NHS 70 YEARS OF THE NHS 1948 - 2018

North East Lincolnshire
Clinical Commissioning Group

Annual Report & Accounts

2017/18

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Clinical Commissioning Group

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Annual Report & Accounts

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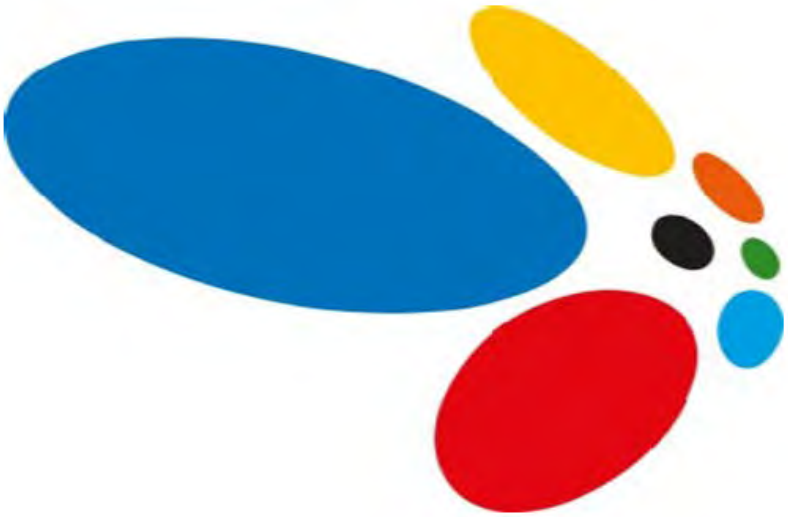
“This section describes how we carry out our role as a Clinical Commissioning Group (CCG) and what our responsibilities are. It also tells the story of the previous 12 month between months between 1 April 2017 and 31 March 2018, including our achievements and challenges, and set out some of the risks that could hinder us achieving our plans for the coming year”



1.0 Performance Report

1.1 Overview

Welcome to the Annual Report and Accounts of NHS North East Lincolnshire Clinical Commissioning Group (CCG) for 2017/18.

NHS organisations like the CCG have a duty to keep the public up to date with their activities by publishing an annual report and financial accounts at the end of each financial year.

The Overview describes how we carry out our role as a commissioning organisation and what our responsibilities are. It also tells the story of the previous 12 months between 1 April 2017 and 31 March 2018, including our achievements and challenges, and describes some of the risks that could hinder us achieving our plans for the coming year.

Much more detailed information about our performance, the way we make decisions and our structure and staffing is available in the rest of the Annual Report. The Financial Statements for the year 2017-18 are presented at the end.

Sustainability is very important to us and 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 the report in your preferred format, please contact us at the address at the end of this section.

Welcome from our Chair and Clinical Chief Officer

2018 sees the NHS celebrate its 70th birthday. Since its establishment by Nye Bevan in July 1946 as the climax of a hugely ambitious plan to bring good healthcare to all, the NHS has constantly evolved. It is more important than ever it continues to adapt as local health and care needs change.

We have seen significant improvements in the life expectancy of the population and people often live for many years following illnesses which in the past they would not have survived. As medicine continues to advance and communities change, the NHS faces significant new challenges. Not only is the population getting bigger, it is getting older, and people not only have greater needs for health and care than the NHS has had to provide for before, they also need different kinds of care.

Through the work of the NHS and our partners in local authority, the face of health and care is changing both through developments in medical technology and advances in the kinds of support that can be provided to people outside of hospital.

Health organisations are mindful of this and have understood for some time they can no longer work in isolation. Our CCG continues to collaborate with different health, care and voluntary organisations from across the Humber area to tackle some of the big issues facing health and adult social care.

As part of this work we are looking at how to provide the best possible hospital services for people living in the Humber area both now and for future generations and make the most of the money, the caring and highly skilled staff and the buildings available to us within the five hospitals in the Humber region. This may include delivering some aspects of care outside of hospital altogether to better meet the needs of local people.

It is no secret there are very real challenges associated with all of the resources available to us, with some areas exceptionally stretched. The Acute Services Review (described above) is currently exploring the future shape of three local hospital services that were impacted last year by serious workforce shortages and were temporarily changed to ensure the hospital could keep providing a safe service for patients who need inpatient Ear, Nose and Throat care, emergency Urology care and for a small number of patients in receipt of complex chemotherapy treatments in the service area known as clinical haematology. You can read more

about what has happened since by visiting https://www.nlg.nhs.uk/about/trust/service-reconfiguration/ and find out more about the review by visiting http://humbercoastandvale.org.uk.

The CCG and North East Lincolnshire Council continue to work together to improve advice, information and care services to support local people to enjoy 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 local communities to do more for themselves and for each other to improve wellbeing.

Wellbeing means a great deal more than enjoying good mental or physical health. Everyone's needs are different and personal to them and there are many aspects to consider when looking at how we can best support people in our local communities to enjoy improved wellbeing.

Both the CCG and Council are in the business of wellbeing. It makes a lot of sense for us to focus, together, on these wider determinants of health – supporting people to have a decent job, a decent home, a decent education and the social mobility this brings.

While health and local government have been working very closely together in North East Lincolnshire since 2007, strengthening the relationship through what has been called the "Union" is now seeing the area's two largest strategic commissioners move towards a single leadership team, overseen by a Board comprising an equal number of elected members and clinical leaders. Appointing Rob Walsh as our joint chief executive in July 2017 was the next natural step although combining resources and capacity is not restricted to the leadership tier and teams across the two organisations are currently exploring exciting new ways of working to directly benefit our local communities.

Housing is an important determinant of wellbeing. This includes being supported to live as independently as possible and recover from ill health in the place you call home. The Strand Court development in Grimsby has proven a great success, enabling people who need more support to be able to live in their own apartment and enjoy being able to come and go through their own front door. There will be two further Extra Care Housing schemes developed in North East Lincolnshire with work to begin on the second soon. Additional work to ascertain local housing needs, changes in population, and how this will impact for local health services is underway so that we have a joined up approach to meeting these local needs.

North East Lincolnshire already has an excellent track record of supporting people with additional needs to enjoy as independent a life as possible and we continue to work with Humber Transforming Care Partnership to make sure children, young people and adults with a learning disability and/or autism have the same opportunities as anyone else to live satisfying and valued lives. You can read the latest news about the work of the partnership here.

We work closely with all of our providers to ensure local patients receive appropriate and quality services and this is particularly important when quality issues have been highlighted. The CCG, for example, has been working closely with our patient transport provider, TASL, to address ongoing performance issues. This has involved regular meetings that continue to take place with the TASL senior management team to understand the governance issues and incident management and the CCG is supporting TASL to make the necessary improvements with regular site visits.

We also continue to work with our local acute trust Northern Lincolnshire and Goole NHS Foundation Trust as it tackles some of its continuing difficulties such as high vacancy levels, long waiting lists, structural and operational financial deficits and estates and equipment problems.

Against these pressures in our health and care system, our annual report sets out how our CCG has performed during the past 12 months and we can look back at our achievements and activities again with some satisfaction. Measuring our performance helps us to ensure services are being delivered to a high quality standard and providing value for money. To make sure improvements in performance come about when needed, we work with internal and external colleagues to identify areas of risk and implement action plans to mitigate these.

The CCG continues to be rated amongst the top performing CCGs in the country in terms of Dementia and Diabetes. We are also rated good for Mental Health. Despite performing well, the CGG continues to focus on improving performance on rates of recovery for people accessing psychological therapies.

There was again room for improvement in how we performed against the national standard for how many patients receive a first cancer treatment within 2 months of referral from their GP. This is expected to remain an area of challenge for 2018/19. However, a great deal of work is underway locally and with the Humber Coast and Vale Cancer Alliance to improve pathways as well as awareness of symptoms and early diagnosis work which can vastly improve outcomes for patients and the CCG is also performing well against a number of national 31 day cancer targets which you can read about in more detail later in this report.

As this report is put together during March and April, we cannot ignore the winter months that have brought unprecedented challenges to the NHS and local authority in North East Lincolnshire (and, of course, the rest of the country).

Due to winter pressures and in response to national guidance, our local hospital trust began to cancel non-urgent operations and some routine appointments during January and February (all cancer operations and time-critical procedures went ahead as planned. The decision let them to focus on patients needing urgent and immediate treatment however it is likely to have further impact on the CCG's Referral to Treatment time performance which is already an area of scrutiny.

Winter takes a serious toll on the health of our communities, especially that of older or frail people or those living with long term conditions and we see large numbers of patients who become poorly enough to need to go into hospital. For example, bed capacity at Grimsby (and neighbouring) hospitals became problematic during early 2018, exacerbated by outbreaks of diarrhoea and vomiting and some flu cases.

The CCG and our main health providers have been working together to support additional bed capacity in the system to help combat the immediate difficulties and start to work on a longer term solution. This kind of joint working will prove to be groundwork for local organisations going forward together as an alliance.

While we once again talk about addressing challenge in our Annual Report we must remember that out of difficult times come partnership, innovation and better ways of working. Healthcare has evolved dramatically over the past 70 Years and exciting developments are set to continue throughout the birthday year of the NHS and beyond here in North East Lincolnshire including delivering a new Social Prescribing service, refreshing how we provide telecare health support at home and developing our primary and urgent care services.

On behalf of the CCG Partnership Board, we are delighted to present our Annual Report for 2017/18 and once more place on record our most heartfelt thanks to our entire team – including managers, staff, community members and partners - for their continued enthusiastic support the past 12 months

Mark Webb
CCG Chair

Dr Peter Melton
Clinical Chief Officer

On behalf of the entire CCG Board, we are delighted to present our Annual Report for 2017/18 and once more place on record our most heartfelt thanks to our entire team – including managers, staff, community members and partners - for their continued enthusiastic support the past 12 months

Our Year in Brief

A round up of some of the news and health and wellbeing advice issued during the year.

April

Leading the way nationally

The NHS Five Year Forward View Next Steps document was published which could see other parts of the country adopting similar arrangements to here in North East Lincolnshire where all health and social care funding is spent under a single local plan.

The positive approach being taken locally has also been highlighted as best practice in a new Government document "**Integration and Better Care Fund Policy Framework 2017-19**''.

Nationally, it is becoming increasingly clear that it is no longer viable to provide the full range of services in a traditional hospital setting within the finances allocated to the NHS. As the health needs of communities change, local NHS organisations must respond with new ways of providing care in order to meet growing demands and pressures.

New NHS service launches for skin complaints

Virgin Care launched an improved skin service for North and North East Lincolnshire, on behalf of the local NHS Clinical Commissioning Groups. This service is provided for the local population and paid for by the NHS.

The North and North East Lincolnshire Dermatology services will now work closer together to deliver a local service in each area, reducing long waiting times and making use of new technology to cut down on unnecessary trips.

Virgin Care has provided North Lincolnshire Dermatology services since 2012, and took on the North East Lincolnshire service from 1 April 2017.

Additional New Service to Benefit Local Eye Patients

Eye patients in North East Lincolnshire benefitted from an additional service to help reduce waiting times for diagnosis and treatment.

The CCG commissioned specialist eye health providers Newmedica to offer a range of treatments from the Cromwell Road Primary Health Centre. The service began in April and includes Cataract Surgery, treatment for Glaucoma and procedures such as Oculoplastics and Lacrimal, YAG Laser Capsulotomy and Peripheral Iridotomy and Medical Retina (excluding AMD) services.

This is an **additional** service to support existing services provided by Northern Lincolnshire and Goole NHS Foundation Trust and St Hugh's Hospital

May

Mental Health Awareness Week

Just like with our physical wellbeing, there are steps we can all take to improve our mental wellbeing and the CCG supported Mental Health Awareness Week by urging local people to take positive action to build resilience to help them cope with the natural ups and downs of life. We shared 10 positive steps from the Mental Health Foundation that we can all take to support better mental health.

"Nearly two thirds of people experience mental health or emotional difficulties at some point in their lives," explained Dr R K Mathews, Clinical Lead for Mental Health and Disability, NHS North East Lincolnshire CCG. "Almost everyone feels low at some point, however if your problems begin impacting your functioning and affecting those around you then it's time to ask for help from your GP or another health professional."

Festival Health Advice

CCG GPs issued health advice to local people heading off to music festivals this summer to help them avoid some of the pitfalls and potential dangers of partying too hard.

"Many people of all ages look forward to the music festivals each year, but they often don't think of their health and safety at these events and fall foul of ill health that can ruin their experience," said Dr Rakesh Pathak, local GP and member of the NHS North East Lincolnshire Clinical Commissioning Group (CCG). "If something goes wrong the festival is remembered for all the wrong reasons, but fortunately, many the injuries and health complaints can be avoided with a bit of planning, taking some precautions and being sensible."

June

Looking after your health made easier with GP online services

The CCG encouraged people to sign up for online services with their GP which helps patients fit looking after their health into busy daily lives. GP online services are available at surgeries across North East Lincolnshire to help people take control and manage their health better which is particularly important for people who are managing long-term health conditions or those who care for children and elderly friends and family.

Patients can book GP appointments and request repeat prescriptions via their computer, smartphone or tablet at a time that suits them, anywhere, anytime – 24 hours a day, seven days a week. It's quick and easy and all the information is secure. People who need repeat prescriptions can request these from the comfort of their own home, rather than venturing out or taking time they don't have to attend the doctor's surgery.

Stay Safe in the changeable British weather

The CCG went out to remind people that it's not just in very hot weather and holidays abroad that our skin needs protecting from harmful rays. It is important to take care every day when you are out and about during the summer as you can burn in the UK, even when it's cloudy and there's a breeze.

Sunburn can be very painful and potentially dangerous, and exposure to too much sun can also increase your risk of getting skin cancer, so it is important you take steps to protect yourself and your family, especially young children and babies whose skin is very sensitive and delicate.

July

Leading the country in how health and social care are commissioned

The CCG and North East Lincolnshire Council announced they were taking another step closer to fully joined up health and social care for our communities with the appointment of a Joint Chief Executive.

The Council's Chief Executive, Rob Walsh was to take on the new role; heading up a single leadership team which will service both statutory organisations and strengthen their ability to deliver the best possible outcomes for the community they serve

Mark Webb, CCG chair, said: "NEL CCG has a history of taking bold decisions and shaping its arrangements to best meet the needs of our community. We are determined to shape a positive way forward; whilst the two statutory organisations will remain, coming closer together with the Council enables us to plan together, combine our people and resources and ultimately deliver more efficient, effective, joined up services for our population."

Improving support for families experiencing mental health difficulties after the birth of a child

Having a baby is a major life event for mums and dads, and it's natural to experience a range of emotions and reactions during and after the pregnancy. But if they start to have a big impact on day to day life, it might be a sign of a mental health problem.

At least one in five women experience mental health difficulties during pregnancy or in the year after giving birth. This might be a new problem or another episode of a mental health problem they have experienced before.

To inform work being carried out to improve the services available to families experiencing perinatal mental health difficulties, the CCG went out to gather views, thoughts and experiences with a series of events held at local children's centres and an online survey.

North East Lincolnshire receives funding to be pioneering site for integrated mental health and physical health treatment

It was announced adults in North East Lincolnshire would soon benefit from new funding from NHS England for 'integrated psychological therapies', which help people with a long-term physical health condition manage mental health problems such as anxiety and depression.

This second phase of Integrated IAPT (Improving Access to Psychological Therapies) funding, delivered as part of NHS England's Five Year Forward View for Mental Health, is a major step towards "parity of esteem" between mental health and physical health services.

"Good" Improvement Assessment Framework (IAF) Rating

The CCG welcomed the publication of the results of its annual assessment that has given the organisation a rating of Good for 2016/17.

Alongside the CCG Improvement and Assessment Framework (CCG IAF) for 2016/17, additional assessments were undertaken by three independent clinical panels and the CCGs were assessed on the work they do in three clinical priority areas, as set out in The Next Steps on the Five Year Forward View: these are cancer, mental health and dementia.

The figures, published on the My NHS data website, found room for improvement in the 62 day from referral by a GP to treatment for cancer locally and cancer survival rates. Work is underway to improve cancer pathways as well as awareness and early diagnosis which can vastly improve outcomes for patients.

August

Extra funding to boost GP workforce

NHS England announced a new wave of funding to recruit talented doctors from overseas for GP practices in North East Lincolnshire and neighbouring areas.

As part of NHS England's International GP Recruitment Programme, more than £2 million has been committed to recruit additional GPs for GP practices in the regional areas. While GP training places are increasing year-on-year and many GPs are returning to practice, more of them are retiring and the number of GPs is not increasing fast enough.

September

"Good" rating for local Children's Services

Independent inspectors, Ofsted, awarded North East Lincolnshire Council's Children's Social Care Service a "good" rating in the latest inspection.

The Council is one of only four other councils in the country with the highest levels of deprivation in their population to be judged Good – a significant achievement.

Inspectors recognised that children are kept safe in the local authority, and praised the progress made in the local authority since the last full inspection in 2012. It acknowledged how services had been strengthened over the last few years, how children's needs are identified and met more quickly, and the joint support delivered via child in need and child protection arrangements..

Celebrating the 10th Birthday of the Mental Capacity Act

CCG staff celebrated the 10th birthday of the Mental Capacity Act (MCA) by tweeting their personal wishes for the future.

They joined social workers and other practitioners in a Day of Action to raise awareness of the Act and what it means to people, which includes greater personal control, human rights and the opportunity to make decisions. Staff were encouraged to think about and share their wishes, particularly what they would want people to know about them and their likes and dislikes if they were to become unable to communicate this.

October

Help keep antibiotics working effectively in the future

While none of us like to be unwell and we expect doctors and nurses to prescribe something to make us better, the CCG issued a timely reminder that many people are using on relying on too many antibiotics.

Taking antibiotics when you don't need them puts you and your family at risk of more severe or longer illness. The CCG spoke out in support of a national campaign by Public Health England urging people to only use antibiotics when they really need to and always take them as advised by a GP or nurse. This will help keep antibiotics working effectively and stop the increase of antibiotic resistance.

Don't put off the flu vaccination – protect yourself and others this winter

Following on from the antibiotic campaign, the CCG and council joined forces to urge people (especially those most at risk) to protect themselves and others by getting the flu vaccination.

The flu vaccination, which is free for those people most at risk, is one simple step everyone can take to help avoid serious health problems this winter,

The free flu vaccine is offered by GPs and pharmacists and provides the best protection against the unpredictable nature of the flu virus although people will need to be vaccinated every year to combat the change in flu strains.

Perinatal Mental Health Training

The CCG announced dates for free perinatal mental health training to anyone who works with children and families to help improve the support available for families experiencing perinatal mental health difficulties.

Perinatal mental health problems are illnesses that are specifically linked to pregnancy, birth and up to a year afterwards. They include conditions such as depression, anxiety, Post-Traumatic Stress Disorder and psychosis, and they are known to affect at least 10% of mums, with dads also being affected.

November

Launch of the "Listening Shop"

As patients, relatives or carers we all sometimes need to turn to someone for advice and support about health and wellbeing and the care that is available to us, and also speak out about the care either we or a loved one have received.

The CCG's Quality Team and Accord Ambassadors are working together to provide the new Listening Shop for people living in North East Lincolnshire. The Listening Shop is a series of informal "drop-in" sessions where members of the public can meet members of our Patient Advice and Liaison Team (PALS) and the Accord Ambassadors to talk about their experiences of local services.

December

Our Place Our Future, a survey for residents in North East Lincolnshire.

In order to help us to understand how it feels to live and work in our area, the services that people use and the activities they undertake, the CCG and council launched Our Place Our Future, a survey for local residents.

The aim of the survey was to measure how local people feel things are improving or getting worse, and understand how organisations like the CCG and council can work better with our communities to tackle challenges and make the most of arising opportunities. People's views and experiences will be used to influence decisions to help create a better North East Lincolnshire. This survey ran until 19th February.

Free flu jab for care home workers

The CCG announced it was supporting the free flu vaccination programme for care and nursing home workers, and local GPs and pharmacies were to offer the vaccine to health and social care staff working in residential/nursing care homes or providing care in people's own homes.

One of the most important things people who care for elderly or frail people can do is get themselves vaccinated and protect the people they care for from the harmful effects of the flu.

Looking after "Future Me"

None of us knows what the future holds but there may come a time when we might need help making important decisions or even need someone to make those decisions for us.

The CCG announced it was running a series of free public events to encourage people to think about safeguarding "Future Me" and making sure important decisions are taken by someone of their choosing. If you don't like the idea of strangers deciding what is right for you, you can appoint someone who knows you well and is a lot more likely to understand what you would want. This is called a Lasting Power of Attorney or LPA for short. At the events, people were able to listen to a talk to help them understand more about appointing an attorney or acting as an attorney (or as a deputy) and ask any questions face to face.

January

Winter Pressures, impact on local planned care

Due to winter pressures and in response to national guidance, our local hospital trust began to cancel non-urgent operations and some routine appointments during January. The decision allowed the Trust to focus on patients needing urgent and immediate treatment, however all cancer operations and time-critical procedures went ahead as planned.

The CCG recognised there were already continuing waiting times issues within the local health care system affecting patients and this decision would further add to the waiting times for people at the two hospital sites in Grimsby and Scunthorpe. Tackling these waiting times is a priority and there are a number of initiatives and work on going to address the situation and improve the waiting times for care and treatment of patients.

The CCG support the actions the Trust has already taken to increase capacity and manage the waiting lists by working with other hospitals to provide services to patients and putting on additional clinics in several specialities, however the busy winter period has presented a high demand on services that the Trust need to address and manage in the short term. The CCG continued to work with the Trust and with other local CCGs to establish alternative providers to offer treatment for patients and help alleviate the pressures.

Outstanding rating for diabetes care

The quality of diabetes care in North East Lincolnshire has been rated Outstanding by NHS England with the CCG among the best in the country.

This is the latest very positive assessment for the CCG in a number of key clinical priority areas. The CCG has been rated in the past 12 months as outstanding for dementia services and good for mental health.

The CCG also recently received a green star (the highest rating) for the way it involves patients and members of the local community in planning and designing health and care services.

The national diabetes assessment looks at the achievement of a number of treatment targets and the numbers of people recently diagnosed with diabetes who attend structured education aimed at helping them to manage their own condition and stay as healthy as possible.

February

Treat yourself better

The CCG highlighted that GP surgeries get very busy dealing with common winter ailments and it isn't always possible for them to see people as quickly as they would like. Winter bugs such as colds, flu and tummy upsets take their toll and GPs across the country reported a 40% increase in visits in the weeks leading up to February 2018.

However, CCG clinicians explained that most people do not need to see a GP for winter ailments and urged people to look at treating some of these relatively mild illnesses at home and save themselves a trip to the doctor's. They stressed that people living with a long term health condition, should visit a pharmacist for advice if they felt a winter illness - such as a cold or flu - coming on to prevent it becoming more serious.

Invitation for community members to attend a practical workshop

The CCG invited members of the community to attend a free workshop looking at how we can ensure everyone, whatever their background, has fair access to health services according to their needs.

During this workshop we looked at the legal and policy context the NHS operates in, and how Equality Impact Assessments help to ensure the NHS pays 'due regard' when it makes decisions to ensure different groups protected from discrimination by the Equality Act 2010 are not disadvantaged.

March

National award recognises the use of technology that is improving local wound care

A high tech approach to chronic wound care that is transforming the lives of local people has won a national award. Access to technology means difficult to treat or slow healing wounds can now be expertly assessed remotely and a treatment plan put together that can be carried out by the patient's own practice nurse.

The telecare system has been developed by Longhand Data and used by expert wound healing clinicians at Healogics. It is currently in use at three North East Lincolnshire GP practices. Since its introduction, the average healing time for complicated wounds has fallen to just over four months. Before it was introduced, the average time was in excess of six months with no obvious signs of healing in severe cases with some patients requiring daily nursing visits. Speeding up recovery time has also reduced costs in both nursing time and dressings, and as a result, the pilot secured the national Cost Effective Wound Management Award.

The Way Forward

The CCG and our local hospital trust joined forces to encourage local people to join in the conversation about safe, sustainable and quality health, care and wellbeing services for the years ahead.

The CCG shared its commissioning priorities for 2018 and there was information about national, regional and local developments in health and care with a number of workshops and discussion groups.

Following a challenging 18 months for the local NHS, the Chief Executive of NLaG, Dr Peter Reading, talked about the progress that has been made around improving quality, performance, finance and emergency care at Grimsby and Scunthorpe Hospitals.

Who we are and what we do

CCGs were created in April 2013 and are made up of GPs, others who work in health or care and members of the public who are not NHS employees. They work together to plan and buy healthcare services for their local area.

We are led by GPs representing 27 practices providing health services to families living in Grimsby, Cleethorpes, Immingham and rural North East Lincolnshire, supported by a team of non-clinical staff who carry out the day-to-day running of the CCG. We are accountable to our members, patients and our local

communities, and we are overseen by NHS England, the executive public body of the Department of Health.

CCGs are allocated an amount of money to spend on health services each year. This is based on a complex formula which takes into account the overall health and wellbeing needs of the people who live in our area. This money has to be shared across the very wide range of services that local people need. These are services such as life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health difficulties. Long term health conditions include dementia, heart and breathing problems, diabetes and their complications which we see a lot of here North East Lincolnshire.

We are unique in England because we are not only responsible for most health care services but also all adult social care services for our local population which is in currently in excess of 165,000 people.

Like all other CCGs, we are not responsible for commissioning preventative or some very specialist health services. The CCG received approval from NHS England in January 2018 to take on delegated commissioning for primary medical services from April 1st this year.

The CCG 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 (Adult Social Care services).

We work with our partners in the local council and public health, as well as with a panel of knowledgeable volunteers from the North East Lincolnshire community (known as the Community Forum) and the organisations that provide health care, to appraise local health and social care needs and decide how to best use the money allocated to us.

Planning and buying the range of health and adult social care services together means we can use the total funds we receive to get the very best value for money for local people. It also means we can make the way that services are delivered across health and social care much more “joined up” which helps us to make sure people do not 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 ensure quality – for example, patient safety, effectiveness of care and the experience of people who use commissioned services – is at the heart of everything we do.

In 2017/18, the CCG was allocated £236.797 million by NHS England. This includes £6.74m mandated surplus and £3.674 million to pay for the management and operation of the organisation which leaves a total of £226.383 million to pay for health 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 2017/18 the CCG received £40.250 million.

How to get in touch with us

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

You can contact North East Lincolnshire CCG in the following ways:

By post: North East Lincolnshire Clinical Commissioning Group Athena Building, 5 Saxon Court, Gilbey Road, 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

Follow us on Twitter

What we want to achieve and the risks we face

Our plan for the coming year 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.

We are working ever more closely with the Local Authority in North East Lincolnshire to ensure that our first priority is North East Lincolnshire as a Borough and a Place and moving 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 ensure we maintain financial balance.

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

AT A GLANCE GUIDE TO

NORTH EAST LINCOLNSHIRE

Main towns	**Grimsby, Cleethorpes & Immingham**
Population	**159,144**
Area	**192 sq km**

12 modern Primary Care Centres house most of the 27 GP practices who provide health services to families living in Grimsby, Cleethorpes, Immingham and rural North East Lincolnshire.

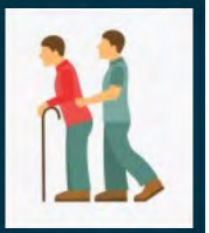
The CCG is made up of GPs, others who work in health or care and members of the public who are not NHS employees. They work together to plan and buy healthcare services for our local area.

Each year we are told by the Government how much money we can spend on local health and care. **In 2017/18 this was £226,383 million.** This money has to be shared across the very wide range of services that people in North East Lincolnshire need.

When we say "Health Services" we include **life-saving emergency care,** the treatment of **acute physical and mental illnesses**, routine **family health care** and managing **long term health difficulties.** Long term health conditions include dementia, heart and breathing problems, diabetes and their complications which we see a lot of locally.

We are also responsible for Adult Social Care. These are support services delivered by our partner organisations for adults who need different levels of practical support because of illness, disability or old age.

There are about 16,500 people with a caring responsibility in North East Lincolnshire.



Almost 20% of the population is of pensionable age and this is expected to rise to almost 27% by 2039.

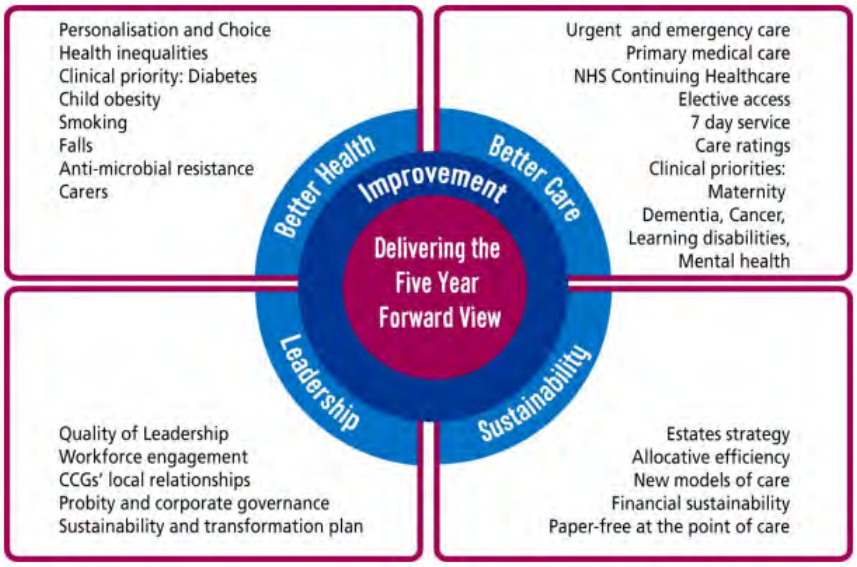
One of our main duties is to "balance the books", while still making sure local people have high quality, safe & affordable services, delivered by skilled people who care about what they do. Health & care organisations have been working together to develop new & innovative ways of doing this and **the CCG continued to operate in financial balance in 2017/18.**

However, we still need local people to help us to help them by using NHS services wisely & choosing the most appropriate service for their needs.

1.2 Performance Analysis

Performance Summary

North East Lincolnshire CCG is assessed against the Improvement and Assessment Framework (IAF) which consists of 4 domains: Better Health, Better Care, Sustainability, and Leadership. CCGs are assessed against these domains by NHS England (NHSE) in quarterly and year-end, face-to-face meetings. North East Lincolnshire CCG's performance is published on My NHS and updated quarterly.



- Better Health looks at how the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve
- Better Care principally focuses on care redesign, performance of constitutional standards and outcomes, including important clinical areas
- Sustainability looks at how the CCG is remaining in financial balance and is securing good value for patients and the public from the money it spends
- Leadership 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.

Within the framework there are *six* clinical priorities, including, cancer, dementia, diabetes, maternity, learning disabilities, and mental health. The initial baseline assessment of the *six* priorities provides CCGs with a snapshot and useful starting point for future assessments. NHS England publishes a rating for each of these *six* clinical areas for each CCG.

In terms of Quality of Leadership, North East Lincolnshire CCG was rated as *'Amber'* for 2016/17. We have completed our self-assessment for 2017-18. The 2017/18 year-end assessment will be available from July 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 is rated as ***'Outstanding'*** and amongst the top performing CCG's in the country.

- For Mental Health NELCCG was rated as *'Good'* which is similar to over a third of other CCGs in the country. (It should be noted approximately half the CCGs are in the '*Requires Improvement or Inadequate* rating). However despite performing well the CGG is focusing on improving performance on rates of recovery for people accessing psychological therapies.

- NELCCG is rated as ***'needs improvement'*** for Learning Disabilities and Maternity. However when compared nationally the majority of other CCGs are rated the same in these areas too.
- In terms of Cancer, NELCCG is rated as ***'Inadequate'***, when compared nationally half the other CCGs are rated as *'Requires Improvement'* or *'Inadequate'.*

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**.

1.2.1 Performance Measures

Reflecting on our performance for 2017/18, our system has performed well against a number of challenging targets but there are still areas for improvement.

Areas of particular scrutiny in 2017-18 for North East Lincolnshire CCG were:

Despite a number of initiatives being put in place to address performance issues, the CCG has missed its Referral to Treatment Time target, with 73.79% of patients waiting less than 18 weeks. NHS England's National Emergency Pressures Panel also extended the deadline for deferral of all non-urgent inpatient elective care, to free up capacity for the sickest of patients and as yet it is unclear what effect this will have on the performance of this measure.

Treating patients within four hours in A&E (Accident and Emergency departments) has been a national challenge through 2017/18. A number of measures have been implemented and we have seen a sustained improvement from the Summer position with Q3 performance for the Trust being 90.6%. Our current year to date position shows NLaG at 86.20%, which is below the All England average figure of 88.71%, with 80.82% of patients treated at DPoW seen within four hours. This remains a key area of challenge for 2018/19.

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. There have been issues with both late referrals and capacity problems with Providers. This also remains a key area of challenge for 2018/19.

Areas of particular success in 2017-18 for North East Lincolnshire CCG were:

Estimated diagnosis rate for people with dementia – North East Lincolnshire CCG stood at 71.3% at January 2018 against the national target of 66.7%.

NELCCG's rate of non-elective spells per 1000 patients performance is in the best quartile when compared nationally and we currently have the lowest rate of admission against our statistical peer group of CCGs who share a similar demographic profile. North East Lincolnshire has realised a 5.4% reduction in activity with a length of stay of one or more days whilst there has been a 1.2% increase nationally.

NELCCG's total number of delayed transfers of care (DToCs) per 100,000 population performance is in the best quartile when compared nationally and we are currently ranked 31st best out of the 151 Local Authorities.

In terms of Adult Social Care the number of adult and older clients receiving a review as a percentage of those receiving a service has improved from 81.95% in 2016/17 to 92.1% for 2017/18.

Cancer waiting times

- Two week wait for first outpatient appointment with suspected cancer - NELCCG year to date performance 97.0% at January 2018 against the national target of 93%.
- 31 day wait for patients receiving first definitive treatment - NELCCG year to date performance 97.2% at January 2018 against the national target of 96%.
- 31 day wait for patients receiving subsequent treatment of surgery - NELCCG year to date performance 95.3% at January 2018 against the national target of 94%.
- 31 day wait for patients receiving a subsequent/adjuvant anti-cancer drug regimen - NELCCG year to date performance 100.0% at January 2018 against the national target of 98%.
- 31 day wait for patients receiving subsequent/adjuvant radiotherapy treatment - NELCCG year to date performance 96.1% at January 2018 against the national target of 94%.

Our latest performance is available on our website

Performance on NHS Constitution Standards.

North East Lincolnshire Clinical Commissioning Group

NHS Constitution Performance 2017/18

On target
Within tolerance of threshold
Off target

Performance Improved from previous year
Performance Declined from previous year
Performance Staying about the same as previous year

Constitution Measures

Referral To Treatment waiting times for non-urgent consultant-led treatment	YTD	Target	Forecast	Trend
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	75.2%	92.0%		

Diagnostic test waiting times	YTD	Target	Forecast	Trend
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	93.3%	99.0%		

A&E waits	YTD	Target	Forecast	Trend
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	86.5%	95.0%		

Cancer waits – 2 week wait	YTD	Target	Forecast	Trend
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	97.0%	93.0%		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	94.2%	93.0%		

Cancer waits – 31 days	YTD	Target	Forecast	Trend
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	97.2%	96.0%		
Maximum 31-day wait for subsequent treatment where that treatment is surgery	95.3%	94.0%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	100.0%	98.0%		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	97.1%	94.0%		

Cancer waits – 62 days	YTD	Target	Forecast	Trend
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	71.5%	85.0%		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	80.6%	90.0%		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	66.7%	90.0%		

1.2.1.1 Quality Premium

The premium is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. This will be based on measures that cover a combination of national and local priorities. A CCG will not receive a quality premium if it is not considered to have operated in a manner that is consistent with Managing Public Money or ends the financial year with an adverse variance against the planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position incurs a qualified audit report. NHS England also reserves the right not to make any payment where there is a serious quality failure.

For 2017/18 it is not expected that the CCG will receive any Quality Premium funding in main due to our performance against the NHS Constitution Standards.

1.2.2 Our 20176/18 Objectives

The Corporate Business Plan is split into four main themes:

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

The Corporate Business Plan comprises more than 70 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 projects and initiatives.

To support the transformation of Out of Hospital care the following priorities for action in 2017/18 were identified and a targeted progress was made against each of them:

Objective	Work areas
Urgent & Emergency Care	❖ GP in A&E service ❖ Urgent treatment centre
Women & Children's Care	❖ Children's community nursing from consultant led to nurse led service ❖ Perinatal mental health ❖ Children & Adolescent Mental Health Services (CAMHS) ❖ Maternity System transformation
Planned Care: Episodic	❖ Support to care homes ❖ Social prescribing ❖ Cancer management within primary care ❖ Domiciliary care ❖ Falls prevention
Planned Care: Long term Condition Management	❖ Enhanced primary care model for COPD, cardiology, diabetes ❖ Extra care housing ❖ Dementia pathway ❖ Crisis pathway for Mental Health & Learning disabilities

1.2.3 Financial Information

North East Lincolnshire CCG is in its fifth year of operation and this report covers the year ending 31 March 2018.

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 = £8.147m)
  - **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 or <£0.25m, whichever is the greater
  - **Achieved**
- Partnership Agreement (Planned to break even)
  - **Achieved**
- Meet the "Better Payment Practice Code" (95%)
  - **Achieved**

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 = £8.147m)

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 2017/2018 was £236.797m, and had a planned surplus of £6.740m (2.8%). The £8.147m reported surplus includes the impact of (i) the release of the £1.127m system risk reserve, and (ii) the category M drugs rebate of £0.280m. The CCG was mandated by NHS England to release as detailed below:

System Risk Reserve

As in 2016/2017, CCGs were asked to set aside a risk reserve at the start of this financial year to provide a buffer to offset any wider system pressures. For 2017/2018 this was reduced to 0.5% of CCGs' allocations. Given the expected deficit position in the provider sector each CCG has been required to release the full amount of the risk reserve as additional underspend in its year end reporting. The impact of this, combined with the risk reserve that NHS England is holding centrally, will be to increase the underspend across the NHS England Group by around £560m.

Category M drugs rebate

Given the scale of the category M drugs rebate expected in 2017/2018 and NHS England needing to ensure that the full benefit of the rebate was seen on the bottom line, NHS England held the rebate until the end of the year, with the return of the rebate being conditional on each CCG meeting its control total for the year.

Given the financial pressures faced by CCGs this year, and in particular the pressures resulting from short stocks of generic drugs NHS England decided that the category M rebate would be returned to all CCGs, with the expectation that the total expected value of the rebate for 2017/2018 (including any amounts to be accrued for the final two months of the year) will result in an improvement to the bottom line position of each CCG.

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 2018, 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 2017/18 was £3.674m with the CCG spending £3.356m on running costs.

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

The CCG received no NHS capital resource in 2017/18

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 and **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 2017/2018 the CCG, on average, paid 97.4% of invoices by number and 99.3% 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 fifth 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

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 needs*

North East Lincolnshire is unique as it has responsibility for commissioning both health and adult social care services on behalf of its registered population through a formal partnership agreement with the Council who have the statutory responsibility to ensure that adult social care is available to meet individual's needs. North East Lincolnshire Council has delegated its responsibility to the CCG so that health and 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, brought 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 organisations 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 and 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 CCG's 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.*

In 2017/18 responsibility for the provision of General Practice, Pharmacy, Dentistry and Optician services or specialist services sat with NHS England who commissioned these services for our registered population.
In 2018/19 the CCG takes on delegated responsibility for General Practice from NHS England and so will be responsible for the commissioning and development of General Practice provision on behalf of its population. Revised governance arrangements are being put in place to support this additional responsibility.

During 2017/18 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 2017/18 will not be fully implemented until 2018/19.

A number of the service developments undertaken during 2017/18 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 within A&E.

To help improve waiting times the CCG has:

- *Commissioned additional activity from St Hugh's for surgical procedures, in particular orthopaedics, and ophthalmology. We have also obtained additional capacity for endoscopy.*
- *Commissioned additional Ophthalmology capacity from a company called Newmedica which has been delivering services from the Cromwell Road Primary Care Centre since April 2017.*
- *Re-commissioned its Dermatology service to secure additional capacity and ensure the service delivers improved waiting times and outcomes for our local population. Virgin Medical has been providing this service from Cromwell Road since 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.*
- *Been working with the hospital and other providers over the winter period to identify gaps and address pressures within current urgent and emergency services, focusing on 3 areas, prior to hospital, in hospital, and discharge and onward care following an emergency admission. During the first half of 2018/19 the CCG will be working with providers to put in place more sustainable solutions building on what has worked well this winter.*

In addition to activities to help improve waiting times the CCG has also:

- *Been working with one of the domiciliary (Homecare) care providers to test out a new way of working with the aim of improving individual client experience and overall service efficiency. Work continues to test and evaluate this new way of working with the service users and staff and will be rolled out across North East Lincolnshire if found to be effective.*
- *Been working with our community and residential care home providers to improve the way that health services provide care to individuals in the homes and support the care homes to provide improved care to their residents, with the aim of improving the overall health of the individuals and therefore to reduce the need for non-elective hospital admissions.*
- *Been working with the Big Lottery to develop a Social Prescribing Service – "Thrive NEL" which will be operational from April 2018. Thrive NEL will provide an alternative approach to supporting people to manage long term conditions through the promotion of self-care and self-management, healthy lifestyle choices, and therefore reducing dependency on statutory services*

Service Redesign

Planned Care

❖ ***Community Cardiology Service***

We have developed and implemented a Community Cardiology Service which includes a heart failure nurse specialist, access to echo tests and a Cardiology Consultant, within the community. The service has provided support to primary care, including advice and guidance in managing cardiology conditions as well as direct referral to the community team where patients are seen in a one stop shop. The service was evaluated in October 2017 and found to be successful with GPs reporting increased confidence in managing cardiology patients, improved outcomes for patients with significantly fewer non-elective admissions to hospital, very positive feedback from patients and financial savings.

As part of the development of this service, an educational programme in primary care has commenced including information sessions and joint clinics to further enhance primary care skills. We are now focussing on the development of an integrated cardiology service across primary, community and hospital care.

❖ ***Community Dermatology Service***

NELCCG has commissioned a community dermatology service which is offered in a range of locations. More doctors have been recruited by the provider, Virgin Care, to provide additional clinical sessions to ensure that waiting times do not fall below an acceptable standard. Currently the service can routinely offer a new patient appointment within 2 weeks for urgent and 4 weeks for routine. We have also seen improved waiting times for surgery that has enabled us to achieve a 6 week target and where possible this has been reduced to a 4 week wait. New treatments, including botox treatment (for hyperhidrosis), and hyperhidrosis treatment are offered where appropriate. We have worked collaboratively with other tertiary providers to improve referral pathways for a more streamlined process for patients.

Teledermatology equipment and training has been made available to all practices. This technology enables GPs to photograph and send images of skin conditions to a consultant dermatologist for advice. When fully implemented, this will reduce the number of outpatient appointments and upskill our GPs. The feedback received thus far from patients and GPs has been very positive.

Our GP skin cancer clinicians work closely with Virgin Care to enable transfer of patients back to primary care where appropriate and both are committed to the ongoing training programme for GPs wishing to participate in this initiative.

- ***Ophthalmology***

Recognising the challenges facing local ophthalmology services, including more patients waiting longer than we would want for appointments, a number of things have been implemented over the last year to improve access. Additional capacity was commissioned through Newmedica with services delivered from Cromwell Road Primary Care Centre. The service provides both outpatients and surgery for a range of eye conditions.

To help shape future services, engagement work has taken place seeking input from patients locally through surveys and focus groups. We are now using this feedback and working closely with the local hospital service to redesign services to meet todays and future demand for ophthalmology care.

- ***Residential and Care Homes***

The long term care service specification and quality framework have been revised and agreed for 2018/19 as a means of improving service standards within Homes and bringing care practice in line with the expectations of the Care Act 2014.

The CCG has continued to work with residential and nursing homes to deliver the enhanced support to care homes model to offer support for those with complex long term conditions residing in the community, nursing or residential care. The purpose of the project is to provide better, more efficient and co-ordinated support and to reduce the incidence of avoidable hospital admissions from care homes. The work so far has enabled:

- Professionals from focus, Navigo, Yarborough Clee, Care Plus Group and NLaG Therapy team to align their service provision so that care homes have more consistent contact with relevant professionals.
- Identification of ways of reducing pharmacy waste including waste reviews in 19 care homes and user level reviews to all residents within the homes.
- The rollout of secure NHS IT and connectivity. This delivers a connection unit that allows all health and social care devices to connect to the NHS.NET and provides care homes with an NHS specification laptop and email accounts.
- Training to use the IT hardware is also being delivered at the same time.

In 2017/18 many of the building blocks of the enhanced support to care homes programme were initiated. Care homes have welcomed the more consistent relationship with the wrap around providers and have appreciated the added support from the pharmacy team and IT providers.

For 2018/19 the rollout will continue across all commissioned care homes. The programme is being refocussed to look at specific areas of care delivery that care homes and clinicians have identified as being central to effective care delivery. This includes:

- Continued support from the pharmacy team
- Reviewing good practice in advanced care planning.
- Pilot access to the summary care record once information governance requirements have been met

- ***Domiciliary Care***

The traditional domiciliary care model of working to strict times of day with a task orientated focus has always had limitations and has now been fully reviewed. Gathering feedback from care providers, discussions with commissioning colleagues, complaints, and concerns and looking to best practice nationally, the CCG has concluded that the current model is not fit for purpose. In the North East Lincolnshire area it has resulted in care providers having very limited capacity to pick up new care packages particularly around the times of 8am, 12noon and 4pm because these are the most popular times stated in care packages.

Due to this demand at key times often care packages cannot be picked up by care providers as soon as we would like resulting in delays of up to two weeks. Discharges from hospital for patients requiring domiciliary care is often delayed due to the limited capacity of care providers to pick up new work.

We have built in two hour "tolerances" around these times, so that care providers have some flexibility on when they deliver the care calls but this is not servicing people's needs adequately. The geographical model of care staff working in a certain area does help in that care providers can allocate more staff resources due to less travel time. Staff work more closely together to support one another but they are still reacting to the assessed care packages and rigid times allocated. This results in little control or flexibility to cover calls due to staff absences or to allow carers to stay longer with service users when they require additional support.

We have been piloting a new way of delivering domiciliary care with HICA which moves away from a focus on time and task, into neighbourhood/community teams with named staff serving groups of service users in a flexible manner that is not time specific. The needs of the individuals and support required are known to the teams and as such can be delivered in a much more personalised way as and when needed. For example if someone is not feeling well enough to get up in the morning, the team can make the person comfortable and return at a later time.

We have been operating a pilot in Humberston, comprising of 60 service users, since April 2017 and in January 2018 this way of working was extended throughout Cleethorpes, an area with 212 service users.

Whilst the actual delivery of services has not changed significantly as existing service users are accustomed to set times, the setting up of care teams allocated to certain zones has freed up capacity for HICA to take on new care packages and this has relieved the pressure on other care providers.

The teams have all been set up with named staff and senior leads and service users have been notified who is on their care team. As with Humberston it is a slow process to move away from the set times that service users and care staff have been used to. Change will occur over the longer term with the focus on new service users who will not be aware of the old system.

The CCG has given their full support to HICA and have assured all care staff that we will support them with queries and complaints from individuals and their families about the these new ways of working. The CCG acknowledges that changes can be hard for individuals to deal with and can intervene to support the change process as required.

We are now awaiting an analysis of commissioned hours against actual hours delivered for December, January and February. This will form the basis of discussion for future invoicing and payment arrangements. We are also awaiting a new payment system that will link directly to the care provider finance systems to ensure a more accurate and efficient way of paying invoices which will further support the new way of working

Mental Health

- ***Child and Adolescent Mental Health Services (CAMHS)***

The current North East Lincolnshire (NEL) CAMH service rated by CQC as ***Outstanding*** is based on a four-tiered model which is now over 20 years old. With transformational aspirations laid down in Future In Mind and the Five Year Forward View for Mental Health it was necessary to redesign our local model with an increased focus on prevention and early help, to ensure children and young people receive the right support, at the right time before concerns escalate. Furthermore, the contract was also up for renewal so we took the opportunity to review and refresh the model of care to meet Future and Mind and the THRIVE model.

From the 1st April 2018 the new service will re-design how children and young people access mental health and emotional wellbeing support across the borough, utilising the methodology and principles of the THRIVE framework.

The Provider 'Lincolnshire Partnership NHS Foundation Trust' (LPFT) will embed the THRIVE model to commission a goal-focused, patient-centred, whole-system approach to supporting children and young people with mental health and emotional wellbeing issues. The service will be designed to fit around the

needs of children and young people locally. LPFT will be the champion across the system, utilising other services to form part of the wider local offer through the use of a whole system collaborative approach and evidence from the needs assessment will support this new model of care.

LPFT will be expected to deliver on our vision and outcomes, aligning with Future In Mind, Five Year Forward View and the 0-19 transformation programme being undertaken by North East Lincolnshire Council.

- ***Perinatal mental Health***

Perinatal mental illness is considered a major public health problem which poses human, social and economic burden to women, their infants, families, and society. Perinatal mental illnesses often present very similar to those Mental Health conditions effecting adults generally, however during the peri-natal period interventions are required urgently as they have a potential to escalate very quickly, impacting on the foetus, baby, wider family and mother's physical health.

Currently there is limited provision for women with perinatal mental health needs (PNMH) across North East Lincolnshire. The services that are available are not targeted to perinatal mental illness, are not part of an overarching pathway and are often dependent upon the particular health professionals involved in care. With this is mind a variety of PNMH task and finish groups have been established across the Sustainable Transformation Plan (STP) region and locally we have developed a multidisciplinary PNMH Steering group which feeds into the regional Humber Coast and Vale group. Extensive work has been undertaken across these task and finish groups to map local services to identify gaps and to inform pathway work currently being developed by the regional group.

PNMH is defined in the Local Transformational Plan for Future in Mind outlining clear ambitions for 'Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, building resilience and improving behaviour'. In North East Lincolnshire we have further invested in training for parenting programmes (stepping stones), attachment, Perinatal Mental Health Champions Training and awareness sessions (Institute of Health Visitors) and will continue to embed and enhance this offer by linking in with the NSPCC 'together for childhood' programme building a trauma informed workforce. Furthermore, there is also a perinatal mental health midwife and bereavement midwife in post at NLaG which will provide additional support for women with mental health and emotional wellbeing concerns during their pregnancy.

Five Year Forward View for Mental Health noted that fewer than 15% of localities provide effective specialist community perinatal services for severe or complex conditions, and more than 40% provide no service at all. By 2020/21, NHS England have committed to ensuring at least 30,000 more women each year can access evidence-based specialist mental health care during the perinatal period. As part of this commitment we have been able to make a case to NHS England for a specialist perinatal mental health service across the Sustainable Transformation Plan, Humber Coast and Vale footprint as North East Lincolnshire currently has no specialist service. This new service will form part of a Humber hub and spoke model. The hub will be based in Hull, where there is an existing service, with a new specialist team providing support in North East Lincolnshire and North Lincolnshire. We are expecting to hear if we have been successful on the 27th April 2018.

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 commissioning Netmeeting Video conferencing in year and the roll out of Skype for Business as part of NHS mail 2.

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. The success of this procedure has meant that during significant disruption due to snow or travel difficulties, all staff were able to work at home continuing day to day events such as meetings using telephone conference calls. This shows continued resilience ability for the organisation to deliver its objectives.

Staff take advantage of this for at least one day per week saving 20% on their home to work travel and associated environmental costs, a small number of staff work more days at home and other staff work compressed hours, which all add to a reduced impact of home to work travel.

Total Business mileage for 2017/18 is 62,829 adjusting for 8,229 miles for staff shared with other CCGs; we have taken our appropriate share. This total compared to 69,181 in 2016/17.

The CCG also took part in the One Public Estate review for North East Lincolnshire which is a multi-agency review of available capacity space and utilisation of all public assets to identify where potential for sharing or reallocating assets which are surplus to requirement can be better used within the public sector setting.

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. 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 still do not have current information from NHSPA but NHSPS will be including our target to reduce our carbon footprint as part of their overall return.

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 generally as we commission services rather than products providers necessarily have to recruit and source ancillary services locally, sustaining investment into the local economy.

All procurements have a schedule where we require bidders to answer 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.

The CCG has been paper light for many years as an agile organisation, and is always looking for the extra area where it can remove the need to print papers.

This includes moving all meeting papers this year to shared drives and the use of Microsoft OneNote for some meetings 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. Usage can be monitored by individual due to having to log in to the printer with an ID card. Usage is reviewed quarterly to see if any use is excessive.

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 obtained silver status and the health topics that the scheme promoted were:

- Physical Activity
- Stop Smoking
- Healthy Eating
- Mental and 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.

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.

The CCG is a member of the Humber Coast and Vale Sustainable Transformation Plan (STP), which seeks to work collectively to deliver sustainable services with the available resources to meet the health and care needs of the population in the best way. 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 (One Public Estate Review)

Adapting to climate change

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 and Public Involvement***

This year we have continued to deliver our strategic aims to strengthen public and stakeholder involvement in our work as set out in our Engagement Strategy which are 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

The statutory assessment of CCG performance (Improvement and Assessment Framework (IAF) this year included a new indicator for patient and community engagement. The CCG received an overall RAG rating of ***Green Star*** (***Outstanding***) for our work engaging with the people and communities that we are responsible for commissioning services on behalf of.

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, which is part of the CCG's governance structure.

Members receive fortnightly e-bulletins providing links to local, regional and national health and care engagement opportunities and a quarterly Accord newsletter, which is produced online, in hard copy and in partnership with local charity Soundscene in audio format.

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. The Accord 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.

Ambassadors' achievements over the year included:

- A new initiative working with the Patient and Liaison team to hold 'Listening Shops' in the community to encourage people to share their views and experience of health and social care services
- Participation in community events to promote Accord
- Giving talks and presentations locally to community and support groups.
- Planning, hosting and evaluating the Accord annual members meeting and Way Forward event;

For more information about Accord visit our website

The Accord steering group held a series of planning and evaluation sessions to set priorities for the coming year. The focus will be "making sure Accord counts" and develop principles with the CCG to ensure and evidence how the involvement of members has influenced commissioning decisions; and explore the potential for closer working with the Local Authority to widen the engagement offer for the membership.

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

- 'People Panel' involvement in the re-procurement of Children and Adolescent Mental Health Services (CAMHS)
- Community member involvement in the procurement of Social Prescribing providers and Adult Services Review provider.
- 'A Clearer View' – public engagement to inform the specification for Community Ophthalmology Services
- Carers Support Services and Telecare Services review
- Caring About Quality - Quality Framework and Long Term Care providers specification
- Humber Coast and Vale Sustainable Transformation Plan workshops – Cancer, Mental Health.
- Perinatal Mental health services
- Better Care fund (BCF) and iBCF

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 feedback reports on the CCG website.

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

1. Our fourth Accord Annual meeting in September and,
2. Our third "Way Forward" event in March, jointly hosted on this occasion with Northern Lincolnshire and Goole NHS Foundation Trust

There are also 'bite-size' evening meetings held after these events for people unable to attend a daytime meeting. The purpose of these events is to share information about priorities, plans and progress and provide opportunities for service leads to engage with participants in smaller discussion groups to inform their commissioning plans. The outcomes and feedback from these sessions are sent to all participants and published on the CCG website.

At the Accord Annual meeting this year we used hand held voting devices to engage with participants on satisfaction with the membership scheme and support for CCG plans. Both events ended with a Question and Answer Panel with NHS, Local Authority and social care leaders, giving participants an opportunity to ask questions about local developments.

Statement from Patient and Public Involvement (PPI) 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. The benefits of this type of public engagement are key to the future progression of the CCG in delivering its strategy over the coming year and beyond. No other local CCG has such a direct route into public consultation and our community engagement seems one step ahead nationally.*

Accord (our community membership) has developed in the last three 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 (ASG) 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 ASG members are highly motivated in ensuring the membership can be used by the CCG and Union Board to help seek public views on delivery of health services in our area.

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.

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. The group has increased in size in the last year and we appear to reach more PPGs as a result. A number of initiatives have been tested in certain PPGs to tackle issues such as patients not attending appointments. Over the last twelve months, the group has encouraged regular attendance from Healthwatch and invited a member of the Accord Steering Group to attend, both initiatives to reach the wider community.

As Lay Member, I am a member of the CCG Quality Committee, to provide lay challenge of Quality initiatives and monitoring of clinical services provided by and for the CCG. In the last twelve months, I have attended the Clinical Harm Review Group established by Northern Lincolnshire and Goole Hospital Trust (NLaG). The group has been tasked with reviewing if harm has occurred to patients as a result of lost patient referrals or huge delays (over 30,000) in outpatient review appointments. I have been an active member of this group providing the lay public/patient perspective in reviewing processes established by NLaG to tackle the problems faced by the Trust.

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. This engagement will be a key challenge in 2018/2019 as key services must be reviewed from both a financial and safety viewpoint.

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 at a time when changes will have to be made in the delivery of health services".

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:

- Proactively encouraging members of staff to update their equality data so we can keep an overview of the diversity of our workforce
- Registering with the Disability Confident scheme to reflect the positive work we do with staff members with disabilities and to work to enhance this

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.

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.

Our engagement processes and outcomes were recognised this year with a "green star" rating reflecting our positive and active approach to engaging with all sectors of the community, including groups with protected characteristics.

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 used this year to enable our health and care community to prepare for publication of data on the gender pay gap and the roll out of the Workforce Disability Equality Standards.

North East Lincolnshire CCG's Partnership Board receives regular updates on progress related to the organisation's 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. We include them in our programme of work related to EDS2 in so far as we seek assurance from hard to reach groups on the way in which we commission services for our communities.

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.

This is informed by reference to our local JSNA which helps to inform and target our efforts in relation to vulnerable groups. For example we know that older people are a particularly vulnerable group in our areas of high deprivation and the work we have done in relation to targeted support to care homes was supported by our analysis of protected groups.

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 2018/19 we have plans in place to prepare for the evolution of the Workforce Race Equality Standards and 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 2017/18. The day to day management of this rests with the Director of Quality and Nursing.

Key achievements in 2017/18 include the following:-

- We have appointed a new Quality Assurance Manager during 2017 that has strengthened our capacity to provide professional expertise to nursing and quality assurance processes. The post-holder is a nurse who works closely with commissioners to seek assurances from providers in terms of the quality of services they provide.
- We have strengthened our CCG Executive team with the appointment of a part-time Medical Director to provide clinical leadership and direction to influence clinically strong commissioning
- We have developed a CCG Strategy for Infection Prevention and Control, and an action plan to reduce the number of gram negative bacilli infections by year 2020.
- Work continued during 2017 to produce a CCG Quality Strategy and Quality Framework; however this work was not completed due to conflicting demands on the team and will be continued again in 2018.
- One new approach that we have embedded over the last year was our process called "Noise in the System". This process triangulates all available data and intelligence, providing a more structured approach to raising concerns as early as possible and we have used this several times during 2017.
- We have been working with North Lincolnshire CCG and with the local hospital as part of the *Right Care Wave 2 programme*, focusing on three specialist clinical outcome areas, to improve

effectiveness and efficiency through newly developed clinical pathways with improved outcomes for patients

- 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 serious incidents.
- The GP Quality Lead 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. This has given us a depth of insight to inform our joint action planning and key messages for primary and community care.
- The GP Quality Lead has been involved in developing a robust method for reviewing the medical records of people who have waited too long for hospital services. The GP Quality Lead worked with hospital staff and doctors and helped to develop the process and gained the engagement of other GP colleagues in delivering a review of the medical records.
- We have escalated areas of concern with regards to a number of providers across primary, community and secondary care, as well as care homes, and we have worked positively with other commissioners, the CQC, NHS England and professional bodies to address shortfalls in the quality of care.
- The CCG has worked with the internal audit team at North East Lincolnshire Council to agree an audit to assess the system and process for complaints management within the CCG. An action plan will be developed accordingly.
- We have continued to develop the CCG's internal process for the review of incidents that are reported through the CCG Incident App to ensure we close the loop and are confident that the learning from the incident is embedded.
- To share lessons learnt from Incidents the CCG continues to produce a newsletter called *'Risky Matters'* – a quarterly bulletin to enable cross-organisational learning from incidents.
- In addition to the monthly Serious Incident meetings the CCG have an established monthly incident meeting to scrutinise the data for themes and trends.
- We have continued to work closely during 2017/18 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 included reviews of case notes which has provided significant learning. Further work is required to continue to develop a strategic approach during 2018/19.
- Work has continued in respect of the Quality Framework applied to Care Homes commissioned by the CCG. The Care Home project continues to work on a number of significant areas to improve quality of care, efficiency of services and joint working. This work will continue into 2018/19
- The Designated Nurse for Adults and Children has developed Safeguarding Standards applicable to health and social care providers. This will strengthen the quality team's approach to securing assurance that safeguarding standards in providers are met.
- The CCG continues to work with partners including Primary Care, across the locality to develop strong leadership and joined up approaches to the delivery of the safeguarding agendas for adults and children.
- The CCG continues to provide leadership and membership to local safeguarding arrangements.
- The CCG has continually worked and where required provided leadership, with providers where quality of care is not strong and requires continued focus on risk and harm, clinical outcomes and patient experience. We have worked with other commissioners and regulators 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 Referral to Treatment Time targets.
- We continue 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 maintain our involvement in Sustainable Transformation Partnership (STP) activity, ensuring a connection with quality arenas in North East Lincolnshire.

Objectives, in relation to quality for 2018/19 are as follows:

The key objectives for 2018/19, in relation to assuring quality within our internal processes and externally with our commissioned providers, are to:

- The CCG will make changes to the way it seeks assurance regarding quality and will seek to align its monitoring of performance and quality into one committee. Clinical Governance assurances will be sought through a separate Clinical Governance Group with strong clinical leadership.
- The Quality Team will re-commence the work around the Quality Strategy and Delivery Plan with the intention of completing that by December 2018. 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 take into account the developing and strengthened partnership working with North East Lincolnshire Council.
- The patient experience domain of our strategy, in particular, still requires more work to ensure we are fully aware of patient experience, and we will build our approach into the developing Quality Strategy.
- In 2017 we started work on the development of quality profiles, to provide an overview of risks, quality and performance. We still have further work to do to develop them fully and will continue work on these in 2018.
- During 2018 we will further develop our mortality strategy and will build upon a piece of work undertaken during 2016/17 to include local plans for End of Life, and the learning from joint work to review deaths with 30 days of hospital discharge.
- We will further develop the quality profiles to become a central resource for CCG Commissioners and for Quality and Performance team members.
- We will continue to work on RightCare pathways and embed good practice through the new clinical pathways, as well as working with the hospital to align another national programme called "*Getting it Right First Time" (*GIRFT).
- 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.
- As the CCG works closer with the NE Lincolnshire Council we are seeking ways of working closer and we will look to align our processes around information governance.

14Z15(2)(b) - CCG's must contribute to the delivery of the joint Health & Wellbeing 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 routinely outside of the formal meeting to set the agendas for the meetings, oversee and assure progress and discuss any issues.

As part of completing this annual report the chair of the Health and Welling 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 set by the Health and Wellbeing Board. The CCG meets regularly with the Director of Public Health and the Portfolio Holder for Health, Wellbeing and Adult Social Care to set the agenda, assess progress and ensure that relevant items are brought to the meeting for discussion. They are an active partner and regular attender at the Board meetings*".

North East Lincolnshire council and its key partners have agreed a **strategic outcomes framework - NELIVES**, to drive and focus and co-ordinate work across all of the key agencies.

As part of the strategic outcomes framework there is a specific Health and Wellbeing outcome which states that:

We want people to be informed, capable of living independent lives, self-supporting and resilient in maintaining/improving their own health. By feeling valued throughout their lives feel, people will be in control of their own wellbeing, have opportunities to be fulfilled and are able to actively engage in life in an environment that promotes health and protects people from avoidable harm.

Access will be made available to safe quality services that prevent ill health, support, maintain and restore people back to optimal health or support them with dignity at end of life as close to home as safety allows: Services that are part of an affordable innovative and quality health and social care system which directs resources according to need.

The above is being used to help inform the new Health and Wellbeing Strategy which is being finalised. The CCG has been actively involved in the development of the new strategy and continues to commission and develop services that will contribute to support delivery of the Health and Wellbeing overarching outcome and the emerging strategy.

Detailed below are a few examples of how the work of the CCG is contributing towards achievement of the above and therefore the overall Health and Wellbeing outcome and strategy:

- The CCG fund 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 bowel screening to ensure that it is able to deliver to the national requirements, this has been cited as good practice by the regional quality assurance lead for bowel screening.
- The CCG has implemented a diabetes prevention programme to support people who are at risk of developing Type II diabetes to understand the risks and make lifestyle changes to reduce their risk of developing the condition.
- The CCG has implemented a community Cardiology pilot to test out alternative approaches to the diagnosis and management of heart conditions.
- The CCG clinical lead is working with our practices and the hospital clinicians to improve pathways to support early diagnosis and treatment of cancer.
- The Health and Care Single Point of Access (Ph: 01472 256256), is a 24 hour 7 days a week information, advice, and access line for people who have queries about health and care and can signpost / refer to community groups and services available in the person’s area that could be of benefit to them.
- 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” an 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 the summer of 2015, and building work will commence on the second scheme shortly with the aim of having 250 extra care homes across the borough in the coming years.

- The CCG has been working with the Big Lottery to develop an initiative called "Thrive NEL" which is a Social Prescribing initiative which will support the development of community groups to create opportunities for individuals and groups to tackle key issues including, 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 Well-being Strategy, can be found on the council website

1.2.7 Access to information (FOI)

During the period from 1 April 2017 to 31 March 2018, the CCG processed the following requests for information under the Freedom of Information Act 2000 (FOIA):

	2017/18
Number of FOI requests processed	234
Percentage of requests responded to within 20 working days	100%
Average time taken to respond to an FOI request	15 days

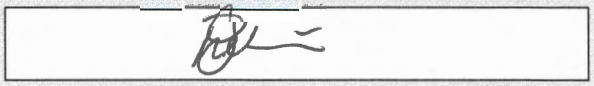
The CCG did not provide the information requested in 36 cases because one or more exemptions applied either to part of, or to the whole request e.g. information was accessible by other means, the cost of providing the information exceeded the limits set by the FOIA, disclosure of information would be likely to prejudice the commercial interests of any person, information related to the personal data of third parties, disclosure would be likely to prejudice effective conduct of public affairs or where a 'repeated request' was received.

The CCG did not provide information in 29 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 routinely published documents; available on our website (http://www.northeastlincolnshireccg.nhs.uk/publication-scheme/)

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 Metori
Accountable Officer

Date 24/05/2018.

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."

2.0 Accountability Report

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 CCG'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 2017/18 up to the signing of the Annual Report and 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 local patients' needs. Our member practices are:

Practice	Representative/s	From – To
MediAccess Ltd Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr Amin	April 2013 – 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 T Bruning Dr Arun Nayyar	July 2016 – May 2017 May 2017 - present
Birkwood Medical Centre, Westward Ho, Grimsby, DN34 5DX	Dr Karin Severin	April 2013 – present
Dr B Biswas & Partner, 142-144 Grimsby Road, Cleethorpes, DN35 7DL	Dr P Ray	April 2013 – present
Dr Chalmers & Dr Meier, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr I Chalmers** 	April 2013 – present April 2013 – present
Chantry Health Group, Cartergate, Grimsby, DN31 1QZ	Dr A M Bamgbala Dr S Menon	April 2013 – November 2017 November 2017 - present
Clee Medical Centre, 323 Grimsby Rd, Grimsby, DN35 7XE	Dr Kazim Sibtain	October 2014 – present
Core Care Family Practice Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH	Dr Arun Nayyar	July 2016 – present
Greenland Surgery & New Waltham Surgery, New Waltham, Grimsby, N E Lincolnshire, DN36 4QG	Dr Jeeten Raghwani	November 2015 - present
Field House Medical Group, Freshney Green Primary Care Centre, Sorrel Rd, Grimsby, DN34 4GB	Dr A Fazil	July 2016 - present
Healing Health Centre, Wisteria Drive, Healing, DN41 7PU	Dr Thomas Maliyil	February 2016 - present
Humberview Surgery, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr David Elder	April 2013 – present
Dr A Kumar, 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
The Lynton Practice (formally Dr Dijoux and Partners), Taylors Avenue Medical Centre, Taylors Avenue,	Dr Sylvere Dijoux Dr J.P Cantin	April 2013 – October 2017 October 2017 - present
Dr Mathews, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr Renju Mathews	April 2013 - present
Open Door, 13 Hainton Ave, Grimsby, DN32 9AS	Jane Miller	January 2016 - present
Pelham Medical Group, Church View Health Centre, Cartergate, DN31 1QZ	Dr David Elder	April 2013 – present
Raj Medical Centre, 307 Laceby Road, Grimsby, DN34 5LP	Dr Rakesh Pathak	April 2013 – present

Roxton at Weelsby, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr Laura Bernal-Gilliver	July 2016 – present
The Roxton Practice, Pilgrim Primary Care Centre, Pelham Road, Immingham, DN40 1JW	Dr Laura Bernal-Gilliver	July 2016 - present
Scartho Medical Centre, Springfield Road, Scartho, Grimsby, DN33 3JF	Dr Catherine Twomey Dr Sudhakar Allamsetty	February 2016 – April 2017 February 2016 – present
Dr A Sinha, Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH	Dr Anupam Sinha	August 2013 - 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	Jane Miller	July 2016 – present
Woodford Medical Centre, Freshney Green Medical Centre, Sorrel Road, Grimsby, DN34 4GB	Dr Peter S John	February 2015 - present

** denotes – both have signed mandate to vote on behalf of their practice – only one vote is counted

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.*

Please see our website for individual board members profiles

NHS North East Lincolnshire Clinical Commissioning Group Board Membership 2017/18

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

Mark Webb **
CCG Chair (Lay Member)
(1 April 2013 – present)

Peter Melton **
Clinical Chief Officer
(1 April 2013 – present)

Rob Walsh **
Joint Chief Executive NELCCG/NELC
(August 2017 – present)

GP Members

Dr Thomas Maliyil
Vice CCG Chair/
Chair of Council of Members
(Sept 16 – present)

Dr Ekta Elson **
Medical Director
Vice Chair of
Council of Members
(February 2018 – present)

Dr Arun Nayyar **
GP Representative
(April 2013 – present)

Dr Rakesh Pathak **
GP Representative
(April 2013 – present)

Lay Representatives

Philip Bond **
Lay Member Community Engagement
(April 2013 – present)

Tim Render **
Lay Member Governance & Audit
(Aug 2016 – present)

Helen Kenyon *
Deputy Chief Executive
(April 2013 – present)

Laura Whitton **
Chief Finance Officer
(January 2017 – present)

Jan Haxby **
Director of Quality /
Registered Strategic Nurse
(July 2015 – present)

Dr David James **
Secondary Care Doctor
(Nov 2015 – present)

Stephen Pintus **
Director of Public Health
(Jan 2015 – present)

Joe Warner **
Chief Executive focus
Independent Adult Social Work
(Sept 2013 – present)

Juliette Cosgrove **
Clinical Member
(April 2013 – 31 March 2018)

Vacant Post **
NEL Primary Care
(Non -GP) Member

Councillor Jane Hyldon-King ***
Portfolio Holder (NELC)
(July 2015 – present)

Councillor Peter Wheatley ***
Portfolio Holder (NELC)
(June 2017 – present)

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

The following Governing Body and Partnership Board members resigned from their position during 2017/18		
Derek Hopper ** Vice Chair of Council of Members		Sept 2016 – Sept 2017
Councillor Matthew Patrick *** Portfolio Holder for Finance and Resources (NELC)		May 2015 – June 2017

2.1.2 Our Committees

Our Governing Body and Partnership Board are supported by the following committees to assist in the delivery of the statutory functions and key strategic objectives of the CCG.

- Integrated Governance and Audit Committee
- Remuneration Committee
- Joint Committee for Primary Care Co-Commissioning
- Community Forum

Full details of committees, functions, membership and attendance for 2017-18 can be found in the Annual Governance Statement

2.1.3 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 and Committee members are required to complete a declaration of interest form to identify any potential conflicts of interest. The CCG ensures that declarations of interests are made and confirmed and updated annually. The register is signed off by the Integrated Governance and Audit Committee.

Any request for historical information must be submitted to the CCG's Chief Finance Officer.

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

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

2.1.4. 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 met 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.
The CCG's complaints process is currently under review and we are seeking the views of wider stakeholders and not just the CCG itself. All complaints are investigated and responded to in line with the Principles for Remedy, any employee errors or maladministration are dealt with accordingly.

We are also making best use of all of our intelligence, from incidents and not just complaints, by triangulating them to identify themes and ensure we capture any concerns early and are able to address them.

The CCG's Deputy Chief Executive and Director of Quality and Nursing personally sign 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 2018/19 the CCG will complete the review of its complaints policy and will be developing a new system to ensure the learning from complaints influences the assurances sought from providers through contract meetings or on-site visits to providers.

Personal data related incidents

Details can be found in the Control Issues section (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 and 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 2017 completed a mandatory self-assessment against the EPPR requirements. In comparison to 2016, the self-assessment demonstrated an improved level of compliance against the core EPRR standards, moving from "partial" in 2016 to "substantial" in 2017 and an action was developed to ensure compliance was maintained and gaps in compliance against the core standards were targeted for improvement.

Further work undertaken to date to support meeting the action plan objectives includes the following; in October 2017, the local Emergency Planning and Response Group (EPARG) held a table top exercise to assess provider Flu response plans, in December 2017, a number of CCG senior managers undertook training on "Strategic Leadership in a Crisis", and further measures have been implemented to improve CCG wide communications in the event of any issues arising requiring broadcast communications to all staff. A

number of CCG staff and local provider communications exercises are planned this year in line with the requirement to perform these at least twice yearly.

Health and Safety

North East Lincolnshire Clinical Commissioning Group recognises its responsibilities and duties under the Health and 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 and safety.

North East Lincolnshire Clinical Commissioning Group has commissioned its Health and 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. In addition to this the CCG has its own in-house first aiders, DSE assessors, Mental Health First Aiders and we also have a selection of staff trained in defibrillator usage.

Fire risk assessments are carried out annually by North East Lincolnshire Council. The latest assessment feedback was that the Athena building (NEL CCG HQ) was very well maintained and managed with good housekeeping in place and evidence provided of regular fire drill tests.

Health and safety is a part of the mandatory e-learning training schedule that needs to be undertaken by all staff. In October 2017, North East Lincolnshire CCG added data screen assessment (DSE) training as an additional mandatory course, all staff are required to complete to ensure personnel using DSE on a regular basis are fully trained in its safe usage.

83% of our staff has completed Health and Safety training

79% of our staff has completed DSE training

For the period April 2017 to March 2018 there were ***four*** reported Health and Safety related incidents none of which were RIDDOR reportable.

Signature

Dr Peter Melton
Accountable Officer

Date 24/05/2018.

2.1.5 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).

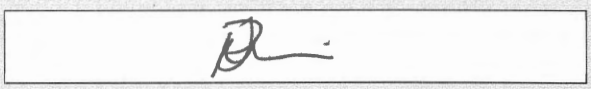
Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must 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 24/05/2018.

2.1.6 Annual Governance Statement

Introduction and 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 2017 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 main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The CCG's Constitution

The CCG's Constitution 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, associated Standing Orders, Prime Financial Policies and Scheme of Delegation, 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. All of which have been approved by the CCG's membership and certified as compliant with the requirements of NHS England

The Scheme of Delegation within the constitution outlines those decisions that are reserved to the Council of Members and those that are the responsibility of its Governing Body (and its committees), CCG committees, individual officers and other employees.

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.

Changes made during 2017/18 are as follows:-

National guidance

- Further refinement of the inclusion of joint working arrangements with respect to a Joint Commissioning Committee for the Humber sub-region of the Humber, Coast and Vale STP;
- Reflection of NHSE updated Managing Conflict of Interest Statutory Guidance for CCGs
- Full reflection of the pre-existing CCG formal committee structure in the Constitution;
- Fully delegated commissioning arrangements (including Scheme of delegation)

Members Information

- Update to the terms of office for GP retirees.

Editorial changes

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

The CCG Constitution can be found on the CCG's website

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 2017/18, 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.

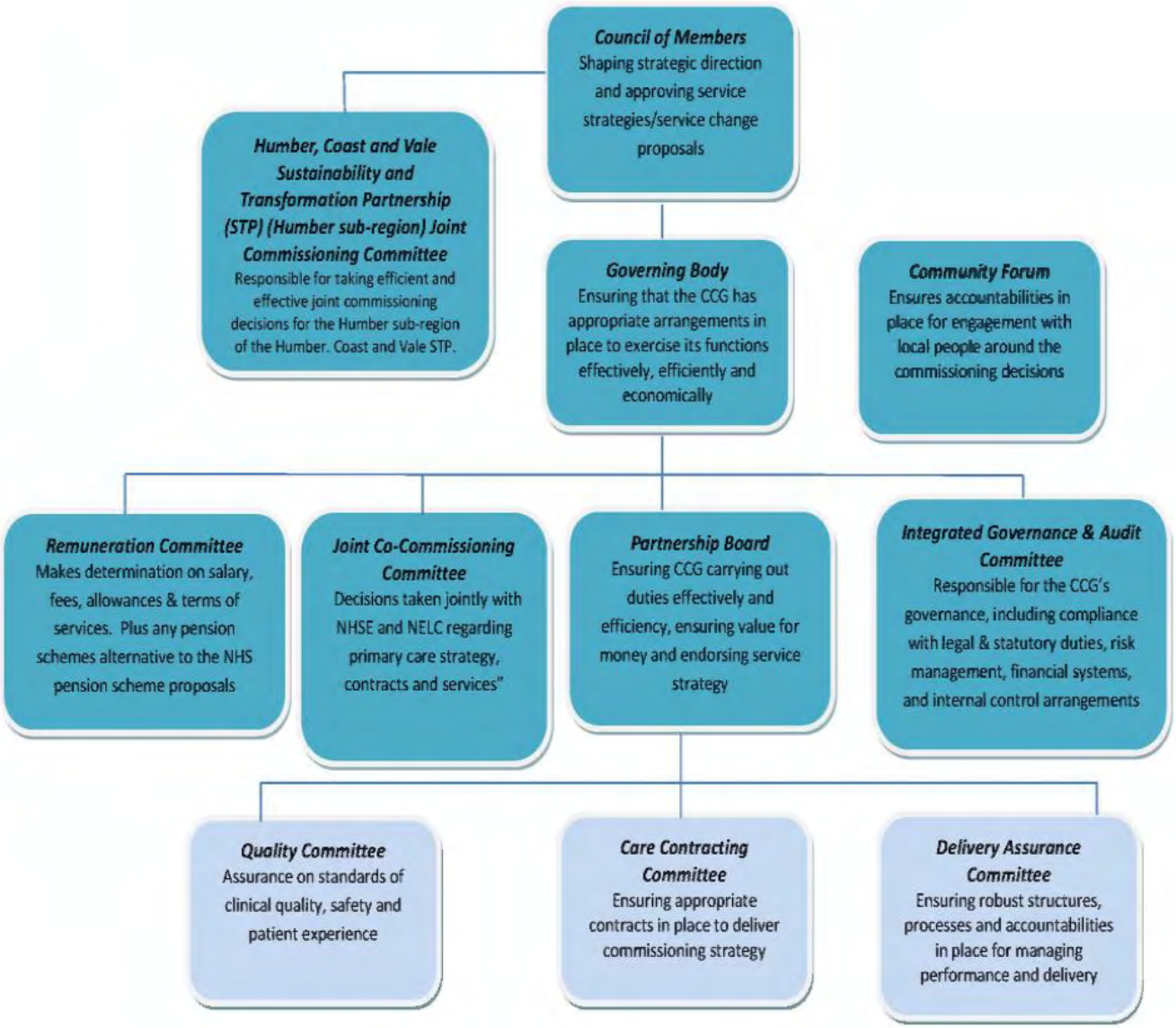
As part of the CCG's governance arrangements there is a requirement for "*public and patient involvement".* The CCG does this via the *Community Forum*. Community Contacts, who are drawn from the CCG's Accord membership scheme, have the opportunity to contribute to the CCG's governance arrangements through positions on Service Triangles, committees and working groups, where they sit as equal partners with health professionals to influence service improvements.

Corporate activity is captured via the corporate business plan and the integrated assurance 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, four risk domains and three quality domains, which incorporate all areas that North East Lincolnshire Clinical Commissioning Group strive to improve on.
A judgment is made on the status for each domain based on the indicators underpinning them. These judgements try to balance the current performance position with the expected year end performance and individual indicator weightings. They also represent the local perspective of performance for North East Lincolnshire rather than the performance against the national definition which, on occasion, covers a broader footprint. Those issues that have an impact on the CCG's corporate performance assessment are also scrutinised at the Delivery Assurance Committee, with escalation to the Partnership Board.

The integrated assurance report can be found on the CCG website

The CCG Governance Committee structure has been established to support the Governing Body in fulfilling its functions and summarised in the diagram below.



Work completed during 2017/18 with regard to the changes required to the CCG governance arrangements in 2018-19,

- **Delegated Commissioning for primary medical services**

In January 2018, NHS England approved the CCG to take on delegated commissioning arrangements for primary medical services from NHS England with effect from 1 April 2018. The constitution has been amended to fully reflect the required changes and these changes have been approved by NHS England subject to the following conditions.

- The terms of reference of the primary care commissioning committee to have an additional lay member on the committee and that person to be identified as the vice chair. This would bring the CCG in line with the statutory guidance on conflicts of interest and guidance on primary care co-commissioning, which is to have a lay chair and a lay vice chair for this committee.

The terms of reference have been updated to reflect the above and approved by the CCG Governing Body in March 2018.

- **Union Arrangement**

In May 2017 Council of Members voted and agreed the proposed plans for greater joint working between the CCG and NELC. In June 2017 the Governing Body voted unanimously to support the Strategic Case for Change. Regular updates have been given to the Council of Members, Partnership Board and emerging Union Board since then by both Rob Walsh and Peter Melton.
A refresh of the current section 75 arrangements is currently taking place. North East Lincolnshire CCG and North East Lincolnshire Council have engaged DAC Beachcroft LLP on a joint basis to undertake this piece of work. Both parties have signed a Collective Interests Agreement. DAC Beachcroft LLP are happy to be engaged on this basis given the focus of the work i.e. the substantially common interest regarding the advice on the place based commissioning model and revision to the existing s75 in place between both parties. Their role is limited to advising how the parties can collaborate to develop a place based commissioning model and documenting revisions to the s75 agreement. This approach was discussed and agreed at the Union Board workshop (which includes CCG Governing Body members) on the 14 December 2017

The CCG has also engaged with Colin McIlwain, Head of Planning and Assurance (North) and Lisa Walder, Head of Planning/Integration/Section 75 development lead NHS England to update them on the approach being taken. The feedback received was that *North East Lincolnshire were "**incredibly structured, careful and considered**" in the way that they were taking all this forward"*

The attendance, membership, and activity summary

The 2017-18 membership, attendance and activity summary of the Council of Members, Governing Body and the Governing Body committees are given 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;
- establishment of Joint Committees.

The Council of Members held formal monthly meetings throughout 2017-18, with the exception of August, which was cancelled due to the high number of apologies, and March which was cancelled due to adverse weather (snow). For the 10 formal meetings within 2017 the committee was fully quorate.

The CCG recognises that there are continued issues in relation to attendance of all member practices at the monthly meetings. This was discussed at the February 2018 meeting where it was agreed that those practices that appear to be struggling to attend will be contacted individually to have conversations regarding the issues that may be preventing them from attending. The CCG is also exploring whether a process could be put in place to link up those practices with other practices within their Federation to agree representation and establish feedback mechanisms. An appointment has also recently been made to a new Medical Director role which will provide clinical oversight for CCG commissioning, project management and governance, and can provide support to help engage those practices.

Over the past year the Council of Members has approved the case for change to progress with the Union arrangements, together with a number of service strategies, service change proposals prior to ratification by the Partnership Board or relevant committee, 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):

    - Ophthalmology services
    - Revised Dementia Pathway
    - Social Prescribing service
    - Community Cardiology
    - Support to care homes
    - Urgent Care
    - Adult ADHD
    - Point of Dispensing enhanced service
    - Carers Strategy
    - Neurology

MEMBERS ATTENDANCE

Members	Attendance (Max 10 meetings)
Medi Access Ltd	0 (10)
Dr P Suresh-Babu	0 (10)
Beacon Medical Centre	8 (10)
Birkwood Medical Centre	5 (10)
Dr B Biswas & Partner	6 (10)
Dr Chalmers & Dr Meier	0 (10)
Chantry Health Group	9 (10)
Clee Medical Centre	6 (10)
Core Care Family Practice (previously Dr R Kumar)	9 (10)
Dr Dijoux and Partners	1 (10)
FieldHouse Medical Group	9 (10)
Greenland Surgery & New Waltham Surgery	2 (10)
Healing Health Centre	9 (10)
Humberview Surgery	6 (10)
Dr A Kumar	0 (10)
Littlefield Surgery	6 (10)
Dr Mathews	5 (10)
Open Door	5 (10)
Pelham Medical Group	6 (10)
Quayside Open Access	5 (10)
Dr O Z Qureshi	0 (10)
Raj Medical Centre	4 (10)
The Roxton Practice	8 (10)
Roxton at Weelsby	8 (10)
Dr A Sinha	9 (10)
Scartho Medical Centre	0 (10)
Woodford Medical Centre	1 (10)
Vice Chair of CoM	8 (10)
Executive Director with responsibility for ASC strategic commissioning	8 (10)
ASC advisor	8 (10)

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.

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 and 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.

This year the Governing Body were also provided with an update of the activities of the Safeguarding team, which included an update of Prevent, and the many challenges that the team face in the North East Lincolnshire region.

The Governing Body also discussed and approved the application to NHS England by the CCG in respect of taking on fully delegated commissioning of general practice services from April 2018.

The Governing Body also discussed and approved the partnership arrangement with North East Lincolnshire Council, and had many detailed discussions regarding the proposed Union.

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 ***four*** times in public during 2017/18 and attendance records demonstrate that every meeting was quorate.

The Governing Body discharged its duties in full in 2017/18.

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		3 (4)
Rob Walsh Joint Chief Executive	Joined 1/8/2017	3 (3)
Helen Kenyon Deputy Chief Executive		3 (4)
Laura Whitton Chief Finance Officer		4 (4)
Derek Hopper Vice Chair Council of Members	Left 1/2/2018	2 (3)
Jan Haxby Director of Quality and Nursing		4 (4)
Dr Arun Nayyar GP representative		3 (4)
Dr Rakesh Pathak GP representative		4 (4)
Philip Bond Lay Member Community Engagement		4 (4)
Tim Render Lay Member Governance and Audit		3 (4)
Dr David James Secondary Care Doctor		3 (4)
Juliette Cosgrove Clinical Lay Member		3 (4)
Joe Warner Managing Director Focus independent adult social care work		3 (4)
Stephen Pintus Director of Public Health (Local Authority Officer)		0 (4)
Dr Ekta Elston Vice Chair Council of Members/GP representative	Joined 1/2/2018	0 (1)

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.
- 2017/18 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.
- Update on Resilience Planning.
- An update of the Adult Services Review.
- An update of the Humber Acute Services Review
- Annual Equality and Diversity Update.
- Quality of services, including standardised Hospital Mortality Index (SHMI) performance and CQC reports.

The Partnership Board 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
- An update given by the Joint Chief Executive of the proposed Union between North East Lincolnshire Clinical Commissioning Group and North East Lincolnshire Council.
- An update provided regarding the development of the Sustainable and Transformation Plan
- An update on the Winter and Integrated Urgent Care situation

The Partnership Board also extensively discussed the CQC's reporting of their concerns at North Lincolnshire and Goole Hospital NHS Foundation Trust.

The Partnership Board also discussed and approved the application to NHS England by the CCG in respect of taking on fully delegated commissioning of general practice services from April 2018.

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

The Partnership Board met ***six*** times throughout 2017/18 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		5 (6)
Rob Walsh Joint Chief Executive	Joined 1/8/2017	4 (4)
Helen Kenyon Deputy Chief Executive		5 (6)
Laura Whitton Chief Finance Officer		6 (6)
Derek Hopper Vice Chair Council of Members	Left 1/2/2018	3 (5)
Jan Haxby Director of Quality and Nursing		5 (6)
Dr Arun Nayyar GP representative		4 (6)
Dr Rakesh Pathak GP representative		5 (6)
Philip Bond Lay Member Community Engagement		6 (6)
Tim Render Lay Member Governance and Audit		6 (6)
Dr David James Secondary Care Doctor		6 (6)
Juliette Cosgrove Clinical Lay Member		4 (6)
Joe Warner Managing Director Focus independent adult social care work		4 (6)
Stephen Pintus Director of Public Health (Local Authority Officer)		2 (6)
Cllr Jane Hyldon- King Deputy Leader & Portfolio Holder for Health & Wellbeing & Adult Social care (NELC)		4 (6)
Cllr Mathew Patrick Portfolio Holder for Finance & Resources (NELC)	Left 25/5/2017	1 (1)
Cllr Peter Wheatley Portfolio Holder for Regeneration, Assets, Skills and Housing (NELC)	Joined 25/5/2017	3 (5)
Dr Ekta Elston Vice Chair Council of Members/GP representative	Joined 1/2/2018	0 (1)

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 2017/18. Meetings are always well-attended and minutes demonstrate that each meeting was quorate. The forum consists of 12 community members of which are appointed for a specific triangle, committee or working group role; plus 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.

All members successful completed Data Security Awareness training as requested by the CCG.

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.

Collectively the forum highlights for 2017/18 include:

- Considered and commented on key commissioning plans and policies including Ophthalmology Services; Children and Adolescent Mental Health Services (CAMHS); Better Care Fund and iBCF submissions; review of Domiciliary Care delivery; Primary Care development including extended hours; Urgent Care redesign and the location of the Urgent Treatment Centre; items which should not be routinely prescribed in primary care and conditions for which over the counter items should not routinely be prescribed in primary care; and the Humber Acute Services Review.
- Received information and commented upon development of the Union and closer working with the local authority with the joint Chief Executive.
- Received information and commented upon presentation by guest speakers including public health and North East Lincolnshire Women's Aid.
- Considered, commented and advised on CCG and STP engagement and communications plans.
- Collaborated with Partnership Board and Council of Members on potential redesign of Triangles.
- Completed Data Awareness Training.

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

- Clinical Pharmacists in General Practice pilot steering group.
- Visiting care homes with commissioners to support the Care Home Trusted Assessor proof of concept and roll out.
- Procurement panel members for Social Prescribing, Adult Social Care Review and CAMHS.
- Carried out consulted on the CAMHS tender specification with community groups.
- Development of engagement materials to gain the view of vulnerable people.
- Shortlisting and judging panel for the Health and Social Care Awards 2017.
- Developing and supporting people panel for CAHMS and Supporting Living procurements
- Dermatology Services bid evaluation.
- Participation in Governance Group re Union Board development and Union Board meetings.
- Participation in multi-agency initiatives such as the Preventative Services Board, SPA Board, Extra Care Housing Scheme panel, health checks project group, Mortality Group, Quality Surveillance Group; Urology Transformation Board, Cardiology Oversight Group, Parent Participation Group.
- Participation in cross-area planning such as the Area Prescribing Committee and Expert by Experience Care and Treatment Review panels (Yorkshire and Humber region).

- Contributed to development of Long Term Care specification and redesign of Quality Framework.
- Developed and implemented engagement initiative re SPA "phone first" facility.
- Participated in design and delivery of workshops within "Way Forward Event".
- Attended Autism Forum and reviewed Children's Autism services with parents.
- Visited and signposted number of community organisations, particularly those providing support for Learning Disabilities, to access support from wider VCSE Alliance.
- Attended Mental Health STP planning group, contributed to discussion to identify way forward.
- Represented NELCCG at multi-agency Equality and Diversity workshop; contributed to delivery of Equality Impact Assessment Training.

Members		**Attendance (Max 12 meetings)**
Anne Hames (Chair)		12 (12)
Albert Bennett Lay Community Lead Older People's Service Triangle		11 (12)
Philip Bond Board Lay Member Community Engagement		9 (12)
Eveline Dawson Lay Community Lead Equality & Diversity	Joined Oct 2017	4 (6)
Diane Edmonds Community Forum Member		10 (12)
Christine Foreman Lay Community Lead Community Care Service Triangle		11 (12)
Bernard Henry Community Forum Member		11 (12)
Margaret Henry Lay Community Lead Prescribing Service Triangle		11 (12)
Barry Osborne Lay Community Lead Disability & Mental Health Service Triangle		11 (12)
Terrence Simco Lay Community Lead Planned Care Triangle		9 (12)
Pam Taylor Lay Community Lead Women & Children's Service Triangle		11 (12)
David Walker Lay Community Lead Representative Delivery Assurance Committee		12 (12)
Wendy Wood Lay Community Lead Representative Council of Members		11 (12)
Michelle Barnard Assistant Director Women & Children		9 (12)
Sally Czabanuik NELCCG Engagement Manager		11 (12)

Integrated Governance and Audit Committee

The Integrated Governance and Audit Committee is accountable to the CCG's Governing Body.

It 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:

a) Economy, effectiveness and efficiency.
b) 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:

a) The group's financial systems and financial information.
b) 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" and "should do's";
- Delivery of the Committee's Annual work plan;
- Focus at each meeting on a specific key risk area, in particular;
    - Implications for the CCG of Northern Lincolnshire and Goole NHS Foundation Trust recovery plans and interventions.
    - Development of the Accountable Care Partnership.
    - Development of the CCG / NELC Union.
- Pro-active involvement of the Audit Chair in the development of the Governance Arrangements of the Union.

The IG&A Committee met ***four*** times throughout 2017/2018 and attendance records demonstrate that each meeting was quorate.

Members		**Attendance (Max 4 meetings)**
Tim Render (Chair) Lay Member Governance and Audit		4 (4)
Joe Warner Partnership Board lay member		4 (4)
Cllr Mathew Patrick Partnership Board lay member	Left 25/05/2017	0 (1)
Dr Karin Severin GP Representative		2 (4)
Cllr Peter Wheatley Partnership Board lay member	Joined 01/08/2017	3 (3)

The Joint Committee for Primary Care Co-commissioning

Having being established in 2015, the Joint Co-Commissioning Committee has just completed its third year of operation. The primary purpose of the Committee is to jointly commission 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.

These joint arrangements mean 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, that the services are planned in a way that meets local need, fit 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 2017/18 five 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.

Work over the past year has included all of the areas set out within the Committee's work plan, and it has overseen a number of pieces of work and has made a number of decisions regarding local services including:

- Approval of a local quality scheme for local general practices.
- Agreement to continue commissioning a range of services that are commissioned from local general practices, over and above their core contract requirements, aimed at treating patients in a more local setting and avoiding the need for hospital treatment (e.g. monitoring of anticoagulation medication; on-going monitoring and injections following prostate cancer).
- Monitoring of progress against the local development and investment plan for general practice, in line with NHS England's GP Forward View paper.
- Approval of a number of small schemes to improve technology within the practices and enable them to work more closely with other practices within the area (e.g. upgrades to telephone systems).
- Mergers of local practices.

The Committee has also had to make some difficult decisions, 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.

This year the Committee also made a recommendation to the CCG's Council of Members and Governing Body that the CCG should take on the responsibility for the commissioning of the core contract for local GP Practices, which currently sits within NHS England. This is in line with what is happening across the country, supported by NHS England, and means that all of the commissioning decisions sit at the local level with the CCG, enabling a more streamlined process and more of a 'place-based' focus.

From April 2018, the CCG will take on this responsibility and will establish a Primary Care Commissioning Committee, which will have additional lay representation, to oversee these decisions.

Members		Attendance (Max 5 meetings)
Mark Webb (Chair)		4 (5)
Philip Bond (Deputy Chair) PPI Lay member	Joined March 2018	1 (1)
Dr Thomas Maliyil Chair of Council of Members		4 (5)
Dr Derek Hopper (Vice chair of Council of Members)	Left December 2017	3 (3)
Zena Robertson NHS England Representative	Left December 2017	1 (3)
Erica Ellerington NHS England Representative	Joined July 2017	4 (4)
Cllr Jane Hyldon-King Deputy Leader & Portfolio Holder for Health & Wellbeing & Adult Social care (NELC)		4 (5)
Steve Pintus Director of Public Health		2 (5)
Laura Whitton Chief Finance Officer		4 (5)
Geoff Day NHS England Representative		5 (5)
Dr Ekta Elston Medical Director and Vice Chair of CoM	Joined January 2018	1 (2)

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 2017/18 and attendance records demonstrate that each meeting was quorate.

Key issues discussed and decisions made during 2017/18 include:

- Appointment process for:
  - Joint Chief Executive (NELCCG and NELC).
  - Medical Director/Vice Chair of Council of Members.
  - Chief Finance Officer
- 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

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

For the financial year ended 31 March 2018, and up to the date of signing this statement, we have applied four out of the five principles of the Code that are directly relevant to a CCG (the code is principally aimed at private companies). We have set out within this annual governance statement and our annual report and accounts how we have fulfilled 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 and Audit Committee in March 2018; 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.

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.

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.

Evidence of continued assurance has been monitored throughout the year by CCG Corporate Assurance Officer and reviewed with the Chief Finance Officer. Regular assurance reports are provided to the Integrated Governance and Audit Committee. The final report provided to the committee in March 2018 identified one area as Amber, the committee were assured this is work in progress and is of a low risk to the CCG.

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.

The CCG Risk Management Strategy was reviewed and ratified by the Integrated Governance and Audit Committee May 2017.

Risks that may affect the ability of the CCG to meet its strategic objectives must be recorded on the Board Assurance Framework (BAF). Operational risks relating to the CCG's day-to-day activity are recorded on the CCG Risk Register.

- Strategic Risks – relate to the delivery of the organisations strategic objectives. They have the highest probability for external impact.
- Operational Risks – relate to the organisations day-to-day business delivery, whilst they may have some external impact, operational risks mostly affect internal functions and services.

The CCG Partnership Board owns and determines the content of the Board Assurance Framework (BAF), identifying the strategic risks acts as a high level risk identification system with regards to compliance of the CCG strategic objectives.

The Board Assurance Framework (BAF) provides an effective focus on strategic and reputational risk, 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 Partnership 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.

To support the Partnership Board in carrying out its duties effectively, the Integrated Governance and Audit Committee monitors the 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 and 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 any significant changes, concerns or issues to the Partnership Board.

The CCG has a cloud based performance and risk management tool in place. Staff have access to a standardised risk assessment form for the recording of risks and the Risk Management Strategy provides a standard risk scoring matrix for risk owners to use to score the level of each particular risk to ensure consistency. All risks that are added to the system are reviewed and approved by the identified risk manager (senior manager) before being accepted as an active risk.

Risk Management is embedded within the activities of the CCG through the risk process. All CCG senior managers are aware of their responsibilities in relation to the identification and management of risks and must ensure that they are recorded on either the Board Assurance Framework or the Risk Register.

Staff are able to report any concerns through the incident reporting process which is openly encouraged and each incident is reviewed and investigated as applicable.

The CCG actively involve Public Stakeholders in managing risks, this is done, through the community forum and 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.

For each new service proposal, service specification, policy or procedure an Equality Impact Analysis will be undertaken utilising the CCG's EQUIA template. The purpose of this is to assess the risk to any group with a protected characteristic of a proposed service or policy change and to identify actions to ameliorate those risks accordingly. Once completed, the EQUIA is submitted to the EQUIA panel. The Panel consists of the Equality and Diversity lead, the Planning manager, and three lay members of the Community Forum.

The Panel will consider each EQUIA and arising actions and feedback any necessary amendments to the proposer.

All amendments and actions are recorded and reviewed as appropriate to ensure implementation.

Risk is evident in everything we do. As demonstrated above the CCG has effective risk management arrangements in place that are set out in the CCG Risk Management Strategy. 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, the impact should they be realised and to manage them efficiently, effectively and economically.

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
2) Counter fraud
3) Others
   - Human Resources (HR) policies *(refer to section 2.2.6 for further details)*
   - Service Proposal Management Tool (*refer to page 82 for further details)*
   - Control Issues (*refer to page 81 for further details)*
   - Performance dashboard *(refer section 1.2 for further details)*
   - Emergency Preparedness (*refer to section 2.1.3 for further details)*

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). 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.

There are annual risk awareness sessions that take place with the risk manager and risk assignee. Each risk is assessed against the original and mitigated scores for their impact and likelihood and tracks the progress of individual risks over time through a standardised risk grading matrix. 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.

The CCG has recently implemented a risk escalation process; to ensure overall organisational understanding of the responsibilities for managing risk and the escalation process within the organisation, up to the Board (where necessary) for those risks that do not address appropriate actions taken to mitigate the risks.

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

Risk updates are reported to Senior Management Team, Operational Leadership Team, Delivery Assurance Committee and the Integrated Governance and Audit Committee. The controls, assurances and gaps in controls and assurance are scrutinised along with any actions required to work towards improving the potential risk. This ensures that the process is maintained and act on behalf of the Partnership Board to ensure that mitigation plans are in place to manage the risks identified.

The Delivery Assurance Committee and Integrated Governance and 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, which highlights any changes in risk rating, addition of new risks and removal of any mitigated risks from the Risk Register. Any significant issues are escalated to the Partnership Board.

Capacity to Handle Risk

The CCG's Clinical Chief Officer remains ultimately accountable for ensuring sound systems for risk management are in place and implemented. Through delegated responsibility, the CCG's Partnership Board is responsible 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.

In January 2018 the Partnership Board carried out a risk awareness workshop, reviewing the risks within the Board Assurance Framework to ensure that these continue to reflect the evolving strategic objectives of the organisation as well as the risk scores are reflective of the level of mitigated risk and risk appetite.

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 Finance 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 and 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.

The CCG fully appreciates its statutory obligations towards risk management and the Partnership Board, Senior Managers and staff work together to provide an integrated approach to the management of risk and in developing a culture of reporting risk, understanding and challenging risk and providing opportunities for the analysis of risk and discussions on risk across the whole organisation. We continue to monitor and review our current risks in-line with NHS England's improvement and assurance framework, and promote risk management.

A deep dive risk session is to be delivered to the Operational Leadership Team in April 2018 to provide a wider understanding of risk and a clear distinctions and understanding of the purpose of the Board Assurance Framework and the Risk Register.

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. Risks are assessed in accordance with the CCG Risk Management Strategy 2017-18 which 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 and ensures a consistent approach to risk assessment regardless of the individual performing it.

The CCG's performance is assessed against a number of different measures but is brought together in the Improvement and Assessment Framework (IAF), the CCG's risk domains correspond to the 4 domains within the IAF.

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 2017/18 there were ***6*** Adult Social Care risks on the risk register.

At the beginning of 2017/18, the CCG identified ***2*** risks on the Board Assurance Framework, ***10*** 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 2017/18 with a residual risk rating being assessed as high level (15+) was ***13.***

The risks on the Board Assurance Framework that were escalated for review by the Partnership Board as at end of Quarter 4 are summarised 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	Controls to mitigate the risks
CCG-BAF.2002	Risks in delivery of key annual performance indicators and standards including constitutional standards	12	20		**Assurances on Controls** Regular reporting in to Partnership Board, Delivery Assurance Committee, CoM and the operational leadership team. **Positive Assurances** July 2017 NHS E have acknowledged the CCG is taking an active leadership role to address the issues in relation to NLaG. 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. NHSE's overall assessment of the CCG in the improvement and assessment framework was 'Good'. In particular A&E four hour wait performance saw significant improvement in quarter 3 of 2017-18 and met the national expectation of 90%. This is a measure that has not met this level of performance for over a year. Q4 performance has dipped again but the Trust are still performing better than the average. 2016/17 Year end position of ASC targets was positive and the Local Account was positive. The CCG also recently received the best available ratings for diabetes services (Outstanding) and Patient & Community Engagement (Green Star) **Gaps in Controls** - None identified **Gaps in Assurance** We recognise that there is significantly increased oversight and assurance mechanisms in place to oversee NLaG performance however gaps will remain until we start to see improvements feeding through. Some improvements have been noted around A&E and Cancer Waiting Times performance but this needs to be delivered consistently to gain greater assurances.
CCG-BAF.2003	NLaG Service Sustainability	20	20		**Assurances on Controls** Chief Executive representation from NL & NEL CCGs and NLaG on the System Improvement Board (SIB) The CCG's Chief Finance Officer represents the CCG on the aligned incentive contract group **Positive Assurances** System Improvement Board whose membership includes NHS England and NHS Improvement. NEL CCG received positive feedback in the second quarter of 2017 at its assurance meeting with NHS England The STP In-hospital Working Group is starting to work more effectively and is addressing issues across providers The ACP is getting more involved and starting to come up with proposals to divert activity and release pressures **Gaps in Controls** - All of the controls listed have only been established very recently and need time to bed in before their full effectiveness can be evaluated. All of the groups have now been operating for a number of months, and improvements in quality and performance are starting to be seen **Gaps in Assurance –** All of the assurances listed have only been established very recently and need time to bed in before their full effectiveness can be evaluated Lack of consistent leadership presence from NLaG due to a number of time limited interims in place

The risks on the Risk Register that were escalated for review by the Integrated Governance and 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	Controls to mitigate the risks
CCG-RR.2005	RTT Performance	20	25		**CCG-RR.2005a** - Performance Reporting Robust performance reporting is produced for the Service Lead to act upon and is monitored at Delivery Assurance Committee with escalation to Council of Members and Partnership Board. **CCG-RR.2005c** - System wide transformation group established. RTT has been established which will feed into the System Transformation Board and the System Improvement Board. Senior leadership at those meetings with clinically led planning to redesign services for optimum efficiency and effectiveness. **CCG-RR.2005e** Clinical Harm Review Groups. There are two clinical harm review groups (one at NLaG and one external). They both meet on a monthly basis and Director of Quality is a member of both groups.
CCG-RR.2004	Failure to achieve Accident and Emergency 4 hour targets	16	20		**CCG-RR.2004b** Action Plans Action plans focussing on all issues with potential impact on 4 hour A&E wait performance. The action plan has been revised to take into account the ECIP findings and recommendations. **CCG-RR.2004c** A&E Delivery Board. A&E delivery board established as part of a national requirement to ensure system wide ownership and delivery against the A&E target required.
CCG-RR.2007	Failure to manage the residential/nursing care market for the elderly, leading to oversupply, poor quality care and instability in the standard sector and undersupply in the nursing sector.	12	16		**CCG-RR.2007a** Market management and joint working with CQC Ongoing market management in the residential section to delivery better occupancy and joint working with the CQC continues to lead to better identification of poor practice. Processes need to be established to pick up on deterioration sooner and react prior to poor practice becoming established. **CCG-RR.2007b** Market Intelligence Failing Services (MIFS) meetings Bi-weekly meetings are held with additional meetings when required to ensure market stability, stabilisation and a speedy response to potential crisis. **CCG-RR.2007c** Quality Framework Reviewed the long term specification to enhance basic care standards which will be implemented from 1st April 2018. This may result in some homes being unable to meet the new standard. Review of the Quality Framework to improve assurance and build on the core specification requirements to further enhance quality of care. An agreement has yet to be made as to how homes will be remunerated for care quality. **CCG-RR.2007d** Support to Care Homes Project The creation of dedicated teams to work with Care Homes will act as both an early warning trigger and also support mechanism to proactively work with Homes and improve poor practice where observed. **CCG-RR.2007e** Fee setting methodology. Some work is underway to develop a fee setting methodology. This is in response to care providers concerns to ensure that we provide a fair cost of care.
CCG-RR.2003	On-going failure to meet Clinical Handover time targets for EMAS patient delivery at DPoW A&E	8	15		**CCG-RR.2003a** CCG Performance is monitored by the CCG and reported to the A&E Delivery Board. Monitoring only.
CCG-RR.2012	Patient Transport Services - operational resilience and quality of service	20	15		**CCG-RR.2012a** Additional capacity To mitigate PTS capacity limitations being a factor in delayed discharges it has been agreed through the A&E Delivery Board to increase capacity through enacting the contracted winter vehicle capacity from Thames and commissioning additional capacity from Amvale. Will require review before end March 2018. **CCG-RR.2012b** Quality and patient safety There have been significant concerns around patient safety and service quality since contract start. The CCG quality team, CQC and a partnership group of Thames commissioners across the region continue to have significant levels of involvement in monitoring these issues. **CCG-RR.2012c** Financial sustainability Since contract started concerns have been raised on a number of occasions relating to the financial sustainability of the provider. The CCG continues to monitor the situation.
CCG-RR.3017	Capacity to undertake required engagement	20	20		**CCG-RR.3017a** Line management Constant reprioritisation of work.

Risk ID	Risk Summary	Initial Risk Rating	Current Risk Rating	Trend	Controls to mitigate the risks
	and consultation activities				**CCG-RR.3017b** Discussion at SCU Reprioritisation of work
CCG-RR.3003	Adult ADHD Pathway breakdown	20	16		**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.3016	Mental Health SilverLink Computer System (Non-Disclosure Applies)	15	15		**CCG-RR.3016a** NAViGO Project Team. Project Plan in place which is overseen by the Programme Manager A NAViGO project team with a CCG representative (Associate Director IT) is to be established. **CCG-RR.3016b** Veeam back up of data Veeam backup of data and servers at 3am every day **CCG-RR.3016c** Real time replication The SilverLink databases are replicated in real time from Care Plus Group primary datacentre to Care Plus Group secondary datacentre. **CCG-RR.3016d** Programme Manager Programme Manager now in place. This is funded by CCG; his role is to manage the project and the implementation of procurement.
CCG-RR.4007	eMBED IT Core Contract Delivery	25	20		**CCG-RR.4007a** Contract in place Contract, detailing service spec and SLA in place. Currently meeting contractual IT KPIs. **CCG-RR.4007b** Contract Management Arrangements in place Regular monthly contract monitoring meeting in place with the CCG and eMBED. Attendees are Associate Director of IT, Assistant Director of Contracting and Performance and the Assistant Director Programme Delivery and Primary Care Strategy attend as and when required. **CCG-RR.4007c** Programme and Project Plans Programme controls in place, used to manage the Project and Programmes. eMBED able to provide tracking tool. The CCG has taken steps to monitor programme delivery on a monthly basis via the Strategy Board. **CCG-RR.4007d** Risk Management in Place Part of programme management of controls and is also picked up by the Strategy group. **CCG-RR.4007e** Local Primary Care Strategy Group A locally focused strategic group has been formed to provide a gateway for approving use of project days and monitoring progress on delivery. This control is scored at partially effective as the group is currently in its initiation phase.
CCG-RR.4004	The DoLS system is unable to cope with the increasing number of requests for authorisation	16	16		**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 (NELCCG) and via the Safeguarding Adults Operational Leadership Group. The NEL MCA Strategic Forum, has now become a formal subgroup of the Safeguarding Adults Board to ensure spread of strategic development and commitment **CCG-RR.4004b** Strategic Mental Capacity Group The Group monitors strategic change and works jointly with the CCG and providers. Group membership is led by CCG representation with other members coming from key stakeholders and voluntary sector. The role and function of this group is being reviewed to try and share and target the work more effectively, Reports from this group go to the CCG Quality Committee and Operational Leadership Group. It has been agreed that this group will be re-formed to be an official subgroup of the Safeguarding Adults Board. **CCG-RR.4004c** Additional capacity to support delivery Increasing recruiting and training best interest assessors across the local health and social care economy. Increase in staffing to support operational delivery and advice. Contract variations being reviewed to ensure that BIA's employed by organisations other than FOCUS are available for use on the Duty Rota. **CCG-RR.4004d** Joint working with NELC legal team Help and support to develop and deliver a process for applications to the court of protection for deprivations in non-standard settings. Providing front end legal advice to practitioners.
CCG-RR.4017	Establishment of the Accountable Care Partnership in North East Lincolnshire	25	16		**CCG-RR.4017a** ACP Shadow Board The CCG is a member of the board. Regular meetings take place to discuss the development of the ACP. **CCG-RR.4017b** ACP Work plan in place Work plan in place 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.

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 ***Integrated Audit and Governance Committee*** have delegated authority to monitor and assess the effectiveness of internal control mechanism and escalate any concerns to the CCG Partnership Board.

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 2018 and up to the date of approval of the Annual Report and Accounts.

During 2017-18 a series of audits were undertaken to review the effectiveness of governance systems. The final reports and agreed action plans from these audits are submitted to the Integrated Governance and Audit Committee. ***Substantial*** assurance has been given, that the system of internal control has been effectively designed to meet the organisation's objectives, and that controls are being consistently applied.

Conflict of Interest Management

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

An audit of Conflicts of Interest was conducted by our internal auditors in March 2018. 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.

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 provided substantial assurance.

Breakdown of the findings is as follows:

Assessment Area	Compliance Level
• Governance arrangements	Fully Compliant
• Declarations of interest and gifts and hospitality	Fully Compliant
• Registers of interest, gifts and hospitality and procurement decisions	Fully Compliant
• Decision making processes	Fully Compliant
• Identifying and managing non-compliance	Fully Compliant

However, the review found ***one*** area where the CCG does not fully comply with the NHS England conflicts of interest guidance, as follows:

- The CCG considers conflicts of interest when appointing Governing Body members, members of committees and sub committees and senior employees. All new appointments are required to declare any interests during the recruitment process.

An action plan has been agreed and the above actions will be addressed, completed and monitored as part of the on-going audit reviews during 2018/19

During 2017/18 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 2017 NHS England made some small amendments to the statutory guidance on managing conflicts of interest.

The key changes include:

- Registers of interest: CCGs have systems in place to satisfy them as a minimum on an annual basis that their registers of interest are accurate and up-to-date, and to require that only decision-making staff are included on the published register.

- Gifts from suppliers or contractors: Gifts of low value (up to £6), such as promotional items, can now be accepted and do not need to be declared. However, all other gifts from suppliers or contractors must be declined and declared.

- Gifts from other sources: Gifts of under £50 (rather than £10) can be accepted from non-suppliers and non-contractors, and do not need to be declared; and gifts with a value of over £50 can now be accepted on behalf of an organisation, but not in a personal capacity and must be declared.

- Hospitality, meals and refreshments: Amendment to the thresholds to advise that hospitality under £25 does not need to be declared. Hospitality between £25 and £75 can be accepted, but must be declared, and hospitality over £75 should be refused unless senior approval is given.

- New care models: A new annex has been added to the guidance to provide further advice on identifying, declaring and managing conflicts of interest in the commissioning of new care models.

In light of this guidance the CCG reviewed their Standard of Business Conduct and Conflict of Interest policy to ensure it meets the requirements of the revised statutory guidance which was ratified by the Integrated Governance and Audit Committee in September 2017.

During June a Conflict of Interest survey was circulated to CCG staff, CCG members, governing body members, and practice staff with involvement in CCG business and members of CCG committees and sub-committees. The purpose of the survey was to help to assist the CCG on the awareness of Conflict of Interest and if any further work is needed.

The feedback highlighted the following key areas for further review:

- Where to find information on Conflict of Interest.
- Mixed response on who is the Conflict of Interest Guardian.
- Actions if fail to disclose relevant interest.

The CCG will continue to maintain awareness of conflict of interest, by providing six monthly communication updates noting the importance of declaring a conflict of interest/actions if fail to declare and useful links and reminder of whom/how/where to report any concerns.

The CCG have completed and submitted the quarterly and annual self-certification returns for 2017/18 without any concerns. The CCG Accountable Officer and Integrated Governance and Audit Chair (Lay Member for Governance and 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

Conflict of Interest Training – NHS England have reviewed and agreed a more targeted approach and the training tool was launch in January 2018 and the deadline for completion of mandatory module one has been extended to 31 May 2018.

From 2018/19 CCGs are therefore required ensure the online training on managing conflicts of interest has been offered to the relevant individuals and 90% compliance rate has been achieved by ***31 May 2018*****.**

Thereafter the training 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 ***31 January*** of each year. CCGs will be required to record their completion rates as part of their annual
conflicts of interest audit.

Please refer to the CCG website for details on "Avoiding Conflicts of Interest"

Data Quality

The Partnership Board is advised by the Delivery Assurance Committee as to the maintenance of a satisfactory level of data quality available to the CCG via the integrated assurance reports and the CCG maintains a process of continuous data quality improvement.

The data received by the Governing Body and its committees is continuously reviewed and the contents of reports are refreshed regularly to ensure that suitable information is available to the CCG.

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.

Information Governance

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

The CCG undertook an assessment of its IG arrangements through completion of the Information Governance Toolkit (IGT). The CCG has been able to submit evidence for 2017-18 resulting in a maintained score of ***74%*** as a result of the comprehensive review of evidence. Six standards have been maintained at Level 3.

An audit was completed in March 2017 on the evidence provided for 7 standards. The table below provides a comparative summary for the sample of the CCG's toolkit requirements reviewed during the IGT audit process. It shows the scores self-assessed by the CCG at the dates we completed our review and the scores that we validated during the audit process.

Requirement Number	March 2018	
	Level Self-Assessed by CCG	Level Assessed by Auditor
130	2	2
134	2	1
230	2	2
237	2	2
345	2	2
346	2	2
348	2	2

It was acknowledged that the differences identified in the level attained may be due to timing issues and that North East Lincolnshire CCG had until 31st March 2018 to upload all relevant evidence to attain the level stated as per the toolkit. The CCG reached the required level in all the requirements.

The CCG 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. The CCG has a suite of approved IG policies and has provided the associated staff awareness 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 2017-18 at ***97%***. (Minimum 95% completion of basic training). In addition the SIRO and Caldicott Guardian have undertaken additional training.

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 investigation of incidents is supported but the eMBED IG Team.

There is a Finance Assurance Sub-Group which oversees Information Governance responsibilities to ensure that assurance is provided to the IG and Audit Committee, with regard to the progress against the IG toolkit and action plan. The CCG has bought in an expert Information Governance advisory service from the eMBED Health Consortium.

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 Spotcheck undertaking in October 2017 showed excellent levels of compliance and understanding from CCG staff.

The CCG in line with the Information Governance toolkit 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. From the 25th of May 2018, the IAR must be General Data Protection Regulation (GDPR) compliant and document the legal basis for processing any personal confidential data

(PCD). The IAR has been monitored and reviewed; and is currently GDPR compliant and is a live document reviewed quarterly. A new IAO handbook was circulated to all staff in 2017 to ensure IAOs are fully aware of their responsibilities.

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. A risk assessment of data flows for all identified information assets must be conducted at least annually. 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.

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 and 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 and 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 and Audit Committee for the completion of all actions.

During 2017/18 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 and 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 Northern Lincolnshire Business Connect.

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 AuditOne and the internal auditors of North East Lincolnshire Council.
- Internal work undertaken by the CCG.
- KIER/EMBED Business Assurance.
- Routine monitoring of the contracts we have in place throughout the year.

I have been advised that adequate assurances have been provided for 2017/18 for the services bought by the CCG

Control Issues

Reflecting on our performance for 2017/18, our system has performed well against a number of challenging targets, however as reported in our Month 9 Governance Statement, there are still areas for improvement.

(Please refer to Performance Measure section of the Annual Report for full details)

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.

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 investigations of incidents are supported by the Quality Team and eMBED Information Governance (IG) Team. For the 2017-18 financial year there have been ***five*** minor IG related incidents and ***no*** serious incidents reported. Minor IG incidents are managed through the low level incident process and have been IG SIRI assessed as level 1 incidents.

With the exception of the risks associated with these areas, the Clinical Commissioning Group overall has a rigorous internal control framework which includes robust governance and risk management systems and processes that helps support the achievements of the organisations aims and objectives.

There have been no other significant control issues been identified in year.

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 is to ensure appropriate arrangements are in place for the CCG to fulfil this duty to the Integrated Governance and Audit Committee and requires that this committee undertakes functions as set out in its Terms of Reference as agreed by the Governing Body.

During Quarter 4, the CCG has undertaken a self-assessment against the ***Quality of Leadership*** domain of the CCG Improvement and Assessment Framework 2017/18. 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. North East Lincolnshire CCG was rated as *'Amber*' for 2016/17. We have completed our self-assessment for 2017-18 and our overall assurance assessment for the Quality of Leadership Indicator for 2017/18 will be available from July on My NHS

The *Chief Finance Officer* is a member of the Governing Body. Being the Governing Body's professional expert on finance they have delegated responsibilities to ensure a sound system of financial controls is in place. The CCG continues to meet all of its statutory financial duties

The CCG's financial plan was developed for 2017-18 and budgets set within this plan, and signed off by the Partnership Board prior to the start of the financial year. The Chief Finance Officer and their team have worked closely with individual budget holders and undertook regular budget review meetings to ensure that any cost pressures are adequately considered, managed or escalated as necessary.

The delivery of savings from the QIPP programme is a key component of the assurance given to the Partnership Board on the effective use of resources. Both the Partnership Board and Integrated Governance and Audit Committee receive a comprehensive finance report from the Chief Finance Officer at every meeting, where open challenge takes place.

The *Integrated Governance and Audit Committee* receive regular reports on financial governance, monitor the internal audit programme and review the draft and final annual accounts. The CCG has a programme of internal audits that provides assurance to the Governing Body and the Integrated Governance and Audit Committee on the effectiveness of its internal processes. The CCG's annual accounts are reviewed by the Integrated Governance and 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 Partnership Board and Integrated Governance and Audit Committee annually.

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.

The CCG has effective commissioning and contract monitoring processing in place to ensure that funding is used effectively and efficiently e.g. 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.

Please refer to the CCG website for details of Contracts awarded.

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 has a Scheme of Reservation and Delegation within its Standing Financial Instructions. It will be reviewed further in 2018 as the CCG look to strengthening the relationship through the "Union" , initiates its new committee structure and makes necessary revisions to the Constitution.

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

(Further details can be found in third party assurances section)

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 Counter Fraud Authority Standards; the LCFS resource is contracted in from AuditOne and is part of a wider Fraud Team resource with additional LCFS resource available as and when required. The Chief Finance 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 and Audit Committee annually.

There is an approved and proportionate risk based counter-fraud plan in place which is monitored at each Integrated Governance and Audit Committee meetings, in line with NHS Counter Fraud Authority standards for Commissioners - this first became effective 1st April 2015 and is reviewed annually. The CCG completed an online Self Review Tool (SRT) quality assessment in March 2018 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 Finance Officer prior to submission. Should a NHS Counter Fraud Authority quality assurance inspection be undertaken then any recommendations would be acted upon – to date the CCG has not been subject to an NHS Counter Fraud Authority quality inspection.

The AuditOne counter fraud team has released a programme of publicity to raise Anti-Crime Awareness to CCG staff which includes posters, leaflets, cartoon videos and payslip messages all of which is aimed at raising awareness of the team and channels for reporting concerns.

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:-

Substantial assurance can be given that the system of internal control has been effectively designed to meet the organisation's objectives, and that controls are being consistently applied.

During the year internal audit issued audit reports:-

Audit area	Assurance			
	Substantial	Good	Reasonable	Limited
Financial Management / Financial Control	√			
QIPP Programme *			√	
Adult Social Care System incl. Financials	√			
Section 75 Agreement	No assurance level provided			
Assurance Framework Opinion	√			
Conflicts of Interest	√			
Corporate Governance Compliance	√			
Risk Management Arrangements	√			
Information Governance	No assurance level provided			
Adult Social Care Data Quality & Returns	√			
Complaints Management	√			
Court of Protection & Power of Attorney / Advocacy *	√			
Adult Social Care Commissioning - Care Packages	√			
Deprivation of Liberty	√			
Total	**11**	**0**	**1**	**0**

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

- Governing Body.
- The Integrated Governance and Audit Committee.
- Delivery Assurance Committee.
- Quality Committee.
- Community Forum.
- Senior Leadership Team.

Plans to address weakness and ensure continuous improvements of the system are in place and are continually reviewed.

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 and 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 and 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** 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:

- The assessment of the CCG through the quarterly Improvement and Assessment meetings with NHS England.
- Our overall assurance assessment for the Quality of Leadership indicator for 2017/18 available on My NHS.
- Work undertaken by internal auditors - No significant issues were identified in this review.
- Assurance received 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.
- Quarterly conflict of interest assessments.
- Integrated Governance and Audit Committee Annual Report
- Annual Reviews of Governing Body (its committees) and Partnership Board subcommittees Terms of Reference.
- The results of staff and stakeholders surveys.
- The statutory external audit undertaken MAZARS, who will provide an opinion on the financial statements and form a conclusion on the CCG's arrangements ensuring economy, efficiency and effectiveness in its use of resources during 2017/18.

Conclusion

With the exception of control issues that I have outlined in this statement, my review confirms that North East Lincolnshire Clinical Commissioning Group overall has a sound internal control framework which includes robust governance and risk management systems. The Governance Framework is clearly articulated within our constitution and is underpinned by our Information Governance Framework and Strategy and Risk Management Strategy. Our Board Assurance Framework ensures that strategic risks are identified and managed effectively. Eleven of the internal audit reports issued during the year provided ***substantial*** *assurance or reached the required level in all the requirements* that controls were suitably designed, consistently applied and effective, with one providing ***reasonable*** assurance.

Signature

Dr Peter Melton
Accountable Officer

Date 24/05/2018

2.2 Remuneration and 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 2017/18, members and attendees were:

Voting Members		
Name		**Attendance (Max 2 meeting)**
Mark Webb (Chair)		1 (2)
Dr David Elder Council of Members GP Representative		2 (2)
Tim Render Lay Member Governance &		2 (2)
Dr Thomas Maliyil (Vice Chair)		2 (2)
Councillor Matthew Patrick Portfolio Holder for Finance and Resources	Left 25/05/2017	1 (1)
Councillor Peter Wheatley Portfolio Holder for Regeneration, Assets, Skills and Housing (NELC)	Joined 25/05/17	1 (1)
Other attendees:		
Helen Kenyon Deputy Chief Executive		2 (2)
Laura Whitton Chief Finance Officer		1 (1)
Emma Kirkwood** Human Resources Business Partner		1 (2)
Emma Collins** Human Resources		1 (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 meetings were quorate.

Senior managers' contracts and payments –

The Chief Finance Officer & Deputy Chief Executive Roles 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 Finance Officer's guidance)

Other very senior manager's (VSM) roles are appointed under the PCT Framework and all remuneration and Terms of Service are approved by Rem Com.

2.2.2 Salaries and 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.

*The CCG makes a financial contribution to North East Lincolnshire Council to the role of Joint Chief Executive as detailed in the table below.

**Due to a 14 year gap in Dr Peter Melton's scheme membership his pension related benefit figure has been inflated due to his rate of pensionable pay being significantly lower when opted out of the scheme than now.

2017-18 **Name and Title**	**(a)** **Salary (bands of £5,000)** **£000**	**(b)** **Expense payments (taxable) to nearest £100** **£00**	**(c)** **Performance pay and bonuses (bands of £5,000)** **£000**	**(d)** **Long-term Performance pay and bonuses (bands of £5,000)** **£000**	**(e)** **All pension related benefits (bands of £2,500)** **£000**	**(f)** **TOTAL (a to e) (bands of £5,000)** **£000**
Dr P Melton, Clinical Chief Officer **	85 - 90				160 - 162.5	245 - 250
Helen Kenyon, Deputy Chief Executive	95 - 100				15 -17.5	110 - 115
Jan Haxby, Director of Quality and Nursing	80 - 85				10 - 12.5	90 - 95
Laura Whitton Chief Finance Officer	85 - 90				25 - 27.5	115 - 120
Mark Webb, Chair	20 - 25					20 - 25
Dr D Hopper, Vice Chair of Council of Members (left February 2018)	10 -15					10 -15
Philip Bond, Lay member Community Engagement	5 - 10					5 - 10
Dr Arun Nayyar, GP Representative	5 - 10				5 - 7.5	15 - 20
Dr Rakesh Pathak, GP Representative	5 - 10				25 - 27.5	35 - 40
Tim Render, Lay Member Governance & Audit	10 - 15					10 - 15
Cllr Matthew Patrick, Portfolio Holder for Finance and Resources NELC (left May 2017)	5 - 10					5 - 10
Cllr Jane Hyldon-King, Portfolio Holder for Health, Wellbeing and Adult Social Care NELC	5 - 10				0 - 2.5	10 - 15
Dr Thomas Maliyil, Vice CCG Chair / Chair of Council of Members (CoM)	15 - 20				10 - 12.5	30 - 35
Dr D James, Secondary Care Doctor	10 - 15					10 - 15
Juliette Cosgrove, Strategic Nurse (left March 2018)	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
Cllr Peter Wheatley NEL Council Portfolio Holder for Regeneration (started May 2017)	5 - 10					5 - 10
Dr Ekta Elston, Vice Chair (Council of Members) / Medical Director (started February 2018)	5 - 10				12.5 - 15	20 - 25
Rob Walsh, NEL Council, Joint Chief Executive (started August 2017)*	25 - 30					25 - 30

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 Finance 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

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 hasn't 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 2018 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr P Melton, Clinical Chief Officer	7.5-10	20-22.5	05-10	25-30	57	121	188	
Helen Kenyon, Deputy Chief Executive	0.0-2.5	0.0-2.5	35-40	90-95	514	35	568	
Jan Haxby, Director of Quality and Nursing	0.0-2.5	0.0-2.5	30-35	90-95	577	35	629	
Laura Whitton Interim Chief Finance Officer	0.0-2.5	5-7.5	25-30	75-80	452	48	517	
Dr Arun Nayyar, GP Representative	0.0-2.5	0.0-2.5	10-15	30-35	195	8	207	
Dr Rakesh Pathak, GP Representative	0.0-2.5	2.5-5	10-15	30-35	136	18	157	
Jane Hyldon-King	0.0-2.5	0.0-2.5	0-05	0-5	0	-1	0	
Dr Thomas Maliyil, GP Representative	0.0-2.5	0.0-2.5	10-15	40-45	227	13	246	
Ekta Elston, Vice Chair (COM)/Medical Director	0.0-2.5	0.0-2.5	5-10	15-20	62	7	70	

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 total 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).

2.2.5 – Compensation on early retirement or for loss of office

Nil return for 2017/2018 – refer to Note 4 of the Financial Statements.

2.2.6 – Payments to past members

Nil return for 2017/2018 – refer to Note 4 of the Financial Statements.

2.2.7 Exit Packages and Severance Payments

*Further details in relation to Exit Packages can be found in note **4** in the Financial Statements*

2.2.8 Pay Multiples

Year	**2017/18**	**2016/17**
Band of highest paid director's total remuneration (£'000)	120-125	120-125
Median total	28,191	26,018
Ratio	4.4	4.7

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 2017-18 was £120,000 - £125,000. (2016-17 £120,000 - £125,000). This was 4.4 times (2016-17 4.7 times) the median remuneration of the workforce, which was £28,191 (2016-17 £26,018).

In 2017-18, no (2016-17, no) employees received remuneration in excess of the highest-paid director as per the remuneration table. Remuneration ranged from £6,300 to £98,306 (2016-17 £2,786 to £97,323).
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.

2.2.9 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.

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 2018, for more than **£245** per day and that last longer than 6 months are as follows:-

Table one – Off- payroll engagements longer than six months

	Number
Number of existing engagements as of 31 March 2018	37
Of Which, the number that have existed:	
• For less than 1 year at the time of reporting	13
• For between 1 and 2 years at the time of reporting	7
• For between 2 and 3 years at the time of reporting	2
• For between 3 and 4 years at the time of reporting	10
• For 4 or more years at the time of reporting	5

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than 6 months:

Table 2: New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	13
Of which:	
Number assessed as caught by IR35	0
Number assessed ad not caught by IR35	13
Number engaged directly (via PSC Contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	24
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

	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.	24

2.2.10 Staff Report

a) Number of directors (or equivalent) –

The Chief Finance Officer & Deputy Chief Executive Roles 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 Finance Officer's guidance) detailed in section 2.2.1. Please refer to section c below for numbers.

b) Employee Benefits and Staff Numbers

	Admin			Programme			Total		
2017-18	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Employee Benefits									
Salaries and wages	2,556	150	**2,706**	418	47	**465**	2,974	197	**3,171**
Social security costs	269	10	**279**	42	1	**43**	311	11	**322**
Employer contributions to the NHS Pension Scheme	345	13	**358**	73	2	**75**	418	15	**433**
Other pension costs	0	0	**0**	0	0	**0**	0	0	**0**
Apprenticeship Levy	1	0	**1**	0	0	**0**	1	0	**1**
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	0	0	**0**	0	0	**0**	0	0	**0**
Gross employee benefits expenditure	**3,171**	**173**	**3,344**	**533**	**50**	**583**	**3,704**	**223**	**3,927**
Less recoveries in respect of employee benefits (note 4.1.2)	-36	0	-36	-38	0	-38	-74	0	-74
Total - Net admin employee benefits including capitalised costs	**3,135**	**173**	**3,308**	**495**	**50**	**545**	**3,630**	**223**	**3,853**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,135**	**173**	**3,308**	**495**	**50**	**545**	**3,630**	**223**	**3,853**

	Admin			Programme			Total		
2016-17	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**
	Admin			**Programme**			**Total**		
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'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 the NHS Pension Scheme	357	13	**370**	34	0	**34**	391	13	**403**
Other pension costs	0	0	**0**	0	0	**0**	0	0	**0**
Apprenticeship Levy	0	0	**1**	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**

c) Staff composition

The CCG has a staffing establishment of 85.1 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 £1.8m in 2017/2018.

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

Gender	Total (Female)	Total (Male)
Band 8a	2	2
Band 8b	7	4
Band 8c	2	1
Band 8d	1	1
Band 9	1	0
VSM	3	0
Governing body	2	10
Any other Spot Salary	0	0
All other employees **(including apprentice if applicable)**	57	12

d) Sickness absence data

The sickness rate at the CCG headquarters is 2.11%, the, 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 *"Gastrointestinal problems"* is shown as the second highest percentage. Turnover rate of employees in 2017/18 has decreased to 0.79% compared to that of 1.51% in 2016/17

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 2017)

Figures converted by DH to best estimates of required Data Items			Statistics Published by HSCIC from ESR Data Warehouse	
Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
83.5	334	4.0	30,481	542

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.

Recognising the benefits of partnership working, the CCG is a member of the North Yorkshire, Humber and Leeds, Yorkshire Social Partnership Forum.

The aim of the Social Partnership Forum is to provide a formal negotiation and consultation group for the CCGs and the Unions to discuss and debate issues in an environment of mutual trust and respect. In particular it:

- engages employers and trade union representatives in meaningful discussion on the development and implications of future policy;
- provides a forum for the exchange of comments and feedback on issues that have a direct or indirect effect on the workforce;
- promotes effective and meaningful communication between all parties that can be subsequently disseminated across the membership.

The CCG continues to use the Social Partnership Forum to approve policies as and when they are finalised by the CCG.

The CCG has an employee advisory group, which consist of staff members as various levels/banding, the group have an opportunity to participate in consultation on policy development the key responsibilities of the group are to

- Consultation of relevant CCG policies.
- Review and agree follow up action staff survey
- Review employee/HR topics

New policies which have been agreed in 2017/18 with support of staff consultation include:

Access to Learning and Development
Alcohol and Substance Misuse
Attendance Management Policy
Objective Setting and Review
Pay Protection
Professional Registration
Relocation Assistance
Secondment Policy
Starting Salary Reckonable service Policy

f) Expenditure on consultancy

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

2.2.11 - Trade Union Facility Time Section

NHS North East Lincolnshire Clinical Commissioning Group is not required to produce a Trade Union Facility Time return as they do not have any employee's that are trade union representatives.

2.2.12 External Audit

The CCG appointed Mazars LLP as the CCG's external auditors for a 3 year period starting in the year 2017/18.

This appointment was made following a mini-competition undertaken for the North Yorkshire and Humber CCGs using the East of England NHS Collaborative Procurement Hub (EoECPH) Financial Services Framework as advertised in OJEU as 2014/S 125-222805. At its meeting held on 2 December 2016, the CCG auditor panel considered the recommendation of an evaluation panel formed for the purpose of reviewing the responses to the mini-competition and following this consideration recommended appointment of Mazars LLP to the CCG Governing Body.

Auditors' remuneration in relation to April 2017 to March 2018 totalled £35,725.00 (excluding VAT). This covered audit services required under the National Audit Office's Code of Audit Practice which requires compliance with International Standards on Auditing (UK & Ireland) (ISAs (UK & Ireland)).

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).

2.2.13 Parliamentary Accountability and Audit Report

NHS North East Lincolnshire Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report as per table below,

Contingent Liabilities	Note 31
Losses and Special Payments	Note 44
Gifts	Not applicable
Fees and Charges	Note 5

An audit certificate and report is also included in section 3.2 of this Annual Report and Accounts

Signature

Dr Peter Milton
Accountable Officer

Date

24/05/2018

The Financial Statements 3.0

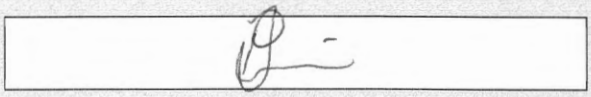
3.0 Financial Statements

3.1 FOREWORD TO THE ACCOUNTS

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2018 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 24/05/2018.

Independent auditor's report to the Governing Body of NHS North East Lincolnshire Clinical Commissioning Group

Opinion

We have audited the financial statements of NHS North East Lincolnshire Clinical Commissioning Group ('the CCG') for the year ended 31 March 2018. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Government Financial Reporting Manual 2017/18 as contained in the Department of Health and Social Care Group Accounting Manual 2017/18, and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to Clinical Commissioning Groups in England ("the Accounts Direction").

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2018 and of its net operating expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Opinion on regularity

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

Basis for opinion

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

Use of the audit report

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. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an 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 Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

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

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

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material

misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.
We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- the parts of the 'Remuneration and Staff Report' subject to audit have been properly prepared in accordance with the Annual Report Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

The parts of the Remuneration and Staff Report subject to audit are:

- the single total figure of remuneration for each Director;
- CETV disclosures for each Director;
- fair pay (pay multiples) disclosures;
- exit packages; and
- analysis of staff numbers and costs.

Matters on which we are required to report by exception
We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under schedule 7(2) 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 2018.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer
As explained more fully in the 'Statement of Accountable Officer's Responsibilities' the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

The Accountable Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the CCG is informed of the intention for dissolution without transfer of services or function to another entity. The Accountable Officer is responsible for assessing each year whether or not it is appropriate for the CCG to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

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

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

We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust 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 Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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.

Certificate
We certify that we have completed the audit of the financial statements 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.

Mark Kirkham
For and on behalf of Mazars LLP
Mazars House
Gelderd Road
Leeds
LS27 7JN
25 May 2018

Statement of Comprehensive Net Expenditure for the year ended 31st March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(2,441)	(1,002)
Other operating income	2	(51,348)	(49,685)
Total operating income		**(53,789)**	**(50,687)**
Staff costs	4	3,927	3,753
Purchase of goods and services	5	277,343	271,567
Provision expense	5	803	576
Other Operating Expenditure	5	367	775
Total operating expenditure		**282,440**	**276,671**
Net Operating Expenditure		**228,651**	**225,984**
Other Comprehensive Expenditure			
Remeasurements of the defined pension liability /asset.		(850)	1,023
Sub total		(850)	1,023
Comprehensive Expenditure for the year ended 31 March 2018		**227,801**	**227,007**

Statement of Financial Position as at 31st March 2018

	Note	2017-18 £'000	2016-17 £'000
Current assets:			
Trade and other receivables	17	3,864	4,531
Cash and cash equivalents	20	13	10
Total current assets		**3,877**	4,541
Total assets		**3,877**	4,541
Current liabilities			
Trade and other payables	23	(13,162)	(13,878)
Provisions	30	(1,616)	(847)
Total current liabilities		**(14,778)**	(14,725)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(10,901)**	(10,184)
Non-current liabilities			
Trade and other payables	23	(2,163)	(3,191)
Total non-current liabilities		**(2,163)**	(3,191)
Assets less Liabilities		**(13,064)**	(13,375)
Financed by Taxpayers' Equity			
General fund		(8,373)	(7,834)
Other reserves		(4,691)	(5,541)
Total taxpayers' equity:		**(13,064)**	(13,375)

The notes on pages 104 to 128 form part of this statement

The financial statements on pages 102 to 103 were approved by the Governing Body on 24th May 2018 and signed on its behalf by:

Accountable Officer
24th May 2018

Statement of Changes In Taxpayers Equity for the year ended 31st March 2018

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(7,834)	0	(5,541)	**(13,375)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(7,834)**	**0**	**(5,541)**	**(13,375)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(228,651)			(228,651)
Movements in other reserves	0	0	850	850
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(228,651)**	**0**	**850**	**(227,801)**
Net funding	228,112	0	0	228,112
Balance at 31 March 2018	**(8,373)**	**0**	**(4,691)**	**(13,064)**

	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)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(7,199)**	**0**	**(4,518)**	**(11,717)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(225,984)			(225,984)
Movements in other reserves	0	0	(1,023)	(1,023)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(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)**

The notes on pages 104 to 128 form part of this statement

Statement of Cash Flows for the year ended 31st March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(229,015)	(225,472)
(Increase)/decrease in trade & other receivables	17	854	1,467
Increase/(decrease) in trade & other payables	23	(718)	(1,699)
Provisions utilised	30	(33)	(223)
Increase/(decrease) in provisions	30	803	576
Net Cash Inflow (Outflow) from Operating Activities		**(228,109)**	(225,351)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(228,109)**	(225,351)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		228,112	225,348
Net Cash Inflow (Outflow) from Financing Activities		**228,112**	225,348
Net Increase (Decrease) in Cash & Cash Equivalents	20	**3**	(3)
Cash & Cash Equivalents at the Beginning of the Financial Year		**10**	13
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**13**	10

The notes on pages 104 to 128 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups (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 2017-18 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 CCGs, 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 any liabilities incurred jointly; and,
- 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
- 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 June, which is after the completion of the audited annual accounts process. 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

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.

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 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (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 DH Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- 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)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year, with the exception of IFRS 16. As the impact of the standard is not yet estimable due to the standard being introduced in 19/20 and detailed guidance not yet being available.

2 Other Operating Revenue

	2017-18 Admin	2017-18 Programme	2017-18 Total	2016-17 Total
	£'000	£'000	£'000	£'000
Recoveries in respect of employee benefits	36	38	74	89
Non-patient care services to other bodies	59	2,382	2,441	1,002
Other revenue*	1,416	49,858	51,274	49,596
Total other operating revenue	1,511	**52,278**	**53,789**	**50,687**

** This includes £39.1m in relation to the adult social care partnership agreement and £8.7m in relation to adult social care private client revenue. In 2016/17 these figures were £39.8m & £9.3m respectively. Further analysis can be found at note 35.*

3 Revenue

All of the income the CCG receives is from the rendering of services . Please see Note 2.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total	
Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits		
Salaries and wages	2,974	197	3,171
Social security costs	311	11	322
Employer Contributions to Pension scheme	418	15	433
Other pension costs	0	0	0
Apprenticeship Levy	1	0	1
Gross employee benefits expenditure	**3,704**	**223**	**3,927**
Less recoveries in respect of employee benefits (note 4.1.2)	(74)	0	(74)
Total - Net admin employee benefits including capitalised costs	**3,630**	**223**	**3,853**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,630**	**223**	**3,853**

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 scheme	391	13	404
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**

4.1.2 Recoveries in respect of employee benefits

2017-18			2016-17
Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(60)	0	(60)	(72)
Social security costs	(6)	0	(6)	(8)
Employer contributions to the NHS Pension Scheme	(8)	0	(8)	(9)
Total recoveries in respect of employee benefits	**(74)**	**0**	**(74)**	**(89)**

4.2 Average number of people employed

2017-18			2016-17
Permanently employed Number	Other Number	Total Number	Total Number
Total	**86**	**2**	**88**	**83**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Exit packages agreed in the financial year

There were no exit packages in 2017 / 18 . In 2016/17 there was 1 for £7,667.

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £397k (2016-17: £369k)were payable to the NHS Pensions Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.

4.5.3 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. With effect from 1st April 2017, the employers contribution rate reduced 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:

4.5.3 Local Government Pension Scheme (Continued)

	31 March 2018	31 March 2017
	% p.a.	% p.a.
Pension Increase rate	**2.4%**	**2.4%**
Salary Increase rate	**2.6%**	**2.6%**
Discount Rate	**2.7%**	**2.6%**

	31st March 2018		31st March 2017	
Mortality Assumptions	**Males Years**	**Females Years**	**Males Years**	**Females Years**
Current Pensioners	**21.7**	**24.2**	**21.7**	**24.2**
Future Pensioners**	**23.7**	**26.4**	**23.7**	**26.4**

** Figures assume members aged 45 as at the last formal valuation date

Sensitivity Analysis	31st March 2018		31st March 2017	
Change in assumptions at year ended 31 March 2018	**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%**	**3,607**	10%	3,618
0.5% increase in the Salary Increase Rate	**0%**	**51**	0%	51
0.5% increase in the Pension Increase Rate	**10%**	**3,545**	10%	3,552

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 2019 will be approximately £328,000.

The above information relates to the LGPS annualised calculation used for the actuarial pension valuation.

Employer Membership Statistics

	31 Mar 2016
	Number
Actives	4
*Deferred pensioners**	286
Pensioners	167
Total	457

* 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

	2017-18 Admin £'000	2017-18 Programme £'000	2017-18 Total £'000	Restated 2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	2,910	583	3,493	3,323
Executive governing body members	434	0	434	430
Total gross employee benefits	**3,344**	**583**	**3,927**	**3,753**
Other costs				
Services from other CCGs and NHS England	58	356	414	387
Services from foundation trusts	0	107,330	107,330	103,167
Services from other NHS trusts	0	14,777	14,777	14,964
Purchase of healthcare from non-NHS bodies	0	70,993	70,993	70,029
Purchase of social care	0	48,369	48,369	48,298
Chair and Non Executive Members	153	0	153	141
Supplies and services – general	74	596	670	1,349
Consultancy services	53	83	136	163
Establishment	238	727	965	585
Transport	5	0	5	5
Premises	225	157	382	283
Impairments and reversals of receivables	0	214	214	634
Audit fees	45	0	45	54
Other non statutory audit expenditure				
· Internal audit services	53	0	53	44
Prescribing costs	0	27,861	27,861	27,447
GPMS/APMS and PCTMS	0	3,871	3,871	2,794
Other professional fees excl. audit	544	783	1,327	1,537
Education and training	26	39	65	27
Provisions	50	753	803	576
CHC Risk Pool contributions	0	0	0	360
Interest (Local Government Pension Scheme)	0	949	949	1,055
Expected Return on Assets (Local Government Pension Scheme)	0	(869)	(869)	(982)
Other expenditure	0	0	0	1
Total other costs	**1,524**	**276,989**	**278,513**	**272,918**
Total operating expenses	**4,868**	**277,572**	**282,440**	**276,671**

Includeed in the 2017/18 figure for External Audit Fees is additional cost of £1,819 relating to 2016/17 audit.

In 2016/17 Purchase of healthcare from non-NHS bodies and GPMS/APMS and PCTMS have been restated. GPMS/APMS and PCTMS has increased by £1,414k and Purchase of healthcare from non-NHS bodies has reduced, this is to ensure the accurate mapping of the primary care PMS premium

Other Professional Fees excl Audit includes Legal Fees of £60k in 2017/18 (in 16/17 £63k)

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**37,491**	**130,975**	39,509	127,046
Total Non-NHS Trade Invoices paid within target	**36,472**	**129,293**	37,427	123,831
Percentage of Non-NHS Trade invoices paid within target	**97.28%**	**98.72%**	**94.73%**	**97.47%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,178**	**124,710**	2,198	119,969
Total NHS Trade Invoices Paid within target	**2,173**	**124,695**	2,189	119,964
Percentage of NHS Trade Invoices paid within target	**99.77%**	**99.99%**	**99.59%**	**99.99%**

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 2018 (31 March 2017: £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 2018 (31 March 2017: £NIL).

9. Other Gains & Losses
The CCG had no other gains and losses as at 31 March 2018 (31 March 2017: £NIL).

10. Finance Costs
The CCG had no finance costs as at 31 March 2018 (31 March 2017: £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 with a review in 2018, the CCG has taken advantage of the break clause & is in a period of notice up to September 2018 on this lease. There are no purchase options or escalation clauses. The lease restrict that the properties can be used as office accommodation only.

12.1.1 Payments recognised as an Expense

	Land £'000	Buildings £'000	Other £'000	2017-18 Total £'000	2016-17 Total £'000
Payments recognised as an expense					
Minimum lease payments	0	76	9	**85**	78
Total	**0**	**76**	**9**	**85**	**78**

12.1.2 Future minimum lease payments

	Land £'000	Buildings £'000	Other £'000	2017-18 Total £'000	2016-17 Total £'000
Payable:					
No later than one year	0	38	5	**43**	79
Between one and five years	0	0	13	**13**	227
Total	**0**	**38**	**18**	**56**	306

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 2018 (31 March 2017: £NIL).

13. Property, Plant & Equipment
The CCG had no property, plant & equipment as at 31 March 2018 (31 March 2017 : £NIL).

14. Intangible Assets
The CCG had no intangible Assets as at 31 March 2018(31 March 2017: £NIL).

15. Investment Property
The CCG had no investment property as at 31 March 2018 (31 March 2017: £NIL).

16. Inventories
The CCG had no inventories as at 31 March 2018 (31 March 2017: £NIL).

17 Trade and other receivables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	104	0	135	0
NHS prepayments	618	0	676	0
NHS accrued income	197	0	5	0
Non-NHS and Other WGA receivables: Revenue	3,188	0	4,564	0
Non-NHS and Other WGA prepayments	740	0	730	0
Non-NHS and Other WGA accrued income	1,196	0	910	0
Provision for the impairment of receivables	(3,056)	0	(3,244)	0
VAT	108	0	0	0
Other receivables and accruals	769	0	755	0
Total Trade & other receivables	**3,864**	**0**	**4,531**	**0**
Total current and non current	**3,864**		**4,531**	
Included above:				
Prepaid pensions contributions	0		0	

The 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 £769k in relation to the Adult Social Care partnership agreement (16/17: £754k).

17.1 Receivables past their due date but not impaired	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	0	(178)	(289)
By three to six months	0	(168)	(312)
By more than six months	0	(90)	(90)
Total	**0**	**(436)**	**(691)**

Since the statement of financial position date, all of the debt more than 6 months old and not impaired has been received.

17.2 Provision for impairment of receivables	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	0	(3,244)	(2,789)
Amounts written off during the year	0	316	180
Amounts recovered during the year	0	641	501
(Increase) decrease in receivables impaired	0	(769)	(1,136)
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**0**	**(3,056)**	**(3,244)**

Provisions relate to 2 main areas :
- Debtors ledger income
- House Sale income which is collected from clients for residential & nursing care

	2017-18 £'000	2016-17 £'000
Receivables are provided against at the following rates:		
NHS debt & Adult Social Care -0 - 6 Months	0%	0%
7 - 9 Months	25%	25%
10 -12 Months	50%	50%
1 - 2 years	75%	75%
Over 2 years	100%	100%

18. Other financial assets

The CCG had no other financial assets as at 31 March 2018 (31 March 2017: £NIL).

19. Other current assets

The CCG had no other current assets as at 31 March 2018 (31 March 2017: £NIL).

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	10	13
Net change in year	3	(3)
Balance at 31 March 2018	**13**	**10**
Made up of:		
Cash with the Government Banking Service	13	10
Cash and cash equivalents as in statement of financial position	**13**	**10**
Balance at 31 March 2018	**13**	**10**
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 2018 (31 March 2017: £NIL).

22. Analysis of Impairments & Reversals

The CCG had no impairments or reversals recognised in expenditure during 2017-18 (2016-17: £NIL).

23 Trade and other payables	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS payables: revenue	276	0	1,451	0
NHS accruals	1,443	0	884	0
Non-NHS and Other WGA payables: Revenue	271	0	1,045	0
Non-NHS and Other WGA accruals	10,971	0	10,208	0
Non-NHS and Other WGA deferred income	18	0	26	0
Social security costs	47	0	43	0
VAT	0	0	33	0
Tax	39	0	39	0
Other payables and accruals	97	2,163	149	3,191
Total Trade & Other Payables	**13,162**	**2,163**	**13,878**	**3,191**
Total current and non-current	**15,325**		**17,069**	

Other payables include £62k outstanding pension contributions at 31 March 2018 (31 March 2017: £55k).

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 2018 (31 March 2017: £NIL).

25. Other Liabilities

The CCG had no other liabilities as at 31 March 2018 (31 March 2017: £NIL).

26. Borrowings

The CCG had no borrowings as at 31 March 2018 (31 March 2017: £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 2018 (31 March 2017: None).

28. Finance Lease Obligations
The CCG had no finance lease obligations as at 31 March 2018 (31 March 2017: None).

29. Finance Lease Receivables
The CCG had no finance lease receivables as at 31 March 2018 (31 March 2018: None).

30 Provisions

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Continuing care	338	0	421	0
Other	1,278	0	426	0
Total	**1,616**	**0**	**847**	**0**
Total current and non-current	**1,616**		**847**	

	Legal Claims £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2017	**0**	**421**	**426**	**847**
Arising during the year	0	0	852	852
Utilised during the year	0	(33)	0	(33)
Reversed unused	0	(50)	0	(50)
Balance at 31 March 2018	**0**	**338**	**1,278**	**1,616**
Expected timing of cash flows:				
Within one year	0	338	1,278	1,616
Balance at 31 March 2018	**0**	**338**	**1,278**	**1,616**

Other provisions relate to three adult social care provisions, and one health provision:

- Adult Social Care ordinary residency case
- Transitional support relating to redesign of Supported Living service (previous years)
- Section 117 reimbursement of client contributions (previous years)
- Dilapidation costs for CCG office.

It is anticipated these provisions will be utilised in full during 2018/19

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 2018 is £75.5k (31 March 2017 is £370k).

31. Contingencies
The CCG had no borrowings as at 31 March 2018 (31 March 2017: £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 2018 (31 March 2017: £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 2018 (31 March 2017: £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'	Loans and Receivables	Available for Sale	Total
	2017-18 £'000	**2017-18 £'000**	**2017-18 £'000**	**2017-18 £'000**
Receivables:				
· NHS	0	301	0	301
· Non-NHS	0	4,384	0	4,384
Cash at bank and in hand	0	13	0	13
Other financial assets	0	769	0	769
Total at 31 March 2018	**0**	**5,467**	**0**	**5,467**

	2016-17 £'000	2016-17 £'000	2016-17 £'000	2016-17 £'000
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 2018	**0**	**6,378**	**0**	**6,378**

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2017-18 £'000	**2017-18 £'000**	**2017-18 £'000**
Payables:			
· NHS	0	1,718	1,718
· Non-NHS	0	13,503	13,503
Total at 31 March 2018	**0**	**15,221**	**15,221**

	2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Payables:			
· NHS	0	2,335	2,335
· Non-NHS	0	14,595	14,595
Total at 31 March 2018	**0**	**16,930**	**16,930**

34. Operating Segments

2017/18	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Health	235,931	(7,280)	**228,651**	1,299	(9,904)	**(8,605)**
Adult Social Care	50,743	(50,743)	**0**	2,578	(7,037)	**(4,459)**
Total	**286,674**	**(58,023)**	**228,651**	**3,877**	**(16,941)**	**(13,064)**

2016/17	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'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)**

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	2017-18 **£'000**	2016-17 **£'000**
NELC Allocation	39,132	39,844
Other Contributions*	11,611	12,076
Total Social Care Expenditure	(50,743)	(51,920)
Total	-	-

*Other Contributions, includes £4.233m 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	2017-18 **£'000**	2016-17 **£'000**
Underspend b/f	521	0
Allocation (Health)	11,357	11,157
Allocation (North East Lincolnshire Council)	2,665	2,188
Allocation IBCF	4,091	0
Health Expenditure	(11,215)	(7,137)
Adult Social Care expenditure	(6,560)	(5,687)
Total	859	521

The £338k underspend in 2017/18 relates to slippage on capital schemes funded from North East Lincolnshire Council allocation. The council will make the funding available for use in 2018/19 and will be used to support the roll out of transformational schemes.

36. NHS LIFT Investments

The CCG had no NHS LIFT investments as at 31 March 2018 (31 March 2017: £NIL).

37. Related Party Transactions

Details of related party transactions with individuals are as follows:

The Department of Health & Social Care 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.

Note that these amounts in the following table are for the full year, although 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.

The amounts shown in the following table relate to the total payments to the related party mentioned, and not amounts that the individual is responsible for.

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
Cllr Jane Hyldon-King				
NELC nominated member of Partnership Board				
Portfolio Holder for Health, Wellbeing and Adult Social Care – North East Lincolnshire Council	5,308	(18,174)	337	(810)
NAViGO	25,698	(1)	1	-
Cllr Matthew Patrick				
NELC Representative				
Portfolio Holder for Finance and Resources - North East Lincolnshire Council	5,308	(18,174)	337	(810)
Cllr Peter Wheatley				
Partnership Board/Integrated Governance & Audit Committee/Remuneration Committee member				
Councillor – North East Lincolnshire Council	5,308	(18,174)	337	(810)
Trustee of Hull and East Yorkshire and Grimsby MIND	4	-	-	-
Dr Arun Nayyar				
Partnership Board GP representative				
Core Care Family Practice Grimsby & Beacon Medical Centre are members of 360 Care Limited	448	-	32	-
Core Care Family Practice Grimsby and Beacon Medical Centre are members of the Panacea Collaborative - a federation of GP practices	614	-	-	-
Director of Core Care Links Ltd	1,972	-	37	-
GP Partner - Beacon Medical Centre	278	-	26	-
GP Partner - Core Care Family Practice Grimsby – Cromwell Primary Care Centre	9	-	-	-
Dr David Elder				
Member of Remuneration Committee/Council of Members				
Engaged with Birkwood Surgery in joint delivery of drug services	269	-	32	-
Engaged with Chantry Surgery in joint delivery of drug services	373	-	50	-
Engaged with Woodford Surgery in joint delivery of drug services	349	-	17	-
Partner in Humberview Surgery	52	-	11	-
Partner in Pelham Medical Group	331	-	25	-
Practice provides an enhanced service for substance misuse to our own patients only, under a contract with NE Lincs Council	5,308	(18,174)	337	(810)
Dr Derek Hopper (Left Feb 2018)				
Partnership Board/Council of members/Joint Co-Commissioning Committee				
Partner at Fieldhouse Medical Centre (Freshney Green) - now retired	522	-	21	-
Dr Ekta Elston				
NEL CCG Medical Director				
Partner GP at The Roxton, Immingham	1,265	-	86	-
Partner GP at The Roxton, Weelsby View, Grimsby	61	-	-	-
Roxton practice is a member of 360 Care Limited (a provider of NHS services)	448	-	32	-
Dr Karin Severin				
Council of Members/ Integrated Governance & Audit Committee				
GP Partner – Birkwood Medical Centre	269	-	32	-
Birkwood Medical Centre is a member of 360 Care Limited (a federation of GP practices)	448	-	32	-
Birkwood Medical Centre is a member of the Panacea Collaborative - a federation of GP practices	614	-	-	-
Foundation Year Two Supervisor North Yorkshire & Humber Appraiser (NHS England)	240	(2,957)	109	(12)
Dr Peter Melton				
Clinical Chief Officer				
GP Principal The Roxton Practice, Immingham	1,265	-	86	-
GP Principal at Roxton at Weelsby View, , Grimsby	61	-	-	-
Roxton practice is a member of 360 Care Limited (a federation of GP practices) & LINCS and wife is employed by 360 Care Ltd	448	-	32	-

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
Dr Rakesh Pathak				
Partnership Board GP representative				
Director of 360 Care Ltd (a federation of GP Practices)	448	-	32	-
Director of Core Care Links Ltd (a provider of primary care services in NEL)	1,972	-	37	-
GP Principal – Raj Medical Centre	173	-	21	(11)
Raj Medical Centre is a member of the Panacea Collaborative - a federation of GP practices	614	-	-	-
Dr Thomas Maliyil				
NELCCG Clinical Lead/Partnership Board/Council of Members/Remuneration Committee				
Director of Core Care Links Ltd	1,972	-	37	-
GP at Healing Health Centre	41	-	7	-
GP Partner – Core Care Family Practice, Cromwell Primary Care Centre	9	-	-	-
Healing Health Centre and Core Care Family Practice are members of the Panacea Collaborative – a federation of GP practices	614	-	-	-
Healing Health Centre Practice and Core Care Family Practice are members of 360 Care Ltd (a provider of NHS services)	448	-	32	-
Eddie McCabe				
NEL CCG Assistant Director Contracting & Performance				
Friend of the Managing Director of Roxton Practice	1,265	-	86	-
Governor for NELCCG at North Lincolnshire & Goole Hospital	104,547	-	1,003	(656)
Helen Kenyon				
NEL CCG Deputy Chief Executive				
Sue Rogerson is a personal friend who is a director of SJW Solutions in Partnership.	94	-	7	-
Joanne Hewson				
Deputy Chief Executive - North East Lincolnshire Council				
Deputy Chief Executive -North East Lincolnshire Council	5,308	(18,174)	337	(810)
Joe Warner				
Social Care Representative				
Chief Executive - Focus Adult Social Care Social Enterprise	5,727	-	38	-
Juliette Cosgrove				
NELCCG Partnership Board Clinical Lay Member				
Assistant Director to the Medical & Nurse Directors at Calderdale & Huddersfield NHS Foundation Trust	18	-	3	-
Husband is a Consultant Neurosurgeon at Lancashire Teaching Hospital NHS Trust	1	-	3	-
Mark Webb				
CCG Chair/Partnership board member/Remuneration committee member				
Managing Director – E-Factor Ltd	1	-	-	-
Phillip Bond				
Partnership Board Lay member Community Engagement/ Integrated Governance & Audit committee member				
Cousin is employed in a senior position at North Lincolnshire and Goole NHS Foundation Trust	104,547	-	1,003	(656)
Registered carer under the Carers Support Service which receives some funding from NELCCG	430	-	-	(25)
Rob Walsh				
Joint Chief Executive NELCCG/NELC				
Chief Executive - North East Lincolnshire Council	5,308	(18,174)	337	(810)
Governor, Grimsby Institute of Further and Higher Education	1	-	-	-
Stephen Pintus				
Partnership Board NELC Officer member				
Director of Public Health – North East Lincolnshire Council	5,308	(18,174)	337	(810)
Tim Render				
Lay Community Member Governance & Audit				
Independent Chair Audit & Governance Committee - North East Lincolnshire Council	5,308	(18,174)	337	(810)

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 2018 (31 March 2017: 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:

	2017-18 Target £	**2017-18 Performance £**	**2016-17** Target £	**2016-17** Performance £
Expenditure not to exceed income	**237,337**	**235,930**	235,511	228,771
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	**230,057**	**228,650**	232,724	225,984
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	**3,674**	**3,356**	3,638	3,292

It should be noted that the table above only relates to NHS funding. The CCG also receives £39.1m from North East Lincolnshire Council. This is a pooled budget arrangement under Section 75 of the National Health Service Act 2006, see note 35.

In 2017/18, the CCG received revenue resource of £236,797k from NHS England, including £6,740k relating to cumulative surplus. In the table above the revenue resource does not include this element of cumulative surplus.

The £8,147k reported surplus comprises of three elements:
a) The CCGs planned surplus of £6,740k
b) £1,127k impact of the release of the system risk reserve, which the CCG has been mandated by NHS England to release.
c) £280k impact of the release of the CAT M prescribing rebate, 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 2017-18 financial year.

42. Analysis of Charitable Reserves

The CCG held no charitable reserves as at 31 March 2018 (31 March 2017: 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 2018 was £34.3 million **(**31 March 2017 was £33.6 million).

Assets	**Value at 31-March-2018 £000**	**Value at 31-March-2017 £000**
Equity Securities	11,623	12,379
Debt Securities	4,525	3,542
Private Equity	1,533	1,572
Real Estate	3,881	3,935
Investment Funds & Unit Trusts	11,768	11,224
Cash & Cash Equivalents	970	983
Total	**34,300**	**33,635**

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-2018 £000**	**31-March-2017 £000**
Fair Value of Employer Assets	34,300	33,635
Present Value of Funded Obligations	(36,463)	(36,826)
Net Asset/(Liability)	**(2,163)**	**(3,191)**

Recognition in the profit or loss	**31-March-2018 £000**	**31-March-2017 £000**
Current service cost	64	31
Interest Cost	949	1,055
Expected Return on Employer Assets	(869)	(982)
Past Service Cost / (Gain)	0	0
Losses / (Gains) on Curtailments and Settlements	0	0
Total	**144**	**104**

Reconciliation of defined benefit obligation	**31-March-2018 £000**	**31-March-2017 £000**
Opening Defined Benefit Obligation	36,826	30,537
Current Service Cost	64	31
Interest Cost	949	1,055
Contribution by Members	10	9
Actuarial Losses/(Gains)	(692)	5,981
Past Service Costs / (Gains)	0	0
Losses / (Gains) on Curtailments	0	0
Estimated Benefits Paid	(694)	(787)
Closing Defined Benefit Obligation	**36,463**	**36,826**

43. FRS Accounting Information - Pensions (Continued)

Reconciliation of fair value of employer assets	31-March-2018	31-March-2017
	£000	£000
Opening Fair Value of Employer Assets	33,635	28,426
Expected Return on Assets	869	982
Contributions by Members	10	9
Contributions by the Employer	322	47
Actuarial Gains/(Losses)	156	4,958
Estimated Benefits Paid	(692)	(787)
Total actuarial gain (loss)	**34,300**	**33,635**

Amounts for the current and previous accounting periods	31-March-2018	31-March-2017
	£000	£000
Fair Value of Employer Assets	34,300	33,635
Present Value of Defined Benefit Obligation	(36,463)	(36,826)
Surplus / (deficit)	(2,163)	(3,191)
Experience Gains/(Losses) on Assets	156	4,958
Experience Gains/(Losses) on Liabilities	(694)	254

Cumulative Statement of Recognised Gains / Losses	31-March-2018	31-March-2017
	£000	£000
Actuarial Gains and Losses	156	4,958
Effect of Surplus Recovery Through Reduced Contributions	694	(5,981)
Actuarial Gains / (Losses) recognised in STRGL	850	(1,023)
Cumulative Actuarial Gains and Losses	(2,543)	(3,393)

44. Losses & Special Payments

In 2017/18 there was 1 loss of minor equipment at a value of £753. In 16/17 There was 1 loss of minor equipment at a value of £660. Please see note 17.2 for details of the provision for impairment of receivables

The CCG had no special payment cases during 2017/18 (2016/17: None)

45. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	(228,650)
Impairment of receivables	(187)
Pension charge	(178)
Net operating costs for the financial year per cash flow	**(229,015)**

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