plan for Mental Health.

Members		Attendance (Max 12 meetings)
Anne Hames (Chair)		12 (12)
April Baker Community Forum Representative		10 (12)
Albert Bennett Lay Community Lead Older People's Service Triangle		11 (12)
Philip Bond Board Lay Member Community Engagement		10 (12)
Christine Foreman Lay Community Lead Community Care Service Triangle		10 (12)
Bernard Henry Community Forum Member		11 (12)
Margaret Henry Lay Community Lead Prescribing Service Triangle		9 (12)
Wendy Wood Lay Community Lead Representative Council of Members		12 (12)
Terrence Simco Lay Community Lead Planned Care Triangle		10 (12)

Members		Attendance (Max 12 meetings)
Barry Osborne Lay Community Lead Disability & Mental Health Service Triangle		12 (12)
David Walker Lay Community Lead Representative Delivery Assurance Committee		7 (12)
Sally Czabanuik NELCCG Engagement Manager		10 (12)
Diane Edmonds Community Forum Member		9 (12)
Michelle Barnard Assistant Director Women & Children	Joined December 2016	4 (4)
Cathy Kennedy Chief Financial Officer/ Deputy Chief Executive	Left December 2016	5 (9)
Roy Rufus-Isaacs Community Forum Member	April 2016 - December 2016	6 (9)

Integrated Governance & Audit Committee

The Integrated Governance & Audit Committee is responsible for providing to the partnership board an independent and objective view of all matters pertaining to that body's functions and responsibilities, notably:

- Economy, effectiveness and efficiency
- Governance arrangements, including compliance with those laws regulations and directions governing the group

It also is responsible for providing the Governing Body and Partnership Board with an independent and objective view of:

- The group's financial systems and financial information
- All other responsibilities of the committee as set out in the groups scheme of delegation and the committee's terms of reference

Performance/highlights include *(Please note: This list is not exhaustive):*

- 100% compliance with the Audit Committee handbook's best practice "must do's" & "should do's"
- Delivery of the Committee's Annual work plan.
- In April 2016 the Committee completed a self–assessment survey based on the NHS Audit Committee Handbook carried out by the CCG external auditors. North East Lincolnshire CCG's scoring was overall better than the benchmarked average in five out of the seven areas assessed.
- The selection and appointment of Mazars LLP to provide external audit services in accordance with the requirements set out in the Local Audit Accountability Act 2014. The appointment is for the period from 1 April 2017 to 31 March 2020.

Members		Attendance (Max 4 meetings)
Sue Whitehouse (Chair) Lay Member Governance and Audit	Left September 2016	2 (2)
Tim Render (Chair) Lay Member Governance and Audit	Joined September 2016	2 (2)
Joe Warner Partnership board lay member		4 (4)
Cllr Mathew Patrick Partnership board lay member		3 (4)
Dr Karin Severin GP Representative		1 (4)

The IG&A Committee met ***four*** times throughout 2016/17 and attendance records demonstrate that each meeting was quorate.

The Joint Committee for Primary Care Co-commissioning

The Joint Co-Commissioning Committee has now been in operation for two years, having been established in 2015 with the primary purpose of jointly commissioning primary medical services (services provided by general practitioners) for the people of North East Lincolnshire. Its membership is drawn from North East Lincolnshire Clinical Commissioning Group (NEL CCG), NHS England (Yorkshire and Humber sub region), and North East Lincolnshire Council (NELC), as all of these organisations are responsible for commissioning different elements of services from primary medical service providers within North East Lincolnshire.

The purpose of having these joint arrangements is so that each of the organisations that are responsible for commissioning such services can discuss and take decisions about those services together. The aim is to ensure that one organisation does not take a decision that adversely affects any of the others, and that the services are planned in a way that meets local need, fits with future service strategy and is affordable within the resources that are available.

Membership of the committee includes lay representatives, GPs, Director of Public Health and Executive Officers of the CCG and NHS England. We also invite representatives from the local Health watch organisation and the Local Medical Committee (LMC, a representative committee of NHS GPs that represents their interests in their localities to the NHS health authorities) to sit in on our committee, although they do not have voting rights when decisions are taken.

During 2016/17 *four* meetings of the committee were held and the attendance records demonstrate that each meeting was quorate. These meetings are also open for members of the public to observe, and the dates of the meetings are advertised on the CCG's website.

Over the past year, the committee has covered all of the areas included within a work plan for the year. It has overseen a number of pieces of work and has made a number of decisions regarding local services including:

- Procurement of a new provider for a local general practice list.
- A new service to support practices to manage patients with complex conditions and the house bound to avoid hospital admission, combining NHS England and CCG requirements and funding into one service.
- Prioritisation of bids to NHS England for investment into general practice to support development of buildings and implementation of new technology, for example online self-assessment tools and automated telephone systems.
- A new local quality scheme for general practices to help improve care in a number of areas, including pre-diabetes care, prescribing, managing patients within the primary care setting and patient experience improvements.
- A local development and investment plan for general practice, in line with NHS England's GP Forward View paper.
- Mergers of local practices.

Difficult decisions continue to have to be taken by the committee, such as a small number of practice requests to temporarily close their lists to new patients. The requests are usually made because the practice has a lot of vacancies or has had a large number of patients that have recently requested to register. It is not easy to take these kinds of decisions, because the committee has to balance the needs of the local population against the need to protect the safety of services and the welfare of the general practice staff.

The committee has an agreed work plan for the coming year and it will continue its work on supporting the development and improvement of local primary medical services.

Members		Attendance (Max 4 meetings)
Mark Webb (Chair)		4 (4)
Dr Thomas Maliyil*** Chair of Council of Members		3 (4)
Dr Derek Hopper ** (vice chair of Council of Members)		1 (2)
Heather Marsh/ Zena Robertson NHS England Representatives		4 (4)
Cllr Jane Hyldon-King Deputy Leader & Portfolio Holder for Health & Wellbeing & Adult Social care (NELC)		3 (4)
Steve Pintus Director of Public Health		2 (4)
Cathy Kennedy Chief Financial Officer/Deputy Chief Executive	Left December 2016	2 (3)
Laura Whitton Interim Chief Financial Officer	Joined January 2017	1 (1)

****change of role April 2016 from vice chair of CoM to Chair of CoM and vice chair of CCG*

*** left position of Chair of CoM/Vice Chair of CCG April 2016 and re-appointed September 2016 as vice chair of CoM*

Remuneration Committee

The Remuneration Committee, on behalf of the Governing Body, makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG, and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme. They also agree the remuneration and terms of service of the Partnership Board Lay Members.

The Remuneration Committee met *twice* throughout 2016/17 and attendance records demonstrate that each meeting was quorate.

Key issues discussed and decisions made during 2016/17 include:-

- Appointment process for Integrated Governance & Audit Chair
- Review of remuneration and terms of service/reference for the following:
  - Very Senior Managers.
  - Governing Body and Partnership Board Members.
  - Clinical leads.
- Review of the performance and annual objectives of Very Senior Management.
- Provide updates on the national guidance and arrangements for Agenda for Change and Very Senior Managers.
- Ratification of applicable HR policies.

Please refer to section 2.2.1 for details of members & attendance

UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for NHS bodies, compliance is considered to be good practice. This governance statement is intended to demonstrate the CCG's compliance with the principles set out in the code.

We have described through the narrative within this annual governance statement and our annual report and accounts how we have fulfilled four of the five main principles of the code; specifically in relation to, leadership, effectiveness, accountability and remuneration. For the financial year ended 31 March 2017, and up to the date of signing this statement, we have applied those principles of the code that are directly relevant, and via this annual governance statement and our annual report and accounts demonstrate how we have discharged our responsibilities.

In line with best practice the CCG has completed a self-assessment against the UK Corporate Governance Code. The self-assessment was presented to the Integrated Governance & Audit Committee in March 2017; the committee were assured the CCG fulfilled the required principles with no gaps identified.

Discharge of the CCG's Statutory Functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group 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.

Compliance with statutory functions was monitored by the Integrated Governance & Audit Committee throughout the year. Work continues within the CCG to continue to monitor statutory duties, and where necessary address any gaps.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directors have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

As a result, I can confirm that the clinical commissioning group 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.

Risk management arrangements and effectiveness

The CCG has adopted a risk management strategy as part of the risk management process. The strategy sets out the process for:

- Ensuring structures and processes are in place to support the identifying, reporting, assessment and management of risks throughout the CCG.
- Achieving a culture that encourages all staff to identify and control risks which may adversely affect the operational ability of the CCG.
- Assuring the public, patients and their carers and representatives, staff and partner organisations that the CCG is committed to managing risk appropriately.
- Managing Information Risk.

Risks are identified from a broad range of sources including incidents, complaints, internal audit reports and reports by external bodies, all risks are recorded on the CCG risk register. Risks that may affect the ability of the CCG to meet its strategic objectives are recorded on the Board Assurance Framework (BAF).

The CCG Risk Management Strategy is due to be reviewed April 2017.

The CCG has **two** risk management processes in place as described in the risk management strategy; the ***Board Assurance Framework (BAF)*** and the ***Risk Register.***

The Board Assurance Framework (BAF) sets out the principal risks to delivering the CCG's strategic objectives. The CCG Partnership Board owns and determines the content of the BAF, identifying the strategic risks acts as a high-level risk identification system with regard to compliance with the CCG's strategic objectives.

The CCG Partnership Board has an opportunity during the financial year to monitor the assurance it has received and identify any gaps that should be addressed in order to be assured.

The BAF provides an effective focus on strategic and reputational risk rather than operational issues, highlighting *gaps in control*, *gaps in assurance* processes and details of necessary action to be taken. It also demonstrates *positive assurance* received to date and any *outstanding gaps in control* or *assurance*. It provides the Partnership Board with assurance that the systems and processes in place are operating in a way that is safe and effective.

The Risk Register sets out all the operational risks (health & adult social care) which represent the day to day issues that the organisation faces whilst working towards its strategic objectives. The risk management framework determines which risks are managed at an operational level on the risk register and those that are escalated to the Board Assurance Framework.

The risk register comprises a description of the risk, the risk assignee, and the controls in place – definition of the control and whether the control is *(effective/partially effective/not effective)* and the risks scores – *original score, current residual score, and target score.*

All staff are responsible for identifying new risks, any new risks identified for inclusion on the risk register and Board Assurance Framework are assessed for likelihood and consequence using a 5 x 5 risk matrix in accordance with the risk management strategy.

Each risk is assessed against the risk matrix to provide the original risk rating that is the risk rating before any controls are in place and the current risk rating, which is the risk rating taking the current controls in to consideration. A target risk rating is also given to each risk, which is the level of risk which the CCG will find acceptable (risk appetite). If the assessment of the risk is higher than the risk appetite, further action is taken to reduce the likelihood and/or impact of the risk occurring. If this is not possible, contingency plans would be put in place to bring the risk exposure level (residual risk) back within the accepted range.

To support the Partnership Board in carrying out its duties effectively the Integrated Governance & Audit Committee monitors Board Assurance Framework and the Risk Register at each of its meetings, which ensures robust and adequate progression of the risks are kept live and relevant. This is an on-going process and the Integrated Governance & Audit Committee act on behalf of the Partnership Board to ensure that mitigation plans are in place to manage the risks identified. The committee escalate developments, concerns or issues to the Partnership Board.

Risk Management is embedded within the activities of North East Lincolnshire CCG through

- Review of the risk register and assurance framework at the monthly Service Leads meeting, which ensures that the process is kept live and relevant. *(With effect from January 2017 the service lead meeting* merged with the senior management team meeting to form "operational leadership team meeting.

- Annual risk management reviews take place with the risk manager and risk assignee.

- Openly encouraging staff to report any concerns through the incident reporting process and each incident is reviewed and investigated as applicable.

- The Senior Information Risk Owner (SIRO) who supports our arrangements for managing and controlling risks relating to information/data security.

- Involvement of Public Stakeholders in managing risks, this is done, through lay membership of the CCG's committees. These measures are in place to ensure that CCG decision making processes are transparent, to ensure that community engagement continues to be embedded in this process and, ultimately, to provide further assurance to the organisation.

Prevention

Risk is evident in everything we do. The risk management strategy is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Governance and internal control of the CCG is an on-going process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of North East Lincolnshire Clinical Commissioning Group.

- Evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically.

To properly respond to a risk the *Risk Manager* may need to bring in experts to understand the actions that can be taken to reduce the likelihood of the risk occurring or the impact if the risk does occur.

In addition to the risk management process described above, the following robust assessment processes are in place as part of the key decision making processes within the CCG;

1) Conflict of Interests (*refer to page 80 for full details*)

2) Counter fraud (*refer to page 88 for full details*)

3) Others

- Human Resources (HR) policies *(refer to section 2.2.6 for further details)*
- Service Proposal Management Tool (*refer to page 87 for further details)*
- Control Issues (*refer to page 84 for further details)*
- Performance dashboard *(refer section 1.2 for further details)*
- Emergency Preparedness (*refer to section 2.1.3 for further details)*

Management

All identified risks have a Senior Manager as the risk owner, and an appointed Risk Assignee to ensure appropriate accountability for the management of the risk with support from the governance team.

Each risk is regularly reviewed at least quarterly (15+ monthly) and six monthly by the risk manager. Risks are forwarded to the risk assignee requesting review and update of their risks. The review/update pays particular attention to the controls and assurances to ensure they remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions. Any additional controls or assurance which could impact on the risk ratings, therefore must reconsider any changes to risk ratings, and a progress update. Risks which are deemed to have reached their target risk rating and are no longer a threat to the CCG are only closed, once approval has been agreed by the senior manager accountable for the risk.

The CCG has a mechanism for monitoring static risks, for example if the risk rating of a risk has not changed for the last four quarters, this is reviewed to assess whether the risk remains relevant and if so what actions will be taken.

The updates are reported to Service Leads meeting (monthly) (now Operational Leadership meeting) Delivery Assurance Committee (bi-monthly) and the Integrated Governance & Audit Committee (quarterly). The controls, assurances and gaps in controls and assurance are scrutinised along with any actions required to work towards improving the potential risk.

The Delivery Assurance Committee and Integrated Governance & Audit Committee duties include ensuring that effective monitoring and review in relation to performance and risks are carried out, this is done by way of regular reporting to each committee. Any significant issues are escalated to the Partnership Board. The Partnership Board receives, on a bi-monthly basis, the *CCG integrated assurance report*, which provides assurance to the Board of how the CCG is performing against the domains developed for the dashboard with regard to its performance measures and risk.

Capacity to Handle Risk

The CCG's Partnership Board is accountable for the performance management of the Risk Management Strategy and systems of clinical, financial and organisational control and oversees the overall system of risk management and assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and public accountability. The Partnership Board uses the risk management process and more specifically the board assurance framework as a means to assist achievement of its goals and provides a clear commitment and direction for risk management within the CCG.

The constitution and the Partnership Board have delegated responsibility for some aspects of risk management to the Integrated Governance and Audit Committee

The Integrated Governance and Audit Committee are responsible for:

- Reviewing the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical, including information and financial risk) to support the achievement of the organisation's objectives.

- Agreeing and monitoring the Internal Audit work plan and seeking assurance to ensure development of the Annual Governance Statement.

There are other committees at which risk may also be considered (please refer to review of effectiveness section)

The Chief Financial Officer has delegated responsibilities for the development and implementation of financial risk management and financial governance including those relating to key financial controls and driving the development of the Risk Management Framework. They are also responsible for implementing the system of internal control, including the risk management process for the assurance framework and risk register for the CCG.

The Director of Quality has delegated responsibility for assuring that the CCG has effective clinical governance arrangements in place and has effective multidisciplinary engagement arrangements in place. Most notably in relation to service planning and redesign for management the development and implementation of clinical risk management, clinical governance and patient safety.

As part of our Corporate Governance Framework, the CCG has assessed the risks facing it and has ensured internal control/mitigations are in place to manage those risks. Staff are trained and equipped to manage risk in a way appropriate to their roles and responsibilities. To measure risks facing our organisation and to ensure appropriate internal control/mitigations are in place, one of the functions is to ensure we continue to monitor and review our current risk in-line with NHS England's improvement & assurance framework, and promote risk management.

Annual risk management reviews take place with the risk manager and risk assignee. The purpose of these sessions is to provide the opportunity for Managers/Assignees to work together to review their risks paying particular attention to the risk ratings/internal controls and look at ways of improving our risk registers.

A wider review of both the CCG's strategic and operational risks is to be undertaken by the Senior Management Team, early 2017/18; this will be followed by an organisational wide risk based workshop.

Risk Assessment

The CCG recognises the need for a robust focus on the identification and management of risks and therefore places risk as an integral part of our overall approach to quality. In assessing risk, the North East Lincolnshire CCG reviews the potential hazards, which are situations with the potential to cause harm against the risk (the probability) of the hazard occurring using the principles of the international standard ISO 31000 for its risk management process which the CCG has adopted as best practice.

Risk is assessed in accordance with the CCG Risk Management Strategy 2015-17. This requires staff to identify risks through established reporting streams and assess the likelihood and impact of the risk occurring. This is done using a 5 x 5 matrix as detailed in the strategy. This is so as to ensure a consistent approach to risk assessment regardless of the individual performing it.

In May 2016 the *Integrated Governance & Audit Committee* agreed for all risks on both the Board Assurance Framework and Risk Register to be mapped to NHS England new Improvement and Assessment Framework for CCGs (CCG IAF). The intention of the CCG IAF is to empower CCGs to deliver the transformation necessary to achieve the Five Year Forward View.

The CCG IAF has been created to cover indicators located in **four** domains as follows:-

1. **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;
2. **Better Care**: this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
3. **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;
4. **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.

In December a risk review meeting took place with the Chief Financial Officer to assess the level of risks, this resulted in a number of risks that were categorised as strategic, but where deemed operational and moved to the risk register and some were removed as perceived to be no longer risks to the CCG.

North East Lincolnshire Clinical Commissioning Group compared with neighbouring CCGs will have more operational risks on their risk register due to the joint partnership working with North East Lincolnshire Council in relation to the commissioning of Adult Social Care. As at Quarter 4 2016/17 there were ***7*** Adult Social Care risks on the risk register.

During the period 21 March 2016 to 21 March 2017, the risk register had ***18*** risks which were closed and ***22*** new risks were identified. The Board Assurance Framework had ***6*** risks closed and ***8*** new risks identified.

The total number of risks on the risk register as at 21 March 2017 was **33** opposed to **29** in March 2016.

The total number of risks on the Board Assurance Framework as at 21 March 2017 was **6**, opposed to **12** in March 2016.

The tables below show the current residual risk ratings for the Board Assurance Framework and Risk Register as at March 2016 - 21 March 2017

March 2016

Board Assurance Framework

	March 16
Total number of risks	12
High level risks (rated at 15+)	4
Medium to high level risks (rated at 12+)	2
Low to medium level risks (rated at 9+),	2
Low level risks (rated at 3+)	4

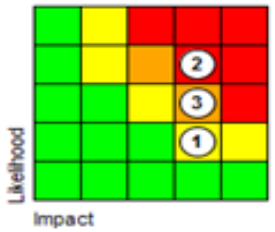
Risk Register

	March 16
Total number of risks	29
High level risks (rated at 15+)	5
Medium to high level risks (rated at 12+)	7
Low to medium level risks (rated at 9+),	6
Low level risks (rated at 3+)	11

At the beginning of 2016/17, the CCG identified ***4*** risks on the Board Assurance Framework, ***5*** risks on the Risk Register with residual risk rating as being assessed as high level. (15+). The total risks held on both Board Assurance Framework and the Risk Register at the end of 2016/17 with a residual risk rating being assessed as high level (15+) was ***11.***

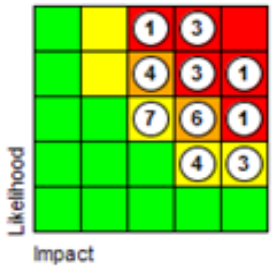
March 2017

Board Assurance Framework



	March 17
Total number of risks	6
High level risks (rated at 15+)	2
Medium to high level risks (rated at 12+)	3
Low to medium level risks (rated at 9+),	0
Low level risks (rated at 3+)	1

Risk Register



	March 17
Total number of risks	33
High level risks (rated at 15+)	9
Medium to high level risks (rated at 12+)	10
Low to medium level risks (rated at 9+),	14
Low level risks (rated at 3+)	0

The risks on the Board Assurance Framework that were escalated for review by the Partnership Board as at end of Quarter 4 are summarised in the tables below.

The North East Lincolnshire CCG principal risks on Board Assurance Framework (that is a risk rating of 15 and above)

Risk ID	Risk Summary	Initial Risk Rating	Current Risk Rating	Trend	Last Review Date	Controls to mitigate the risks
CCG-BAF.2002	Risks in delivery of key annual performance indicators and standards including constitutional standards	12	16	–	03-Mar-2017	**Assurances on Controls** Regular reporting in to Partnership Board, Delivery Assurance Committee, Council of Members and the Planning and Service Leads meeting. **Positive Assurances** The CCG performed well against the CCG Assurance Framework in 2015-16 with the CCG assured as good against the performance domain. Further assessment of six clinical areas in the CCG Improvement and Assessment Framework demonstrate that NEL are in the top five CCGs in the country, although improvement is required in three. **Gaps in Controls** - None identified **Gaps in Assurance** – None identified
CCG-BAF.3003	Financial challenges	20	16	–	03-Mar-2017	**Assurances on Controls** Routine financial reports to Partnership Board (finance and HLHF) Delivery Assurance Committee scrutiny of financial plan delivery QiPP oversight group, with escalation to SMT Local health community financial monitoring and reporting **Positive Assurances** Integrated Governance & Audit (IG&A) review of key risks and actions Medium Term Financial Plan reports to IG&A and Board Internal audit plan is risk –based **Gaps in Controls** - None identified **Gaps in Assurance** – None identified

The risks on the Risk Register that were escalated for review by the Integrated Governance & Audit Committee as at end of Quarter 4 are summarised below:-

The North East Lincolnshire CCG principal risks on Risk Register (that is a risk rating of 15 and above)

Risk ID	Risk Summary	Initial Risk Rating	Current Risk Rating	Trend	Last Review Date	Controls to mitigate the risks
CCG-RR.1005	Failure to deliver 300 Extra Care Housing flats by the end of 2018	12	15		15-Mar-2017	CCG-RR.1005a Delivery vehicle in place Joint venture between CCG and developer CCG-RR.1005b Extra Care Housing Steering Group representation on the group is NELC & NELCCG
CCG-RR.2004	Failure to achieve Accident and Emergency 4 hour targets	16	20		10-Mar-2017	CCG-RR.2004b Action Plans Action plans focussing on all issues with potential impact on 4 hour A&E wait performance. CCG-RR.2004c A&E Delivery Board A new national structure, to operate across Northern Lincolnshire, with a specific mandate on A&E performance recovery. This forum will replace the SRG (now disbanded) as the main control for system wide monitoring and action planning on the recovery of A&E 4 hour wait performance at Northern Lincolnshire & Goole (NLaG) hospitals.
CCG-RR.2005	RTT Performance	20	20		01-Mar-2017	CCG-RR.2005a Commissioning Action Plan The commissioning action plan is in place and reported through the Delivery Assurance Committee (DAC) for progress. CCG-RR.2006b Updates go to Service Lead meetings, CoM and System Resilience Grp These groups receive updates for information, discussion and action. CCG-RR.2005c Clinically led collaborative meeting with providers Meeting discusses service delivery concerns/improvements CCG-RR.2005d Financial Penalties Monitoring of individual contract performance via contract meetings. Financial penalties imposed on providers for non- achievement of key performance indicators.
CCG-RR.2010	Infection Prevention and Control	20	16		17-Mar-2017	CCG-RR.2010a Quality Committee The Quality Committee have been briefed on the current risk and monitor the action plan following the gap analysis. CCG-RR.2010b Quality Team Meeting The Quality Team meetings review the Infection Prevention Control (IPC) gap analysis action plan.
CCG-RR.3003	Adult ADHD Pathway breakdown	20	16		10-Mar-2017	CCG-RR.3003a Council of Members (CoM) Quarterly report to CoM CCG-RR.3003b PALs monitoring logs Monitoring through logs of concerns via PALs
CCG-RR.4004	The new DoLS requirements are unable to cope with the increasing number of requests for authorisation	16	20		21-Mar-2017	CCG-RR.4004a Monitoring of activity at DAC and Safeguarding Board. The risks are monitored as part of the strategic plan and reviewed on a regular basis by the Chair and Deputy Chair of the Safeguarding Adults Board. CCG-RR.4004b Strategic Mental Capacity Group The Group monitors strategic change and works jointly with the CCG and providers.
CCG-RR.4017	Establishment of the Accountable Care Partnership in North East Lincolnshire	25	20		10-Mar-2017	CCG-RR.4017a Accountable Care Partnership (ACP) Shadow Board The CCG is a member of the shadow board. Regular meetings take place to discuss the development of the ACP CCG-RR.4017b ACP Work plan in place The Work plan in place is to provide timelines and oversight on progress of the ACP CCG-RR.4017c Programme Manager appointed A Programme Manager has been appointed to support overall delivery of the programme
CCG-RR.4008	Cash flow and management of one Domiciliary Care Provider (LQCS)	20	16		15-Mar-2017	CCG-RR.4008a On-going close monitoring of situation The CCG requesting additional support form Approved Provider (Hales) CCG-RR.4008b Actions from LQCS Look to sub contract to gain additional support to pick up new packages.
CCG-RR.4016	Sustainability Transformation Plan	20	15		10-Mar-2017	CCG-RR.4016a Executive Group The CCG's Deputy Chief Exec and Clinical Chief Officer are both members of the Executive group. The group has been established to oversee continued development and delivery of Sustainability Transformation Plan (STP) CCG-RR.4016b STP Programme Manager Programme Manager in place to support the delivery of the STP CCG-RR.4016c Healthy Lives Healthy Future (HLHF) Programme Director The HLHF programme director links into the STP to undertake the at scale work. CCG-RR.4016d Clinical group A Clinical group has been established across the STP to support the work of the executive group and ensure that there is appropriate clinical engagement and sign up to the plans, NEL Chief Clinical Officer is chairing that group

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group 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 system of internal control within the CCG is based on an on-going process designed to identify and prioritise the risks. It is frequently the case that whilst the impact of the risk may remain the same as the original raw assessment, successful mitigating actions/internal controls will reduce the likelihood of the risk occurring. The system has been in place in the CCG for the year ending 31 March 2017 and up to the date of approval of the Annual Report and Accounts.

Conflict of Interest Management

During 2016/17 the CCG has continued to carefully manage potential Conflicts of Interest; we adopt strict adherence to our overarching standard of business conduct and conflicts of interest policies and we maintain a robust register of declared interests which is updated on an on-going basis.

In June 2016, NHS England published revised statutory guidance on managing conflicts of interest for CCGs. Conflicts of interest are inevitable in commissioning and it is how we manage them that matters. The guidance includes a number of strengthened safeguards to mitigate the risk of real and perceived conflicts of interest arising in CCGs.

In light of the new guidance, the CCG has reviewed/refreshed our current arrangement for management of conflict of interest as follows:

- Appointed a Conflict of interest guardian
- Register of interest published six monthly on the CCG website
- Strengthened provisions around the management of gifts and hospitality
- Strengthened decision-making processes:
    - Committee Chair's briefing note and checklist produced
    - Governance structure committee's terms of reference (TofR) updated to include standard Conflict of interest paragraph
    - Strengthen recording of conflict of interest on governance structure minutes – Standard templates used across all Governance Structure Committees, which include recording of conflict of interest
- Strengthened process for managing breaches and publication of anonymised breaches

The standard of business conduct and management of conflict of interest policy was refreshed and ratified by the Integrated Governance & Audit Committee January 2017.

With the introduction of the new Improvement & Assessment Framework for CCGs from 2016/17 onwards, the management of conflicts of interest is a key indicator of the new framework. As part of the new framework, CCGs are required to submit quarterly and annual self-certification returns to demonstrate compliance with the requirements of the revised statutory guidance that clear policies and processes for the management of conflicts of interest are in place.

CCGs are under a duty to ensure the information reported in the self-certification is accurate and up to date. We can confirm the CCG has completed and returned the self-certifications in advance of the time frame to NHS England. The CCG Accountable Officer and Integrated Governance & Audit Chair (Lay Member for Governance & Finance) signed off the self-certifications as accurate and confirm the CCG's compliance with the conflict of interest guidance.

The CCG is required to publish any breaches in relation to the CCG's Conflicts of Interest Policy. There have been ***no*** reported breaches during 2016/17.

In addition there is a requirement for CCGs to undertake an annual internal audit on the management of conflicts of interest to provide further assurance about the degree of compliance with the statutory guidance.

An audit of Conflicts of Interest has been conducted by our internal auditors early 2017. The objective of this audit was to evaluate the design and operating effectiveness of the arrangements that the CCG has in place to manage conflicts of interest and gifts and hospitality, including compliance with NHS England's statutory guidance on managing conflicts of interest for CCGs.

To support CCGs in this mandatory requirement, NHS England issued a framework for this internal audit, the 'NHS England CCG Conflicts of Interest Internal Audit Framework 2016/17'. This was therefore used as a basis for the audit; it includes a detailed checklist covering the following key conflict of interest review areas, for each of which an assessment of the level of compliance is required:

- Governance arrangements
- Declarations of interest and gifts and hospitality
- Registers of interest, gifts and hospitality and procurement decisions
- Decision making processes and contract monitoring
- Identifying and managing non-compliance

The review found that in general, conflicts of interest were being managed appropriately by the CCG and that arrangements were in place to capture declarations and conflicts of interest for the CCG as part of the processes of general declarations of interest, disclosure of gifts, hospitality and sponsorship and the procurement and contracting procedures; therefore, the audit can provide ***significant assurance***.

However, the review found that there are four areas where the CCG does not fully comply with the NHS England conflicts of interest guidance, as follows:

- The Gifts and Hospitality Register does not include all details required by the NHSE Guidance on Conflicts of Interest.
- The Contract Database (Procurement Register) does not include all details required by the NHSE Guidance on Conflicts of Interest.
- One Conflict of Interest Declaration for a contractor had not been properly completed or followed up by CCG staff.
- A flowchart detailing the process for managing different types of COI breaches is planned but was not in place at the time of the review.

An action plan has been agreed and the above actions will be addressed, completed and monitored as part of the ongoing audit reviews during 2017/18.

Conflict of Interest Training – CCGs must ensure that training is offered to all employees, governing body members and members of CCG committees and sub-committees on the management of conflicts of interest. This is to ensure staff and others within the CCG understand what conflicts are and how to manage them effectively. NHS England is developing an online training package for CCG staff, governing body and committee members. This will be rolled out in the spring of 2017.

This will need to be completed on a yearly basis to raise awareness of the risks of conflicts of interest and to support staff in managing conflicts of interest. The annual training will be mandatory and will need to be completed by all staff by ***31 January*** of each year. CCGs will be record to record their completion rates as part of their annual conflicts of interest audit.

Please refer to the our website for details on how we avoid Conflicts of Interest.

Data Quality

The CCG has robust processes and governance arrangements in place to ensure that the quality of data used by Council of Members, Governing Body, Partnership Board and sub-committees is accurate and fit for purpose. Members are aware of the importance of maintaining high standards of information governance and securing confidentiality of patients.

The CCG, in line with its annual Information Governance toolkit requirements has produced and maintains an Information Asset Register which identifies business critical models and their asset owners in the organisation. The Senior Information Risk Owner (SIRO) has nominated Information Asset Owners covering all areas of the organisation. The SIRO and Caldicott Guardian have responsibility for data as part of the overall model including quality assurance. Data flow mapping has also been conducted which enables an understanding of the flows of information related to these key business critical models to be identified, and Information Asset Owners are responsible for all quality checking of these processes which informs key decision making.

The CCG received support from eMBED Health Consortium for specialist advice and training for information governance issues. eMBED Health Consortium has in place internal procedures and controls in order to ensure data presented is of the best quality possible. Any data issues noted in source data is reviewed and identified with the source provider.

Information Governance

The CCG has bought in an expert Information Governance advisory service from the eMBED Health Consortium.

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 clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG has been able to submit evidence for 2016-17 resulting in an improved score of *74%* as a result of the comprehensive review of evidence. ***Six*** standards have been assessed at ***Level 3*** for the first time including those related to:

- Information Governance Management and associated policies, strategies and procedures;
- The adequacy of Information Governance skills, knowledge and experience available to the CCG
- Assurances on overseas processing.
- SIRO & Information Risk planning and records management.

Assurances of the quality of evidence provided, internal audit carried out an assessment of the evidence and provided ***significant assurance*** on the information provided.

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 have developed information governance processes and procedures in line with the information governance toolkit. We have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities All our Information Governance suite of policies and procedures has been reviewed and are up to date, and staff have been made aware of these via a communications briefing. All our policies and procedures can be found on our CCG intranet.

The CCG has a board-level officer responsible for information security and the associated management processes, and this role is known as the Senior Information Risk Owner (SIRO). The CCG has a board-level clinician responsible for ensuring that all flows of patient information are justified and secure, and this role is known as the Caldicott Guardian.

Information Governance training is mandatory for all staff, to ensure that staff are aware of their information governance roles and responsibilities. The CCG achieved the required levels of training for 2016-17 at 98%. (Minimum 95% completion of basic training) and specialised staff have the necessary additional training.

The IG Training Tool provided online by NHS Digital was withdrawn in December 2016 and the replacement tool is expected to be available in spring 2017. The CCG will review its Training Needs Analysis and related documents once the new system is functional.

There are processes in place for incident reporting and investigation of serious incidents. Data security incidents are reported via the CCG's incident reporting app and notified to the Information Governance Manager for investigation.

Information Governance Awareness - It is important to ensure that Information Governance is embedded across the CCG through communications, presentations and bulletins and by 'testing' compliance. Evidence of this nature would allow the CCG to demonstrate continued improvement. An informal unannounced walk-round in March 2017 showed excellent levels of compliance and understanding from CCG staff.

Business Critical Models

North East Lincolnshire Clinical Commissioning Group recognised the principles as reflected in the Macpherson report as a direction of travel for business modelling in respect of service analysis, planning and delivery. A quality assurance framework is being developed as part of the Quality Strategy this will be used for all business critical models in line with recommendations in the Macpherson report

In line with the Macpherson report we recognise and have identified that policy simulation (its impact on people and finances), forecasting, financial evaluation, allocation, workforce, procurement and planning are key areas where we use models.

The main CCG critical model is our long term financial model, the output of which is subject to NHS England assurance and audit review.

As part of this process, and to provide effective risk management, there are a range of business critical models in place:-

- Financial reporting
- Business Intelligence reporting.
- Customer Care (PALS & Complaints)
- Risk Assessment (including risk registers and an assurance framework).
- Internal and External Audit.
- Corporate Action Plan
- Document Control process.
- Public and Patient Involvement and Engagement. (Community Forum /ACCORD membership)
- Third Party Assurance mechanisms (Service Auditor reports / NHS England/ Business Continuity)

Third Party Assurances

Internal and external auditors have been appointed to provide the Partnership Board with independent assurance of its process of internal control and to assure itself of the validity of this Governance Statement. Throughout the year a series of audits have been undertaken to review the effectiveness of governance systems. The reports from these audits are submitted to the Integrated Governance & Audit Committee.

Audit reports generally contain recommendations for improvement and associated action plans. All actions are assigned to a senior manager with responsibility to complete within a designated timescale. Managers are held to account by the Integrated Governance & Audit Committee for the completion of all actions.

During 2016/17 the CCG contracted with a number of external organisations for the provision of support services; the largest of these arrangements were with:

- the eMBED Health Consortium, who provide GPIT, Corporate IT, Information Governance, Human Resources & Finance support, and
- North East Commissioning Support (NECS) who provide Medicines Management, Individual Funding Request (IFR), Non Contract Activity Support, and Data Services for Commissioning Regional Offices (DSCRO) support

Other bought-in support services include payroll services from Northumbria Healthcare NHS Foundation Trust, and a number of specific Adult Social Care support services (notably finance) from North East Lincolnshire Council.

For each of the material systems where transactions are handled by third parties the CCG has gained assurance via the following:

- External assurance e.g. Service Auditor reports
- Work undertaken by the East Coast Audit Consortium and the internal auditors of NE Lincolnshire Council
- Internal work undertaken by the CCG

I have been advised that adequate assurances have been provided for 2016/17 for the services bought by the CCG

Control Issues

Our internal auditors independently assessed our compliance with the Information Governance Toolkit (February 2017). The audit objective was to review and assess the evidence in place to support compliance with the nationally defined Information Governance Standards to ensure that valid evidence supported the CCG's own Information Governance assessment for 2016/17.

The work was undertaken with the support of, and input from the Information Governance (IG) Team within eMBED Health Consortium who updates and maintains our Information Governance Toolkit as part of a wider service contract. Assurances of the quality of evidence provided, internal audit provided ***significant assurance*** on the information provided.

The CCG maintains an Information Asset Register (IAR). The Information Asset Owners (IAOs) are responsible for managing information risks to the assets within their control. This involves developing system security policies and business continuity plans as well as documenting their personal data information flows, updating asset registers and conducting regular information risk assessments. The IAR must document the legal basis for processing any personal confidential data (PCD).

The Senior Information Risk Owner (SIRO) is responsible for overseeing the development and implementation of the CCG's Information Risk Strategy. The SIRO is supported in this by the information governance leads, eMBED and by the IAOs within each business area.

During 2016/17 the IG Team completed a risk assessment of data flows for all identified information assets. A summary report has been signed off by the SIRO which has confirmed that no identified data flow is classed as high risk and that all information processing has clear legal justification for the activity identified.

The CCG has arrangements in place to ensure data security. It has contractual arrangements in place with an accredited IT provider eMBED Health Consortium. The CCG also uses national IT systems such as SBS financials.

The CCG recognises the importance of maintaining data in a safe and secure environment. The investigation of incidents is supported by the eMBED IG Team. For the 2016-17 year, there have been ***five*** minor IG related incidents and ***two*** serious incidents. The two incidents relate to data security breaches; these have been assessed and graded as a level 2 and externally reportable to Information Commissioners Officer (ICO) and Department of Health (DoH). Both incidents have been entered on the IG toolkit. The incidents have also been logged as a serious incident on Strategic Executive Information System (Steis) and will be subject to the NHS England Serious Incident Framework for scrutiny by NHS England.

Incident 1

Unlocked electronic folders - Access to files containing personal data has been open to access by all staff employed by the CCG. The incident is being managed internally by a dedicated Root Cause Analysis (RCA) reviewer and reported updates to Serious Incident Group and Integrated Governance & Audit Committee.

The Information Commissioners Office (ICO) has provided a report to the CCG, ICO concluded that;

"there has been a potential breach of the seventh data protection principle…We have considered the information you have provided and we have decided that no further action is necessary at this stage"

The following recommendations (for consideration) were provided by the ICO:

1. Review your policies and procedures for handling data in this area.
2. Review your approach to staff training, including putting the correct restrictions in place.

These recommendations will be considered as part of the serious incident report/action plan for 2017/18.

Following the above incident various measures to ensure future and on-going compliance with the Data Protection Act 1998 have been completed:

- All folders that have been identified as holding such information (for clients, carers, staff or any other individual) have been moved to a fully secure area that is operated with additional access security controls.
- The IAR was also reviewed to ensure that all PCD processed by the CCG was accounted for and held in secure folders with controlled access.
- A new handbook was circulated to all staff in 2017 to ensure IAOs are fully aware of their responsibilities.
- Incident reporting process map developed and incorporated within Information Governance Framework & Strategy.
- Various communications have been circulated to staff via the SIRO and a briefing at a Timeout was conducted– "Handling confidential emails safely".

Incident 2

Adult Social Care - service user records left in a secure property by the owner of Care Home post closure. The incident is being managed internally by a dedicated Root Cause Analysis (RCA) reviewer and reported updates to Serious Incident Group and Integrated Governance & Audit Committee.

The Information Commissioners Office (ICO) contacted the CCG to request further information, this request was completed. The ICO have made an additional request in March 2017 for additional information. This request has been completed and we await response from the ICO.

Following the above incident various measures to ensure future and on-going compliance with the Data Protection Act 1998 have been completed.

- An Adult Social Care practitioner attended the CCG and found that there were records relating to 9 individuals; 3 have since passed away with 2 out of 3 having passed away before the home closed. Therefore 7 out of 9 records were returned to the home the individual currently resides at, or passed away at.
- The documents were signed out of the CCG building and the current care home signed them into their possession and filed them in accordance with retention legislation.
- The remaining 2 records have been stored at the CCG to be destroyed in line with retention requirements.

- Adult Social Care are responsible for the documents and under the Section 75 agreement between the Council and the CCG.
- It is the CCG's responsibility to gain assurances for the security of the documents and retention under home closures.
- NELCCG Met with the focus adult social care practitioner involved in the closure of the home and the re-provision of services to a new provider for the remaining residents to discuss the process of a home closure and how to improve the existing procedure to mitigate the risk of a reoccurrence.
- Review of the North East Lincolnshire CCG, North East Lincolnshire Council and focus policies and procedures in relation to home closures and the retention of documents.
- NELCCG met with the Advanced Practitioner (AP) within focus to discuss the action going forward for any care home closure. The AP agreed to discuss at the next Advanced Practitioner meeting.

The final serious incident report was signed off by the Director of Adult Services & the Director of Quality and Nursing on the 20 March 2017 and taken through the NELCCG Serious incident meeting for review on the 29 March 2017 - where it gained an Assured Status.

Additional actions identified following the conclusion of the serious incident reports will be considered and implemented where required during 2017/18.

Review of Economy, Efficiency and Effectiveness of the use of Resources

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically in accordance with the NHS principles of good governance.

Our constitution delegates responsibility to ensure appropriate arrangements are in place for the CCG to fulfil this duty to the Integrated Governance & Audit Committee and requires that this committee undertakes functions as set out in its Terms of Reference as agreed by the Governing Body. The Partnership Board receives a comprehensive finance report from the Chief Financial Officer at every meeting, where open challenge takes place.

The *Chief Financial Officer* is a member of the Governing Body and is responsible for providing financial advice to the group and for supervising financial control and accounting systems. The role of Chief Financial Officer includes:

- Being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
- Making appropriate arrangements to support, monitor on the CCG's finances;
- Overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources;
- Being able to advise the Governing Body on the effective, efficient and economic use of the CCG's allocation to remain within that allocation and deliver required financial targets and duties;
- Producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;
- Being the Governing Body lead officer for Business Information Intelligence.

The *Integrated Governance & Audit Committee* receives regular reports on financial governance, monitors the internal audit programme and reviews the draft and final annual accounts. The CCG has a programme of internal audits that provides assurance to the Governing Body & Integrated Governance & Audit Committee on the effectiveness of its internal processes.

The CCG's annual accounts are reviewed by the Integrated Governance & Audit Committee and audited by our external auditors.

Internal Audit is responsible for assessing the effectiveness of the system of internal control within the CCG, details of which are summarised in the Head of Internal Audit Opinion Statement which is presented to the Governing Body and Integrated Governance & Audit Committee annually.

Third party assurances (where available) are provided where services are provided by external bodies.

The CCG has in place a number of processes, procedures and governance arrangements to ensure that the services it commissions are delivering best value and outcomes and that any associated risks are adequately managed. The Service Proposal Management Tool is a process to support the CCG's procurement and business planning process. This online tool allows any individual, practice or group providing services to the CCG to submit an idea for service provision or reorganisation which improves quality or efficiency or contributes to the transformation of health or social care in our area. It ensures that all business cases are assessed by each service triangle, an endorsement panel and approved by the CCG Care Contracting Committee.

All cases submitted for approval via the Service Proposal Management Tool are assessed against the same criteria so that they are able to deliver an equal or improved quality of service for less expenditure than is currently committed, or to increase the safety and quality of the service currently in place for the population of North East Lincolnshire. In addition, it also considers any possible equality and diversity implications of the proposed service, further reducing potential risk to the organisation. The aim of the tool is to increase efficiency and value the CCG gets for its investment into services with providers.

For established contracts, the contracts team and contract leads monitor progress on a monthly basis. The contracts team for Adult Social Care visit residential home providers to ensure they meet the quality standards that the CCG has set out and contract leads will hold to account other providers at regular meetings to ensure the services performance and quality have been met as per the contract. These meetings will inform the key performance indicators (KPI's) and Commissioning for Quality and Innovation Indicator (CQUINS) measurement. Providers can be financially penalised for failing to meet these measurements, e.g. A&E 4 hour waiting times.

Please refer to our website for details of Contracts awarded.

The CCG performance, across its whole commissioning agenda, is monitored internally by the Delivery Assurance Committee and the Quality Committee, where any contract issues will be discussed and identified for further investigation or action. The CCG has effective commissioning and contract monitoring processing in place to ensure that funding is used effectively and efficiently.

During Quarter 4, the CCG has undertaken a self-assessment against the *Quality of Leadership* domain of the CCG Improvement & Assessment Framework 2016/17. This 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.

It shows the organisation's assurance against the key indicators within this component of the framework, with any gaps in assurance and any mitigating actions. NHS England publishes a rating for each domain for each CCG, the latest available results for Quarter 2 2016/17 can be found on **My NHS**.

Our overall assessment for the quality of leadership indicator will be available from July 2017 on **My NHS**.

Delegation of functions

The CCG's Accountable Officer (AO) delegates responsibilities within the organisation so as to control its business. The systems used to do this provide adequate insight into the business of the organisation and its use of resources to allow the AO to make informed decisions about progress against business plans and, if necessary may also rely on information from the following:-

- The Chief Financial Officer
- Senior Management Team
- Clinical Leads

The CCG receives a wide range of assurances regarding business, use of resources and responses to risk through the delegation of functions both internally and externally to support the organisation

- Service Auditor Reports (*further details can be found in third party assurances section)*
- Internal Audit work
- KIER/EMBED Business Assurance (*third party assurances section)*
- Routine monitoring of the contracts we have in place throughout the year

Counter Fraud Arrangements

The Integrated Governance and Audit Committee has assured itself that the organisation has adequate arrangements in place for countering fraud and regularly reviews the outcomes of counter fraud work.

The CCG has an accredited Local Counter Fraud Specialist (LCFS) in place to undertake work against NHS Protect Standards; the LCFS resource is contracted in from East Coast Audit Consortium and is part of a wider Fraud Team resource with additional LCFS resource available as and when required. The Chief Financial Officer is accountable for fraud work undertaken and a Counter Fraud Annual Report (detailing counter fraud work undertaken against each standard) is reported to the Integrated Governance & Audit Committee annually.

There is an approved and proportionate risk based counter-fraud plan in place which is monitored at each Integrated Governance & Audit Committee meetings. In line with NHS Protect Commissioner Standards, this first became effective 1st April 2015 and is reviewed annually.

The CCG completed an online Self Review Tool (SRT) quality assessment in March 2017 to assess the work completed around anti-fraud, bribery and corruption work and assessed itself as a *'Green'* rating. This self-assessment detailing our scoring was approved by Chief Financial Officer prior to submission. Should a NHS Protect quality assurance inspection be undertaken then any recommendations would be acted upon – to date the CCG has not been subject to an NHS Protect quality inspection.

During 2016-17 to raise Anti-Crime Awareness to CCG staff the LCFS undertook a walkabout within the CCG premises distributing leaflets, posters and freebies and to chat to staff about any aspects of crime awareness and give advice on what to look out for and how to report crime. A short survey was also conducted to assess the levels of crime awareness with staff and the results feed into the self-assessment submissions to NHS Protect for fraud and security.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's systems of risk management, governance and internal control. The Head of Internal Audit concluded 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 weaknesses in the design or inconsistent application of controls put the achievement of a particular objective at risk

During the year internal audit issued audit reports:

Area of Audit	Level of Assurance Given
Assurance Framework	Significant Assurance
Procurement	Significant Assurance
Home Care Contracts	Significant Assurance
Incident Management	Significant Assurance
Partnership Working	Significant Assurance
Extra Care Housing	Significant Assurance
Patient & Stakeholder Engagement	Significant Assurance
Conflict of Interest	Significant Assurance
Supported Living	Significant Assurance
Lead Provider Framework (LPF) Arrangements - eMBED	Significant Assurance
Information Governance	Significant Assurance

At the time of the opinion, the following reviews are in progress still to be completed:
Financial Management – MTFP & Financial Viability
Adult Social Care Financial Systems
Residential Care Contracts

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 and the executive managers and clinical leads within the clinical commissioning group 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 management letter and other reports.

Our Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principle objectives have been reviewed.

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, Integrated Governance & Audit Committee, Delivery Assurance Committee, and the Quality Committee. Plans to address weaknesses and ensure continuous improvement of the system are in place.

The Governing Body plays a key role in ensuring that the organisation consistently follows the principles of good governance applicable to NHS organisations. This includes the oversight of systems and processes for financial control, organisational control, clinical governance and risk management.

The **Integrated Governance & Audit Committee** reviews the CCG's financial reporting and internal control principles and ensures that an appropriate relationship with both internal and external auditors is maintained. It approves a comprehensive risk management system , internal control, including budgetary and Information Governance controls that underpin the effective, efficient and economic operation of the CCG. It undertakes an annual self-assessment of its own performance. All duties are reflected within the CCG's constitution and the Integrated Governance & Audit Committee Terms of Reference.

The **Delivery Assurance Committee** oversees the continuous development of the organisation's internal performance and delivery assurance framework, encompassing balanced scorecard and exception reporting. The committee provides delivery assurance to the Partnership Board that there are robust structures, processes and accountabilities in place for managing performance and delivery throughout the organisation.

The **Quality Committee** provides assurance to the Partnership Board on the clinical governance arrangements in commissioned services and ensuring these are being delivered in a high quality and safe manner. In addition, the delivery of governance and statutory requirements as identified by the Governing Body as being within the remit of the committee.

The **Community Forum Committee** challenges the CCG to ensure that patient and public involvement in the design and delivery of local health and wellbeing services has been effective and meaningful.

My review was particularly informed by:

- Quarterly Assurance reports to NHS England.
- Conflict of interest self-certifications
- Our overall assurance assessment for Quality of Leadership indicator will be available from July 2017 on **My NHS**.
- Internal Audit reviews of systems of internal control and progress reports to the Integrated Governance & Audit Committee.
- External Audit providing progress reports to the Integrated Governance & Audit Committee, the Annual Management Letter and their annual value for money conclusion.
- Regular summary reports to the Partnership Board from each of the CCG's formal committees and the Community Forum
- Assurance received from the Integrated Governance & Audit Committee, on the CCG's governance, risk management and internal controls. Review of the Board Assurance Framework. Action plans to address any identified weaknesses, and ensure continuous improvement of the system, are in place via action plan embedded within the Board Assurance Framework and the Risk Register capturing key risks across the spectrum of corporate governance.
- A self-assessment undertaken by the Integrated Governance & Audit Committee to ensure adherence to the principles contained within the NHS Audit Committee Handbook.
- Regular performance reports to Delivery Assurance Committee and quality reports to the Quality Committee
- Adult Social Care Peer Review
- Adult Social Care Local Account
- Annual reviews of Governing Body and Partnership Board committees/sub-committees Terms of Reference
- The results of staff and stakeholders surveys.

The Integrated Governance & Audit Committee annual report was presented to the Governing Body on 9th March 2017, detailing the outcomes of the review of the effectiveness of the committee. The report assured the members of the effective governance arrangements of the organisation, and specifically that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance.

Conclusion

During 2016/17 the CCG has developed and strengthened its system of internal control. The Governance Framework is clearly articulated within our constitution and is underpinned by our Information Governance Framework & Strategy and Risk Management Strategy. Our refreshed Board Assurance Framework ensures that strategic risks are identified and managed effectively. All internal audit reports issued during the year provided either full or significant assurance that controls were suitably designed, consistently applied and effective.

The Head of Internal Audit Opinion states that the CCG can take "significant assurance" that there is a generally sound system of internal control which is designed to meet the CCG's objectives, and that controls are generally being applied consistently. I am therefore satisfied that the CCG operates effective and sound systems of internal control. *Please refer to Head of Internal Audit section of this report for full details.*

Signature

Dr Peter Melton
Accountable Officer

Date

2.2 Remuneration & Staff Report

2.2.1 Remuneration Committee Members

The Remuneration Committee is a formal sub-committee of the Governing Body whose members were appointed by the Governing Body. In 2016/17, members and attendees were:

Voting Members		
Name		**Attendance (Max 2 meeting)**
Mark Webb (Chair)		2 (2)
Dr David Elder Council of Members GP Representative		2 (2)
Susan Whitehouse Lay Member Governance & Audit	Left September 2016	1 (1)
Tim Render Lay Member Governance & Audit	Joined September 2016	1 (1)
Dr Thomas Maliyil (Vice Chair) Chair of Council of Members (CoM)		0 (2)
Councilor Matthew Patrick Portfolio Holder for Finance and Resources, (NELC)		0 (2)
Other attendees:		
Cathy Kennedy, * Chief Financial Officer/ Deputy Chief Executive	Left December 2016	2 (2)
Helen Kenyon Deputy Chief Executive	Joined January 2017	0 (0)
Emma Kirkwood ** Human Resources Business Partner		2 (2)

** attends to present papers from the CCG*

*** attends to advise the panel on HR implications*

The Remuneration Committee met ***twice*** during the financial year to address agenda requirements, at all times the process followed good principles of governance with special reference to conflicts of interest and the requirements of the terms of reference.

The meeting were quorate.

Senior managers' contracts and payments

Very Senior Manager (VSM) pay was in line with the national guidance entitled "Clinical Commissioning Groups Remuneration Guidance for Chief Officers" (where the senior manager also undertakes the Accountable Officer role & Chief Financial Officer's guidance).

As part of the VSM framework and contract of employment these senior managers are eligible for access to a non-consolidated bonus based on their annual performance. The decision to make a non-consolidated bonus payment is made by the remuneration committee.

All VSMs are employed on permanent contracts, with notice periods and termination being in line with national guidelines.

2.2.2 Salaries & Allowances

Pension related benefit is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year adjusted for inflation. The difference is then multiplied by 20 which represents the average number of years an employee receives their pension (20 years is a figure set out in the CCG Annual Reporting Guidance. These figures do not represent actual cash payments. It should be noted that the GP representative figures are affected by previous employments in non-practitioner roles which can lead to a distortion in the numbers.

2016-17 Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term Performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Dr P Melton, Clinical Chief Officer	85-90					85-90
Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer (left Dec16)	75-80				22.5- 25.0	100 -105
Helen Kenyon, Deputy Chief Executive	95-100				30.0 -32.5	125-130
Jan Haxby, Director of Quality and Nursing	80-85				45.0 – 47.5	125 -130
Laura Whitton Interim Chief Financial Officer (Started Jan17)	20-25				5.0 -7.5	25.30
Mark Webb, Chair	20-25					20-25
Dr D Hopper, Vice Chair of Council of Members	5-10					5-10
Philip Bond, Lay member Community Engagement	5-10					5-10
Dr Arun Nayyar, GP Representative	5-10				2.5 – 5.0	10-15
Dr Rakesh Pathak, GP Representative	5-10				2.5 – 5.0	10-15
Susan Whitehouse, Lay Member Governance & Audit (left Sept16)	5-10					5-10
Tim Render, Lay Member Governance & Audit (started Aug16)	5-10					5-10
Cllr Matthew Patrick, Portfolio Holder for Finance and Resources NELC	5-10				2.5 – 5.0	10-15
Cllr Jane Hyldon-King, Portfolio Holder for Health, Wellbeing and Adult Social Care NELC	5-10				2.5 – 5.0	10-15
Dr Thomas Maliyil, Vice CCG Chair / Chair of Council of Members (CoM)	5-10				22.5 -25.0	30-35
Nicky Chatterton,(Known as Nicky Hull) Locally practicing nurse (left post 31 March 2017)	0-5					0-5
Dr D James, Secondary Care Doctor	10-15					10-15
Juliette Cosgrove, Strategic Nurse	5-10					5-10
Joe Warner, Partnership Board Social Care Representative	0-5					0-5
Stephen Pintus, Director of Public Health	0-5					0-5

2015-16 Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term Performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) Total (a-e) (bands of £5,000)
Dr P Melton, Clinical Chief Officer	85-90					85-90
Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer	100-105		0.0-5.0		12.5-15.0	120-125
Helen Kenyon, Deputy Chief Executive	95-100				40.0-42.5	135-140
Jan Haxby, Director of Quality and Nursing (Started Jul15)	55-60				72.5-75.0	130-135
Mark Webb, CCG Chair	20-25					20-25
Dr D Hopper, Vice CCG Chair & Chair of Council of members	5-10					5-10
Philip Bond, Lay member Community Engagement	5-10					5-10
Dr Arun Navyar, GP Representative	5-10				5.0-7.5	15-20
Dr Rakesh Pathak, GP Representative	5-10				2.5-5.0	10-15
Cllr Michael Burnett, Portfolio Holder for Tourism & culture NELC (Deceased 1/6/15)	0-5					0-5
Susan Whitehouse, Lay Member Governance & Audit	10-15					10-15
Cllr Matthew Patrick, Portfolio Holder for Finance and Resources NELC (started June 16)	5-10				0.0-2.5	5-10
Cllr Jane Hyldon-King, Portfolio Holder for Health, Wellbeing and Adult Social Care NELC (started June 16)	5-10				0.0-2.5	5-10
Dr Thomas Maliyil, GP Representative	10-15				52.5-55.0	65-70
Nicky Chatterton, (known as Nicky Hull) NEL Primary Care (non-GP) Member (Started Apr15)	0-5					0-5
Dr D James, Secondary Care Doctor (started Nov15)	5-10					5-10
Juliette Cosgrove, Strategic Nurse	5-10					5-10
Joe Warner, Partnership Board Social Care Representative	0					0
Stephen Pintus, Director of Public Health	0					0

2.2.3 Pension Benefits

It is important to note that the pension benefit figures for the GPs relate to their non-practitioner employment only and the pensionable pay figure is grossed up to reflect a whole time equivalent post. The pension data used in these calculations has been provided by the Business Services Authority. Whilst this will include, the work undertaken in their capacity as a senior manager of the CCG it might also include other, non-practitioner work. These pension benefit figures will also include contributions made in previous employments in a non-practitioner role.

Certain Members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain Members.

The CCG has not made any payments in respect of compensation on early retirement, the loss of office, or payments to past directors.

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Name and title	**Real increase in pension at age 60 (bands of £2,500)**	**Real increase in pension lump sum at aged 60 (bands of £2,500)**	**Total accrued pension at age 60 at 31 March 2017 (bands of £5,000)**	**Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)**	**Cash Equivalent Transfer Value at 1 April 2016**	**Real increase in Cash Equivalent Transfer Value**	**Cash Equivalent Transfer Value at 31 March 2017**	**Employer's contribution to stakeholder pension**
	£000	£000	£000	£000	£000	£000	£000	£000
Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer	0.0-2.5	2.5-5.0	40-45	120-125	712	24	769	
Helen Kenyon, Deputy Chief Executive	0.0-2.5	0.0-2.5	30-35	90-95	479	22	514	
Jan Haxby, Director of Quality and Nursing	0.0-2.5	5.0-7.5	30-35	90-95	517	49	577	
Laura Whitton, Interim Chief Finance Officer	0.0-2.5	0.0-2.5	20-25	70-75	425	6	452	
Dr Arun Nayyar, GP Representative	0.0-2.5	0.0-2.5	10-15	30-35	195	-1	195	
Dr Rakesh Pathak, GP Representative	0.0-2.5	0.0-2.5	05-10	25-30	123	11	136	
Dr Thomas Maliyil, Vice CCG Chair / Chair of Council of Members (CoM)	0.0-2.5	7.5-10	10-15	35-40	184	42	227	
Cllr Jane Hyldon-King, Portfolio Holder for Health, Wellbeing and Adult Social Care NELC	0.0-2.5	0.0-2.5	0-05	0-5	0	0	0	
Cllr Matthew Patrick, Portfolio Holder for Finance and Resources NELC	0.0-2.5	0.0-2.5	0-05	0-5	1	1	2	

2.2.4 Cash Equivalent Transfer Values

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that an individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement when 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.

2.2.4.1 Real increase in CETV

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

2.2.5 Pay Multiples

Year	2016/17	2015/16
Band of highest paid director's total remuneration (£'000)	120-125	120-125
Median total	26,018	26,698
Ratio	4.7	4.6

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, in North East Lincolnshire Clinical Commissioning Group in the financial year 2016-17 was £120,000 - £125,000. (2015-16 £120,000 - £125,000). This was 4.7 times (2015-16 4.6) the median remuneration of the workforce, which was £26,018 (2015-16 £26,698).

In 2016-17, no (2015-16, no) employees received remuneration in excess of the highest-paid director as per the remuneration table. Remuneration ranged from £2,786 to £97,323 (2015-16 £2,786 to £106,229).

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

2.2.6 Staff Report

a) Number of directors (or equivalent)

Directors are remunerated with the national guidance entitled "Clinical Commissioning Groups Remuneration Guidance for Chief Officers' detailed in section 2.2.1. Please refer to section c below for numbers.

b) Employee Benefits and Staff Numbers (see following page for 2015-16)

	Admin			Programme			Total		
2016-17	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee benefits									
Salaries and wages	2,485	108	**2,593**	381	58	**439**	2,866	166	**3,032**
Social security costs	260	11	**271**	38	0	**38**	298	11	**309**
Employer Contributions to NHS Pension scheme	357	13	**370**	34	0	**34**	391	13	**404**
Other pension costs	0	0	**0**	0	0	**0**	0	0	**0**
Other post-employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Other employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Termination benefits	8	0	**8**	0	0	**0**	8	0	**8**
Gross employee benefits expenditure	**3,110**	**132**	**3,242**	**453**	**58**	**511**	**3,563**	**190**	**3,753**
Less recoveries in respect of employee benefits (note 4.1.2)	(80)	0	(**80**)	(9)	0	(**9**)	(89)	0	(**89**)
Total - Net admin employee benefits including capitalised costs	**3,030**	**132**	**3,162**	**444**	**58**	**502**	**3,474**	**190**	**3,664**
Less: Employee costs capitalised	0	0	**0**	0	**0**	0	0	0	**0**
Net employee benefits excluding capitalised costs	**3,030**	**132**	**3,162**	**444**	**58**	**502**	**3,474**	**190**	**3,664**

Employee Benefits and Staff Numbers Continued.

	Admin			Programme			Total		
2015-16	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee benefits									
Salaries and wages	2,350	55	2,405	324	112	436	2,674	167	2,841
Social security costs	201	1	202	23	0	23	224	1	225
Employer Contributions to NHS Pension scheme	343	1	344	32	0	32	375	1	376
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	43	0	43	0	0	0	43	0	43
Gross employee benefits expenditure	**2937**	57	**2994**	**379**	**112**	**491**	**3316**	**169**	**3485**
Less recoveries in respect of employee benefits (note 4.1.2)	(21)	(0)	(21)	(0)	(0)	(0)	(21)	(0)	**(21)**
Total - Net admin employee benefits including capitalised costs	**2,916**	**57**	**2,973**	**379**	**112**	**491**	**3295**	**169**	**3464**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,916**	**57**	**2,973**	**379**	**112**	**491**	**3,295**	**169**	**3,464**

C) Staff composition

The CCG has a staffing establishment of 79.48 whole time equivalents, in its headquarters functions, and also has formal arrangements in place to buy in a range of support services from a number of different providers at a cost of £2.2 million in 2016/17.

The number of persons of each sex who were directors (or equivalent) and employees of the company as detailed in the table to the right.

Pay Band	Total (Female)	Total (Male)
Governing body	5	9
Partnership Board	6	10
Band 8a	4	1
Band 8b	4	3
Band 8c	2	1
Band 8d	1	1
Band 9	0	0
VSM (**counted in Governing Body**)	0	0
Any other Spot Salary	0	0
All other employees **(including apprentice)**	54	12

D) Sickness absence data

The sickness rate at the CCG headquarters is 2.01%, the majority of the sickness absence is classed as long term sickness. In terms of short term sickness "*Cold, Cough, Flu – Influenza*" remains high, whilst *"Cold, Cough, Flu – Influenza"* shows as the highest percentage of episodes over the year, the reason *"Other"* known causes - *not elsewhere classified'* is shown as the second highest percentage. Turnover rate of employees in 2016/17 has increased to 1.51% compared to that of 0.91% in 2015/16

All sickness absence at the CCG is managed in line with the Attendance Management policy; this policy enables managers to address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner. It is recognised however that all cases must be dealt with on an individual basis because of differing circumstances. Managers and staff have access to the Occupational Health Service and Counselling services as appropriate.

The sickness data provided are calendar year figures (January - December 2016)

Figures converted by DH to best estimates of required Data Items			Statistics Published by HSCIC from ESR Data Warehouse	
Average FTE 2016	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
79	211	2.7	28,989	342

The sickness absence data is included in the employee benefits note 4.3 of the Financial Statements

E) Staff policies applied during the financial year

As an employer we actively work to remove any discriminatory practices, eliminate all forms of harassment and promote equality of opportunity in our recruitment, training, performance management and development practices. The CCG has a number of policies and processes in place to support this.

Policies ratified during 2016/17 are as follows:

Attendance Management Policy
Recruitment and Selection Policy
Disciplinary Policy
Grievance Policy
Retirement Policy
Smoking Policy
Induction & Probationary period policy
Managing Stress in the workplace policy
Redeployment Policy
Pay Protection Policy
Starting Salaries Policy

F) Expenditure on consultancy

Further details in relation to expenditure on consultancy can be found in note 5 in the Financial Statements.

2.2.7 Off Payroll engagements

Off payroll engagements are any and all engagements for the services of an individual where payment is not made through payroll, and therefore after the deduction of income tax and national insurance. This therefore includes all payments to GP practices as well as payments to individuals who claim to be self-employed, and are therefore paid through accounts payable.

Assurance is gained for all off payroll engagements by receiving a signed declaration from individuals.

New off payroll legislation has come into effect from 6th April 2017 and the responsibility for deciding if the legislation should be applied, shifts from the worker's intermediary to the public authority the worker is supplying their services to. The CCG has put in additional processes to ensure it meets its new duties around off payroll legislation.

Off payroll engagements as of 31st March 2017, for more than £220 per day and that last longer than 6 months are as follows:

	Number
Number of existing engagements as of 31 March 2017	31
Of Which, the number that have existed:	
• For less than 1 year at the time of reporting	8
• For between 1 and 2 years at the time of reporting	5
• For between 2 and 3 years at the time of reporting	11
• For between 3 and 4 years at the time of reporting	7
• For 4 or more years at the time of reporting	0

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	8
Number of new engagements which include contractual clauses giving the Clinical Commissioning Group the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	8
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

	Number
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.	26

2.2.8 Exit Packages and Severance Payments

Further details in relation to Exit Packages can be found in note 4.4 in the Financial Statements

2.2.9 External Audit

The Audit Commission appointed KPMG as the CCG's auditors for a 4 year period starting in the year 2013/14. Auditors' remuneration in relation to April 2016 to March 2017 totalled £46,500.00 (excluding VAT).

This covered audit services required under the National Audit Office's Code of Audit Practice (giving opinion on the Annual Accounts and Value for Money conclusion).

Our Integrated Governance & Audit Committee receives our external auditor's Annual Audit Letter and other external audit reports. The external auditor is required to comply with the Public Sector Audit Appointments standard in respect of independence and objectivity and with International Auditing Standard 260 for UK & Ireland (Standard 260: The auditor's communication with those charged with governance).

Work undertaken by the external auditor during financial year 2016/17 is summarised as follows

- Audit services: the statutory audit and services carried out in relation to the statutory audit (e.g. reports to NHS England)

Signature

Dr Peter Melton
Accountable Officer

Date

Financial Statements 3.0

3.1 Foreword to the Accounts

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2017 have been prepared by NHS North East Lincolnshire Clinical Commissioning Group under section 232 (schedule 15.3(1) of the National Health Service Act 2006 in the form which the Secretary of State has, within the approval of the Treasury, directed.

Signature

Dr Peter Melton
Accountable Officer

Date

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS NORTH EAST LINCOLNSHIRE CCG

We have audited the financial statements of NHS North East Lincolnshire CCG for the year ended 31 March 2017 on pages 109 to 142 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 55, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the

purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2017 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Certificate

We certify that we have completed the audit of the accounts of NHS North East Lincolnshire CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

John Graham Prentice FCCA MBA
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants

1 Sovereign Square
Sovereign Street
Leeds LS1 4DA

26 May 2017

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(1,002)	(479)
Other operating income	2	(49,685)	(48,001)
Total operating income		**(50,687)**	**(48,480)**
Staff costs	4	3,753	3,485
Purchase of goods and services	5	271,567	266,331
Depreciation and impairment charges	5	0	0
Provision expense	5	576	336
Other Operating Expenditure	5	775	618
Total operating expenditure		**276,671**	**270,770**
Net Operating Expenditure		**225,984**	**222,290**
Finance income		0	0
Finance expense	10	0	0
Net expenditure for the year		**225,984**	**222,290**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**225,984**	**222,290**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Net Actuarial (gain)/loss in pension schemes		1,023	(3,533)
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		1,023	(3,533)
Comprehensive Expenditure for the year ended 31 March 2017		**227,007**	**218,757**

The notes on pages 113 to 142 form part of this statement

Statement of Financial Position as at 31 March 2017

		31 March 2017	31 March 2016
	Note	**£'000**	£'000
Non-current assets:			
Property, plant and equipment	13	0	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		0	0
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	4,531	6,452
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	10	13
Total current assets		**4,541**	6,465
Non-current assets held for sale	21	0	0
Total current assets		**4,541**	6,465
Total assets		**4,541**	6,465
Current liabilities			
Trade and other payables	23	(13,878)	(15,577)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(847)	(486)
Total current liabilities		**(14,725)**	(16,063)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(10,184)**	(9,598)
Non-current liabilities			
Trade and other payables	23	(3,191)	(2,111)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	(8)
Total non-current liabilities		**(3,191)**	(2,119)
Assets less Liabilities		**(13,375)**	(11,717)
Financed by Taxpayers' Equity			
General fund		(7,834)	(7,199)
Revaluation reserve		0	0
Other reserves		(5,541)	(4,518)
Charitable Reserves		0	0
Total taxpayers' equity:		**(13,375)**	(11,717)

The notes on pages 113 to 142 form part of this statement

The financial statements on pages 109 to 112 were approved by the Information Governance & Audit Committee on 26th May 2017 and signed on its behalf by:

Peter Melton
Accountable Officer
26 May 2017

Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(7,199)	0	(4,518)	**(11,717)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted balance at 31 March 2017	**(7,199)**	**0**	**(4,518)**	**(11,717)**
Changes in taxpayers' equity for 2016-17				
Net operating expenditure for the financial year	(225,984)	0	0	(225,984)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	(1,023)	(1,023)
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised Expenditure for the Financial Year	**(225,984)**	**0**	**(1,023)**	**(227,007)**
Net funding	225,348	0	0	225,348
Balance at 31 March 2017	**(7,834)**	**0**	**(5,541)**	**(13,375)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(7,540)**	**0**	**(8,052)**	**(15,592)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	**0**	**0**	**0**	**0**
Adjusted balance at 31 March 2016	**(7,540)**	**0**	**(8,052)**	**(15,592)**
Changes in taxpayers' equity for 2015-16				
Net operating costs for the financial year	(222,290)	0	0	(222,290)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	3,533	3,533
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised Expenditure for the Financial Year	**(222,290)**	**0**	**3,533**	**(218,757)**
Net funding	222,631	0	0	222,631
Balance at 31 March 2016	**(7,199)**	**0**	**(4,518)**	**(11,717)**

The notes on pages 113 to 142 form part of this statement

Statement of Cash Flows for the year ended 31 March 2017

	Note	**2016-17 £'000**	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year	45	(225,472)	(222,462)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	1,467	853
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(1,699)	(1,134)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(223)	(257)
Increase/(decrease) in provisions	30	576	336
Net Cash Inflow (Outflow) from Operating Activities		**(225,351)**	(222,664)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(225,351)**	(222,664)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		225,348	222,631
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**225,348**	222,631
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(3)**	(33)
Cash & Cash Equivalents at the Beginning of the Financial Year		**13**	46
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**10**	13

The notes on pages 113 to 142 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of CCG's shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCG's, 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 CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG 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 CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 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 Acquisitions & Discontinued Operations

Activities are considered to be „acquired" only if they are taken on from outside the public sector. Activities are considered to be „discontinued" only if they cease entirely. They are not considered to be „discontinued" if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Charitable Funds

Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities" accounts.

1.6 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the CCG is in a “jointly controlled operation”, the CCG recognises:

- The assets the CCG controls;
- The liabilities the CCG incurs;
- The expenses the CCG incurs; and,
- The CCG"s share of the income from the pooled budget activities.

If the CCG is involved in a “jointly controlled assets” arrangement, in addition to the above, the CCG recognises:

- The CCG"s share of the jointly controlled assets (classified according to the nature of the assets);
- The CCG"s share of the expenses jointly incurred.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the CCG"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.

1.7.1 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 CCG"s accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Bad Debt Provision
- Continuing Care Provision
- Local Government Pension Scheme as advised by the actuaries Hymans Robertson LLP

1.7.2 Key Sources of Estimation Uncertainty

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

- Secondary Care Activity; Counting and coding of secondary care is not finalised until after the completion of the audited annual accounts process in June. Assumptions have been made around the liabilities of this for the CCG with a range of secondary care providers based on a number of factors including historical activity performance and known changes in activity, as well as non PBR tariffed contract arrangements. The actual cost of activity will be different to the carrying amounts held in the Statement of Financial Performance and any variance will need to be managed in the Statement of Comprehensive Net Expenditure in the subsequent year. There is unlikely to be a significant change to the carrying value of assets and liabilities once activity is validated based on previous years out-turn verses actual.

- Prescribing - The full year figure is estimated on the spend for the first 10 months of the year

- Continuing Care - This is based upon the client data base of occupancy at the financial year end.

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

1.9.1 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.

1.9.2 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 CCG 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 CCG commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the CCG"s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.10 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 CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

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

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

1.11.2 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 CCG"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.

1.11.3 Subsequent Expenditure

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

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG's business or which arise from contractual or other legal rights. They are recognised only:

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

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

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

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

1.13 Depreciation, Amortisation & Impairments

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

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 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.

1.17.1 The CCG 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 CCG"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.

1.17.2 The CCG as Lessor

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

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

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The CCG therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract „lifecycle replacement".

1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within „operating expenses".

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the CCG"s approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to „finance costs" within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract („lifecycle replacement") are capitalised where they meet the CCG"s criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator"s planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a „free" asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the CCG to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the CCG"s Statement of Financial Position.

1.18.6 Other Assets Contributed by the CCG to the Operator

Assets contributed (e.g. cash payments, surplus property) by the CCG to the operator before the asset is brought into use, which are intended to defray the operator"s capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the CCG, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

1.19 Inventories

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

1.20 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 CCG"s cash management.

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

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

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

1.22 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the CCG 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 CCG.

1.23 Non-clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG 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.

1.24 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 CCG contribute annually to a pooled fund, which is used to settle the claims.

1.25 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the CCG makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.26 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.27 Financial Assets

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

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.27.1 Financial Assets at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the CCG"s surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 Available For Sale Financial Assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.27.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the CCG assesses whether any financial assets, other than those held at „fair value through profit and loss" are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset"s carrying amount and the present value of the revised future cash flows discounted at the asset"s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the CCG 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.

1.28.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the CCG"s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.28.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.29 Value Added Tax

Most of the activities of the CCG 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.

1.30 Foreign Currencies

The CCG"s functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the CCG"s surplus/deficit in the period in which they arise.

1.31 Third Party Assets

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

1.32 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 CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 Subsidiaries

Material entities over which the CCG has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary"s accounting policies are not aligned with the CCG or where the subsidiary"s accounting date is not co-terminus.

Subsidiaries that are classified as „held for sale" are measured at the lower of their carrying amount or „fair value less costs to sell".

1.34 Associates

Material entities over which the CCG has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the CCG"s accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the CCG"s share of the entity"s profit/loss and other gains/losses. It is also reduced when any distribution is received by the CCG from the entity.

Joint ventures that are classified as „held for sale" are measured at the lower of their carrying amount or „fair value less costs to sell".

1.35 Joint Ventures

Material entities over which the CCG has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as „held for sale" are measured at the lower of their carrying amount or „fair value less costs to sell".

1.36 Joint Operations

Joint operations are activities undertaken by the CCG in conjunction with one or more other parties but which are not performed through a separate entity. The CCG records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 Research & Development

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.38 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Admin £'000	2016-17 Programme £'000	2016-17 Total £'000	2015-16 Total £'000
Recoveries in respect of employee benefits	80	9	89	21
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	4
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies *	26	976	1,002	475
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue **	1,413	48,183	49,596	47,980
Total other operating revenue	**1,519**	**49,168**	**50,687**	**48,480**

** This relates to funding drawndown from North East Lincolnshire Council for specific schemes such as: Healthy Lives Healthy Futures, joint substance misuse team.*

*** This includes £39.8m in relation to the adult social care partnership agreement and £9.3m in relation to adult social care private client revenue. In 2015/16 these figures were £38.5m & £8m respectively. Further analysis can be found at note 35.*

3 Revenue

	2016-17 Admin £'000	2016-17 Programme £'000	2016-17 Total £'000	2015-16 Total £'000
From rendering of services	1,519	49,168	50,687	48,480
From sale of goods	0	0	0	0
Total	**1,519**	**49,168**	**50,687**	**48,480**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2016-17	Total	
Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits		
Salaries and wages	2,866	166	**3,032**
Social security costs	298	11	**309**
Employer Contributions to Pension Schemes	391	13	**404**
Other pension costs	0	0	**0**
Other post-employment benefits	0	0	**0**
Other employment benefits	0	0	**0**
Termination benefits	8	0	**8**
Gross employee benefits expenditure	**3,563**	**190**	**3,753**
Less recoveries in respect of employee benefits (note 4.1.2)	(89)	0	**(89)**
Total - Net admin employee benefits including capitalised costs	**3,474**	**190**	**3,664**
Less: Employee costs capitalised	0	0	**0**
Net employee benefits excluding capitalised costs	**3,474**	**190**	**3,664**

2015-16	Total	
Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits		
Salaries and wages	2,674	167	2,841
Social security costs	224	1	225
Employer Contributions to Pension Schemes	375	1	376
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	43	0	43
Gross employee benefits expenditure	**3,316**	**169**	**3,485**
Less recoveries in respect of employee benefits (note 4.1.2)	(21)	0	(21)
Total - Net admin employee benefits including capitalised costs	**3,295**	**169**	**3,464**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,295**	**169**	**3,464**

4.1.2 Recoveries in respect of employee benefits

2016-17			2015-16
Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(72)	0	**(72)**	(17)
Social security costs	(8)	0	**(8)**	(2)
Employer contributions to the NHS Pension Scheme	(9)	0	**(9)**	(2)
Other pension costs	0	0	**0**	0
Other post-employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	0
Total recoveries in respect of employee benefits	**(89)**	**0**	**(89)**	**(21)**

4.2 Average number of people employed

	2016-17			2015-16
	Permanently employed Number	Other Number	Total Number	Total Number
Total	**80**	**3**	**83**	**76**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	211	155
Total Staff Years	79	69
Average working Days Lost	3	2

The sickness data provided are calendar year figures

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	0	0

	£'000	£'000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	7,667	0	0	1	7,667
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**1**	**7,667**	**0**	**0**	**1**	**7,667**

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	1	42,802	1	42,802
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**1**	**42,802**	**1**	**42,802**

Analysis of Other Agreed Departures

	2016-17 Other agreed departures		2015-16 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	1	42,802
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**1**	**42,802**

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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 CCG of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2016-17, employers" contributions of £369k (2015-16: £341k) were payable to the NHS Pension Scheme at the rate of 14.3% 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.

4.5.2 Local Government Pension Scheme
The CCG has admitted body status within the Local Government Pension Scheme in respect of former council employees and new employees performing social care functions. The scheme provides members with defined benefits related to pay and service. The costs of the employers contributions is equal to the contributions paid to the funded pension scheme for these employees.

The contributions rate is determined by the Funds Actuary based on triennial actuarial valuations : the last formal valuation was carried out at 31st March 2016. The CCGs accounts include an employers contribution 34.8% of gross salary with effect from 1st April 14. With effect from 1st April 2017, the employers contribution rate will be reducing to 25.8%, along with a monthly supplementary payment .

The Local Government Scheme is accounted for as a defined benefits scheme :

- The liabilities of The East Riding of Yorkshire pension scheme attributable to the CCG are included in the balance sheet on an actuarial basis using the projected unit method i.e. an assessment of the future payments that will be made in relation to retirement benefits earned to date by employees, based on assumptions about mortality rates, employee turnover rates, etc. and projections of projected earnings for current employees.

- Liabilities are discounted to their value at current prices, using a discount rate based on the Corporate bond yield curve which is constructed based on the constituents of the iBoxx £ Corporates AA index and using the UBS delta curve fitting methodology.

- the principle assumptions used by the independent qualified actuaries in updating the latest valuations of the Fund for IAS 19 purposes were:

4.5.2 Local Government Pension Scheme (Continued)

	31 March 2017	31 March 2016
	% p.a.	% p.a.
Pension Increase rate	**2.4%**	**2.2%**
Salary Increase rate	**2.6%**	**3.7%**
Discount Rate	**2.6%**	**3.5%**

	31st March 2017		31st March 2016	
Mortality Assumptions	**Males Years**	**Females Years**	**Males Years**	**Females Years**
Current Pensioners	**21.7**	**24.2**	**21.9**	**24.1**
Future Pensioners**	**23.7**	**26.4**	**24.2**	**26.7**

** Figures assume members aged 45 as at the last formal valuation date

Sensitivity Analysis	31st March 2017		31st March 2016	
Change in assumptions at year ended 31 March 2017	**Approximate % increase to Employer liability**	**Approximate monetary amount £'000**	Approximate % increase to Employer liability	Approximate monetary amount £'000
0.5% decrease in Real Discount Rate	**10%**	**3,618**	11%	3,326
1 year increase in member life expectancy*	**-**	**-**	3%	916
0.5% increase in the Salary Increase Rate	**0%**	**51**	0%	89
0.5% increase in the Pension Increase Rate	**10%**	**3,552**	11%	3,258

* Although excluded from the table for 2017, the Actuary estimated that a one year life expectancy would approximately increase the Employers Defined Benefit Obligation by around 3-5%.

The change in the net pensions liability is analysed into seven components:

- Current service cost; the increase in present liabilities expected to arise from employee service in the current period (allocated to the revenue accounts of services for which the employees worked in the Income and Expenditure Account).
- Past service cost; the increase in liabilities arising from current year decisions whose effect relates to years of service earned in earlier years.
- Interest cost; the expected increase in the present value of liabilities during the year as they move one year closer to being paid.
- Expected return on assets; is based on the long term future expected investment return for each asset class at the beginning of the period.
- Gains/losses on settlements and curtailments; the cost of the early payment of pension benefits if any employee has been made redundant in the previous financial year.
- Actuarial gains and losses; changes in actuarial deficits or surpluses that arise because events have not coincided with the actuarial assumptions made for the last valuation (experience gains and losses) or the actuarial assumptions have changed.
- Contributions paid to the East Riding Pension fund; cash paid as employer"s contributions to the pension fund.

The estimated Employers Contributions payable in the year to 31 March 2018 will be approximately £317,000.

The above information relates to the LGPS annualised calculation used for the actuarial pension valuation.

Employer Membership Statistics

	31 Mar 2016	***31 Dec 2014***
	Number	***Number***
Actives	4	4
*Deferred pensioners**	286	305
Pensioners	167	146
Total	457	455

* Deferred pensioners include undecided leavers & frozen refunds.

The membership numbers do not affect any calculations and are provided purely for information purposes only.

5. Operating expenses

	2016-17 Admin £'000	2016-17 Programme £'000	2016-17 Total £'000	2015-16 Total £'000 *(Restated)*
Gross employee benefits				
Employee benefits excluding governing body members	2,812	511	3,323	3,064
Executive governing body members	430	0	430	421
Total gross employee benefits	**3,242**	**511**	**3,753**	**3,485**
Other costs				
Services from other CCGs and NHS England	50	337	387	1,908
Services from foundation trusts	0	103,167	103,167	101,146
Services from other NHS trusts	4	14,960	14,964	14,880
Purchase of healthcare from non-NHS bodies	0	70,029	70,029	66,204
Social Care from independent Providers	0	49,712	49,712	49,483
Chair and Non Executive Members	141	0	141	128
Supplies and services – clinical	0	0	0	0
Supplies and services – general	89	1,260	1,349	1,397
Consultancy services	120	43	163	103
Establishment	195	390	585	401
Transport	5	0	5	9
Premises	142	141	283	533
Impairments and reversals of receivables	0	634	634	381
Inventories written down and consumed	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	54	0	54	56
Other non statutory audit expenditure				
· Internal audit services	44	0	44	75
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	0	27,447	27,447	27,716
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	0	1,380	1,380	882
Other professional fees excl. audit	716	821	1,537	433
Grants to Other bodies	0	0	0	108
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	9	18	27	29
Change in discount rate	0	0	0	0
Provisions	0	576	576	336
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	0	360	360	901
Interest (Local Government Pension Scheme)	0	1,055	1,055	1,085
Expected Return on Assets (Local Government Pension Scheme)	0	(982)	(982)	(910)
Other expenditure	1	0	1	1
Total other costs	**1,570**	**271,348**	**272,918**	**267,285**
Total operating expenses	**4,812**	**271,859**	**276,671**	**270,770**

In 2015/16 Purchase of healthcare from non-NHS bodies and GPMS/APMS and PCTMS have been restated. GPMS/APMS and PCTMS has increased by £489k and Purchase of healthcare from non-NHS bodies has reduced, this is to ensure the accurate mapping of the primary care PMS premium

6.1 Better Payment Practice Code

Measure of compliance	2016-17 Number	2016-17 £'000	2015-16 Number	2015-16 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	39,509	127,046	38,486	122,571
Total Non-NHS Trade Invoices paid within target	37,427	123,831	36,283	118,421
Percentage of Non-NHS Trade invoices paid within target	**94.73%**	**97.47%**	**94.28%**	**96.61%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,198	119,969	2,059	117,446
Total NHS Trade Invoices Paid within target	2,189	119,964	2,027	117,413
Percentage of NHS Trade Invoices paid within target	**99.59%**	**100.00%**	**98.45%**	**99.97%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The CCG had no late payment of commercial debts for the year ending 31 March 2017 (31 March 2016: £NIL).

7. Income Generation Activities

The CCG does not undertake any income generation activities.

8. Investment Revenue

The CCG had no investment revenue as at 31 March 2017 (31 March 2016: £NIL).

9. Other Gains & Losses

The CCG had no other gains and losses as at 31 March 2017 (31 March 2016: £NIL).

10. Finance Costs

The CCG had no finance costs as at 31 March 2017 (31 March 2016: £NIL).

11. Net Gain (Loss) on Transfer by Absorption

The CCG has no recognised gain or loss on transfer by absorption in the Statement of Comprehensive Net Expenditure.

12. Operating Leases

12.1 As lessee

The CCG makes payments to NHS Property Services Ltd under an operating lease arrangement. There are no contingent rental obligations. The lease was signed in September 2015 and will run for 5 years, with a review in 2018. There are no purchase options or escalation clauses. The lease restrict that the properties can be used as office accomodation only.

12.1.1 Payments recognised as an Expense

	Land £'000	Buildings £'000	Other £'000	2016-17 Total £'000	2015-16 Total £'000
Payments recognised as an expense					
Minimum lease payments	0	70	8	**78**	**68**
Contingent rents	0	0	0	**0**	**0**
Sub-lease payments	0	0	0	**0**	**0**
Total	**0**	**70**	**8**	**78**	**68**

12.1.2 Future minimum lease payments

	Land £'000	Buildings £'000	Other £'000	2016-17 Total £'000	2015-16 Total £'000
Payable:					
No later than one year	0	70	9	**79**	**65**
Between one and five years	0	209	18	**227**	**227**
After five years	0	0	0	**0**	**2**
Total	**0**	**279**	**27**	**306**	**294**

12.2 As lessor

The CCG is not a lessor.

12.2.1 Rental revenue

The CCG had no rental revenue as at 31 March 2017 (31 March 2016: £NIL).

13. Property, Plant & Equipment

The CCG had no property, plant & equipment as at 31 March 2017 (31 March 2016 : £NIL).

14. Intangible Assets

The CCG had no intangible Assets as at 31 March 2017 (31 March 2016: £NIL).

15. Investment Property

The CCG had no investment property as at 31 March 2017 (31 March 2016: £NIL).

16. Inventories

The CCG had no inventories as at 31 March 2017 (31 March 2016: £NIL).

17 Trade and other receivables	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	135	0	250	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	676	0	725	0
NHS accrued income	5	0	25	0
Non-NHS and Other WGA receivables: Revenue	4,564	0	3,521	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	730	0	698	0
Non-NHS and Other WGA accrued income	910	0	2,332	0
Provision for the impairment of receivables	(3,244)	0	(2,789)	0
VAT	0	0	2	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	755	0	1,688	0
Total Trade & other receivables	**4,531**	**0**	**6,452**	**0**
Total current and non current	**4,531**		**6,452**	
Included above:				
Prepaid pensions contributions	0		0	

The great majority of trade is with NHS England & North East Lincolnshire Council. As both are funded by Government, no credit scoring is considered necessary

Other receivables include £754k in relation to the adult social care partnership agreement (15/16: £1,604k).

17.1 Receivables past their due date but not impaired	2016-17 £'000	2015-16 £'000
By up to three months	(289)	(208)
By three to six months	(312)	(390)
By more than six months	(90)	0
Total	**(691)**	**(598)**

17.2 Provision for impairment of receivables	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	(2,789)	(3,126)
Amounts written off during the year	180	718
Amounts recovered during the year	501	592
(Increase) decrease in receivables impaired	(1,136)	(973)
Transfer (to) from other public sector body	0	0
Balance at 31 March 2017	**(3,244)**	**(2,789)**

Provisions relate to 2 main areas :
- Debtors ledger income
- House Sale income which is collected from clients for residential & nursing care

Receivables are provided against at the following rates:	2016-17 £'000	2015-16 £'000
NHS Debt & Adult Social Care Debt 0-6 months	0%	0%
7 to 9 months	25%	25%
10 to 12 months	50%	50%
1 to 2 years	75%	75%
over 2 years	100%	100%

It should be noted that where a sales invoice raised relates to backdated care costs, the provision has been calculated based on the period of care that the debt relates to not the date the invoice was raised.

18. Other financial assets

The CCG had no other financial assets as at 31 March 2017 (31 March 2016: £NIL).

19. Other current assets

The CCG had no other current assets as at 31 March 2017 (31 March 2016: £NIL).

20 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	13	46
Net change in year	(3)	(33)
Balance at 31 March 2017	**10**	**13**
Made up of:		
Cash with the Government Banking Service	10	13
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**10**	**13**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**10**	**13**
Patients" money held by the clinical commissioning group, not included above	0	0

21. Non-current Assets Held for Sale

The CCG had no non-current assets held for sale as at 31 March 2017 (31 March 2016: £NIL).

22. Analysis of Impairments & Reversals

The CCG had no impairments or reversals recognised in expenditure during 2016-17 (2015-16: £NIL).

23 Trade and other payables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
Interest payable	0	0	0	0
NHS payables: revenue	1,451	0	1,243	0
NHS payables: capital	0	0	0	0
NHS accruals	884	0	1,650	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	1,045	0	826	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	10,208	0	11,622	0
Non-NHS and Other WGA deferred income	26	0	23	0
Social security costs	43	0	36	0
VAT	33	0	0	0
Tax	39	0	39	0
Payments received on account	0	0	0	0
Other payables and accruals	149	3,191	138	2,111
Total Trade & Other Payables	**13,878**	**3,191**	**15,577**	**2,111**
Total current and non-current	**17,069**		**17,688**	

Other payables include £55k outstanding pension contributions at 31 March 2017 (31 March 2016: £56k).

Other non-current other payables relate to the Local Government Pension Scheme.

24. Other Financial Liabilities

The CCG had no other financial liabilities as at 31 March 2017 (31 March 2016: £NIL).

25. Other Liabilities

The CCG had no other liabilities as at 31 March 2017 (31 March 2016: £NIL).

26. Borrowings

The CCG had no borrowings as at 31 March 2017 (31 March 2016: £NIL).

27. Private Finance Initiative, LIFT & Other Service Concession Arrangements

The CCG had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2017 (31 March 2016: None).

28. Finance Lease Obligations
The CCG had no finance lease obligations as at 31 March 2017 (31 March 2016: None).

29. Finance Lease Receivables
The CCG had no finance lease receivables as at 31 March 2017 (31 March 2016: None).

30 Provisions

	Current 2016-17 £'000	Current 2015-16 £'000	**Non-current 2016-17 £'000**	Non-current 2015-16 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	8
Continuing care	421	212	0	0
Other	426	274	0	0
Total	**847**	**486**	**0**	**8**

Total current and non-current	**847**	**494**

	Legal Claims £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2016	**8**	**212**	**274**	**494**
Arising during the year	0	372	284	656
Utilised during the year	(8)	(83)	(132)	(223)
Reversed unused	0	(80)	0	(80)
Unwinding of discount	0	0	0	0
Change in discount rate	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0
Transfer (to) from other public sector body under absorption	0	0	0	0
Balance at 31 March 2017	**0**	**421**	**426**	**847**
Expected timing of cash flows:				
Within one year	0	421	426	847
Between one and five years	0	0	0	0
After five years	0	0	0	0
Balance at 31 March 2017	**0**	**421**	**426**	**847**

Other provisions relate to two adult social care provisions, one created in 16/17 and one a continuation from previous year.

• Transitional support relating to redesign of Supported Living service

• Section 117 reimbursement of client contributions (previous year)

It is anticipated these provisions will be utilised in full during 2017/18

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2017 is £370k (31 March 2016 is £1,374k). The deadline for completing all of this work was 31 March 2017.

31. Contingencies
The CCG had no borrowings as at 31 March 2017 (31 March 2016: £NIL).

32. Commitments

32.1 Capital commitments
The CCG had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2017 (31 March 2016: £NIL).

32.2 Other financial commitments
The CCG had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2017 (31 March 2016: £NIL).

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the CCG 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 CCG 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 CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG and internal auditors.

33.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations. The CCG and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.4 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	140	0	140
· Non-NHS	0	5,473	0	5,473
Cash at bank and in hand	0	10	0	10
Other financial assets	0	755	0	755
Total at 31 March 2017	**0**	**6,378**	**0**	**6,378**

	2015-16 £'000	2015-16 £'000	2015-16 £'000	2015-16 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	275	0	275
· Non-NHS	0	5,854	0	5,854
Cash at bank and in hand	0	13	0	13
Other financial assets	0	1,688	0	1,688
Total at 31 March 2017	**0**	**7,830**	**0**	**7,830**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,335	2,335
· Non-NHS	0	14,595	14,595
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**16,930**	**16,930**

	2015-16 £'000	2015-16 £'000	2015-16 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,892	2,892
· Non-NHS	0	14,697	14,697
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**17,589**	**17,589**

34. Operating Segments

In addition to the core role of the CCG, being commissioning of health services for the North East Lincolnshire aewa, the CCG also operates a pooled budget arrangement with the North East Lincolnshire Council for the commissioning of Adult Social Care. See note 35 for further information.

2016/17	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Health	228,771	(2,787)	**225,984**	1,570	(11,270)	**(9,700)**
Adult Social Care	51,920	(51,920)	**0**	2,971	(6,646)	**(3,675)**
Total	**280,691**	**(54,707)**	**225,984**	**4,541**	**(17,916)**	**(13,375)**

2015/16	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Health	224,001	(1,711)	**222,290**	2,465	(12,094)	**(9,629)**
Adult Social Care	50,782	(50,782)	**0**	4,000	(6,088)	**(2,088)**
Total	**274,783**	**(52,493)**	**222,290**	**6,465**	**(18,182)**	**(11,717)**

35. Pooled budgets

The CCG has a pooled budget with North East Lincolnshire Council . The pool is hosted by NHS North East Lincolnshire CCG and forms part of the overall integrated health & social care budget that the CCG has responsibility for.

Under the arrangement funds are pooled under Section 75 of the National Health Service Act 2006 for the provision of Adult Social Care and Better Care Fund expenditure within North East Lincolnshire.

The tables below provides a summary of the income and expenditure in the financial year.

Adult Social Care Partnership Agreement	**2016-17**	2015-16
	£000	£000
NELC Allocation	**39,844**	**38,491**
Other Contributions*	**12,076**	**12,291**
Total Social Care Expenditure	**(51,920)**	**(50,782)**
Total	0	0

*Other Contributions, includes £4.0m funding from the Health Better Care Fund Allocation. This is an internal recharge between the Health & Adult Social Care Operating Segments and as such is not reflected as Income & Expenditure on the SOCNE.

Better Care Fund	**2016-17**	2015-16
	£000	£000
Allocation (Health)	**11,157**	**11,246**
Allocation (North East Lincolnshire Council)	**2,188**	**1,582**
Health Expenditure	**(7,137)**	**(7,672)**
Adult Social Care expenditure	**(5,687)**	**(5,010)**
Total	**521**	**146**

The £521k underspend relates to slippage on capital schemes funded from North East Lincolnshire Council allocation. The council will make the funding available for use in 2017/18 and will be used to support the role out of transformational schemes.

The Better Care Fund, which creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, came into effect from the 1st April 2015. The Better Care Fund has built on the Partnership Agreement arrangements already in place in North East Lincolnshire.

36. NHS LIFT Investments

The CCG had no NHS LIFT investments as at 31 March 2017 (31 March 2016: £NIL).

37. Related Party Transactions

Details of related party transactions with individuals are as follows:

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions (greater than £1 million) with entities for which the Department is regarded as the parent Department. This Includes:

- **NHS England (including commissioning support units);**
- **NHS Foundation Trusts**
  Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
- **NHS Trusts;**
  East Midlands Ambulance Service NHS Trust
  Hull & East Yorkshire Hospitals NHS Trust
- **NHS Business Services Authority.**

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 North East Lincolnshire Council in respect of the provision of adult social care.

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Cathy Kennedy				
Deputy Chief Executive (left December 2016)				
Member of Healthcare Finance Managers Association (HfMA)	1	-	-	-
Husband is IT Project Manager with Kier Business Services Ltd	1,223	-	-	(7)
Cllr Jane Hyldon-King				
NELC nominated member of Partnership Board				
Deputy Leader and Portfolio Holder for Health, Wellbeing and Adult Social Care – North East Lincolnshire Council	3,737	(11,393)	131	(1,331)
NAViGO	25,136	-	294	-
Cllr Matthew Patrick				
NELC Representative				
Portfolio Holder for Finance and Resources – North East Lincolnshire Council.	3,737	(11,393)	131	(1,331)
Dr Arun Nayyar				
Partnership Board GP representative				
Core Care Family Practice Grimsby & Beacon Medical Centre are members of 360 Care Limited (a federation of GP practices)	597	-	25	-
Core Care Family Practice Grimsby & Beacon Medical Centre are members of LINCS (a federation of GP practices)	12	-	-	-
Director of Core Care Links Ltd	1,976	-	39	-
GP Partner - Beacon Medical Centre	299	-	54	-
Dr David Elder				
Member of Remuneration Committee/Council of Members				
Partner in Pelham Medical Group	293	-	40	-
Partner in Humberview Surgery	13	-	9	-
Practice provides an enhanced service for substance misuse to our own patients only, under a contract with North East Lincolnshire Council	3,737	(11,393)	131	(1,331)
Engaged with Birkwood in joint delivery of drug services	182	-	83	-
Engaged with Chantry in joint delivery of drug services	273	-	47	-
Engaged with Woodford in joint delivery of drug services	208	-	42	-
Dr Derek Hopper				
Partnership Board Vice Chair/Remuneration committee member/ Vice Chair of Council of Members (wef Sept 16)				
Partner at Fieldhouse Medical Centre but has now retired	475	-	58	-
Dr Karin Severin				
Council of Members/ Integrated Governance & Audit Committee				
Birkwood Medical Centre is a member of 360 Care Limited (a federation of GP practices)	597	-	25	-
GP Partner – Birkwood Medical Centre	182	-	83	-
North Yorkshire & Humber Appraiser (NHS England)	213	(2,601)	-	(83)
Dr Peter Melton				
Clinical Chief Officer				
GP Principal at The Roxton at Weelsby View, Weelsby View, Grimsby	40	-	30	-
GP Principal The Roxton Practice, Immingham (including Dr Opie & Spalding)	1,374	-	93	-
Roxton practice is a member of 360 Care Ltd (a federation of GP practices) & wife is employed by 360 Care Ltd	597	-	25	-
Roxton practice is a member of LINCS (a federation of GP practices)	12	-	-	-

37 Related party transactions (continued)

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Dr Rakesh Pathak				
Partnership Board GP representative				
GP Principal – Raj Medical Centre	139	-	25	-
Director of Core Care Links Ltd	1,976	-	39	-
Director of 360 Care Ltd & Raj Medical is a member of 360 Care Ltd (a federation of GP practices)	597	-	25	-
Dr Thomas Maliyil				
Chair Council Of Members (wef Sept 16) / Partnership Board GP Representative				
GP at Healing Health Centre	29	-	9	-
Healing Health Centre Practice and Core Care Family Practice are members of 360 Care Ltd (a federation of GP practices)	597	-	25	-
Healing Health Centre Practice and Core Care Family Practice are members of LINCS (a federation of GP practices)	12	-	-	-
Director of Core Care Links Ltd	1,976	-	39	-
Helen Kenyon				
Deputy Chief Executive				
Sue Rogerson is a personal friend who is a director of SJW Solutions in Partnership	119	-	-	-
Joanne Hewson				
Member of Partnership Board				
Deputy Chief Executive - North East Lincolnshire Council	3,737	(11,393)	131	(1,331)
Joe Warner				
Social Care Representative				
Chief Executive - Focus Adult Social Care Social Enterprise	5,724	-	30	-
Juliette Cosgrove				
Partnership board registered nurse				
Assistant Director to the Medical & Nurse Directors Calderdale & Huddersfield NHS Foundation Trust	8	-	0	-
Husband is a Consultant Neurosurgeon at Lancashire Teaching Hospital NHS Trust	9	-	-	-
Nicky Hull (left March 2016)				
NEL Primary Care (Non-GP) Member				
Beacon Medical Centre is a member of 360 Care limited (a federation of GP practices)	597	-	25	-
Practice Manager Beacon Medical	299	-	54	-
The Practice provides a LARC service (Family Planning Clinic) via North East Lincolnshire Council	3,737	(11,393)	131	(1,331)
Phillip Bond				
Partnership Board Lay member Community Engagement/ Integrated Governance & Audit committee member				
Cousin is employed in a senior position at Northern Lincolnshire & Goole NHS Foundation Trust	100,382	(41)	510	(676)
Stephen Pintus				
Partnership Board NELC Officer member				
Director of Public Health – North East Lincolnshire Council	3,737	(11,393)	131	(1,331)
Tim Render (Started September 2016)				
Lay Community Member Governance & Audit				
Independent Chair Audit & Governance Committee - North East Lincolnshire Council	3,737	(11,393)	131	(1,331)

Note that these amounts are full year though some of the individuals worked for the CCG for part of the year.

The payments made to GP's are not in relation to their GP core contract, which is managed by NHS England but are in relation to reimbursement of GP drugs, enhanced services and service improvement plans.

38 Events after the end of the reporting period

There were no events after the end of the reporting period

39. Third Party Assets

The CCG held no third party assets as at 31 March 2017 (31 March 2016: None)

40 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	2016-17 Target £000's	**2016-17 Performance £000's**	**2015-16** Target **£000's**	**2015-16** Performance **£000's**
Expenditure not to exceed income (reported surplus £6,740k*)	235,511	228,771	228,532	224,001
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	232,724	225,984	226,821	222,290
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	3,638	3,292	3,923	3,570

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

It should be noted that the table above only relates to NHS funding. The CCG also receives £39.8m from North East Lincolnshire Council. This is a pooled budget arrangement under Section 75 of the National Health Service Act 2006, see note 35.

* The £6,740k reported surplus comprises of two elements:
a) The CCGs planned surplus of £4,531k
b) £2,209k impact of the release of the system risk reserve, which the CCG has been mandated by NHS England to release.
Please see section 1.2.3 of the Performance Report within the Annual Report for further detail.

41. Impact of IFRS

Accounting under IFRS had no impact on the results of the CCG during 2016-17 financial year.

42. Analysis of Charitable Reserves

The CCG held no charitable reserves as at 31 March 2017 (31 March 2016: None).

43. FRS Accounting Information - Pensions

The disclosures in this note relate to the East Riding Pension Fund (the Fund). The CCG participates in the Local Government Pension Scheme. The Local Government Pension Scheme is a defined benefit scheme based on final pensionable salary.

In accordance with International Accounting Standards- IAS 19 Employee Benefits disclosure of certain information concerning assets, liabilities, income and expenditure related to pension schemes is required.

The actuaries report states that the market value of the assets of the Pension fund as at 31 March 2017 was £33.6 million (31 March 2016 was £28.4 million).

Assets	Value at 31-March-2017 £000	Value at 31-March-2016 £000
Equity Securities	12,379	12,426
Debt Securities	3,542	2,833
Private Equity	1,572	1,434
Real Estate	3,935	3,352
Investment Funds & Unit Trusts	11,224	7,583
Cash & Cash Equivalents	983	798
Total	**33,635**	**28,426**

Funding Position

The following amounts, needed for reconciliation to the balance sheet, were measured in accordance with the requirements of IAS19:

Fair Value	31-March-2017 £000	31-March-2016 £000
Fair Value of Employer Assets	33,635	28,426
Present Value of Funded Obligations	(36,826)	(30,537)
Net Asset/(Liability)	**(3,191)**	**(2,111)**

Recognition in the profit or loss	31-March-2017 £000	31-March-2016 £000
Current service cost	31	41
Interest Cost	1,055	1,085
Expected Return on Employer Assets	(982)	(910)
Past Service Cost / (Gain)	0	0
Losses / (Gains) on Curtailments and Settlements	0	0
Total	**104**	**216**

Reconciliation of defined benefit obligation	31-March-2017 £000	31-March-2016 £000
Opening Defined Benefit Obligation	30,537	34,253
Current Service Cost	31	41
Interest Cost	1,055	1,085
Contribution by Members	9	10
Actuarial Losses/(Gains)	5,981	(4,120)
Past Service Costs / (Gains)	0	0
Losses / (Gains) on Curtailments	0	0
Estimated Benefits Paid	(787)	(732)
Closing Defined Benefit Obligation	**36,826**	**30,537**

43. FRS Accounting Information - Pensions (Continued)

Reconciliation of fair value of employer assets	31-March-2017	31-March-2016
	£000	£000
Opening Fair Value of Employer Assets	28,426	28,774
Expected Return on Assets	982	910
Contributions by Members	9	10
Contributions by the Employer	47	51
Actuarial Gains/(Losses)	4,958	(587)
Estimated Benefits Paid	(787)	(732)
Total actuarial gain (loss)	**33,635**	**28,426**

Amounts for the current and previous accounting periods	31-March-2017	31-March-2016
	£000	£000
Fair Value of Employer Assets	33,635	28,426
Present Value of Defined Benefit Obligation	(36,826)	(30,537)
Surplus / (deficit)	(3,191)	(2,111)
Experience Gains/(Losses) on Assets	4,958	(587)
Experience Gains/(Losses) on Liabilities	254	(786)

Cumulative Statement of Recognised Gains / Losses	31-March-2017	31-March-2016
	£000	£000
Actuarial Gains and Losses	4,958	(587)
Effect of Surplus Recovery Through Reduced Contributions	(5,981)	4,120
Actuarial Gains / (Losses) recognised in STRGL	(1,023)	3,533
Cumulative Actuarial Gains and Losses	(3,394)	(2,371)

44. Losses & Special Payments

In 2016/17 there was 1 loss of minor equipment at a value of £660. In 2015/16 there were 4 losses of minor equipment at a value of £1,370. Please see note 17.2 for details of the provision for impairment of receivables

The CCG had no special payment cases during 2016/17 (2015/16: None)

45. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	(225,984)
Impairment of receivables	455
Pension charge	57
Net operating costs for the financial year per cash flow	**(225,472)**

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